Report Number : ICRR0020433

1. Project Data

Project ID	Project Name
P082672	VN-Northern Upland Health Support Proje
Country	**Practice Area(Lead)**
Vietnam	Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-43980	31-Aug-2014	66,000,000.00
Bank Approval Date	**Closing Date (Actual)**	
13-Mar-2008	29-Feb-2016	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	60,000,000.00	0.00
Revised Commitment	58,277,237.03	0.00
Actual	56,697,996.48	0.00

Prepared by	Reviewed by	ICR Review Coordinator	Group
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2. Project Objectives and Components

a. Objectives

The objective of the Project was "to increase the utilization of district health services, especially among the poor and ethnic minorities population of the Northern Upland Provinces through improving the quality of district-level hospitals and reducing financial constraints to access health services" (Financing Agreement, 7/10/2008, p. 5). The PAD's statement is materially consistent with the Legal Agreement.

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

No

c. Will a split evaluation be undertaken?

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d. Components

Component 1: Strengthening District-level Health Services (Appraisal US$ 42.90 million; Actual US$40.40 million).
Improving the quality of district hospitals through the following: (a) human resources development, including strengthening health workforce capacity and expertise, increasing staff retention, and provision of long-term training for doctors and specialists; (b) improving the quality of district hospitals through the provision of basic medical equipment and selective facility repair and refurbishment; and (c) improving hospital management by creating a management environment that would sustain project outcomes.

Component 2: Increasing Financial Access to Healthcare Services for Decision 139 Beneficiaries (Appraisal US$10.0 million; Actual US$10.03 million).
Addressing demand-side constraints of access to services, the component included: (a) support for direct catastrophic and nonmedical expenditures of health care for Decision 139 beneficiaries; (b) strengthening the capacity of Health Care Funds for the Poor through institutional capacity-building activities to increase the financial capacity of the district hospitals to enroll beneficiaries and recover the medical expenses incurred by them; and (c) strengthening local access to health services through promoting health seeking behavior, and increasing knowledge and understanding of the rights, entitlements, and benefits covered by Health Care Funds for the Poor among the beneficiary population through information, education and communication campaigns.

Component 3: Monitoring, Evaluation, and Project Management (Appraisal US$13.10 million; Actual US$9.71 million).
Setting up and managing the Central Project Management Unit and the Provincial Project Management Units through: (a) consulting services for technical issues, procurement, financial management, and disbursement; (b) training of project management staff; (c) provision of necessary office equipment; (d) financing of incremental operating costs; and (d) M&E activities, including baseline data collection, indicator updates, midterm review, and end-of-project completion report and audits. This component also included the streamlining of the Ministry of Health internal procurement review and approval processes.

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

Project costs, financing, and Borrower contribution. The original project cost at appraisal was estimated at US$66 million, including an original IDA credit commitment of US$60 million, and an estimated Borrower contribution of US$6 million. Due to exchange rate loss, the final project cost amounted to US$58.4 million, including an actual IDA credit of US$56.7 million, and an actual Borrower contribution of US$1.73 million. US$1.0 million was returned to the Bank.

Dates. The project became effective on 10/08/2008 and underwent a mid-term review on 07/16/2012. A level-2 restructuring on 08/29/2014 extended the closing date by 18 months, from 8/31/2014 to 2/29/2016, and marginally reallocated the remaining funds. The main reasons for the extension were to ensure proper management of Health Care Funds for the Poor in the provinces, continue training activities, and strengthen technical assistance for health services with emphasis on maternal and child health care related to the achievement of the Millennium Development Goals. The project closed on 2/29/2016.

3. Relevance of Objectives & Design

a. Relevance of Objectives

At appraisal, the project was responsive to the needs of the Northern Upland Provinces as they lagged behind the national average in health indicators. The infant mortality rate was 60 per 1,000 live births compared to the national average of 18 per 1,000 live births, and fewer than 20% of births by ethnic minority women were attended by qualified personnel compared to a majority of attended births elsewhere. The district hospitals of the Northern Upland Provinces lacked qualified human resources, had poor physical infrastructure, poor quality of services, and difficult access, all resulting in poor utilization of services by the poor and ethnic minorities. The Northern Upland Provinces constitute the most disadvantaged region in Vietnam, with the highest concentration of poor and ethnic minorities. The vast majority of the population in the Northern Upland Provinces are poor. This includes ethnic minorities (82%) and non-ethnic minorities (18%). The Northern Upland Provinces account for 74% of the country's poor, and yet they constitute only 15% of the country's population (TTL clarification, 9/21/2016).

The project was responsive to the country's goal to address health disparities across the regions, and was aligned with country's Health Sector Development Plan (2011–2015) as it supported the government health policy to improve equity in achieving health outcomes at the regional level. The operation was a priority to the Ministry of Health and provincial authorities because of its relevance to reducing inequities in health coverage, strengthening district hospital performance, and contributing to meet health care needs of mountainous areas under the Vietnamese Health Reform priorities. The project was aligned with Vietnam's Country Partnership Strategies 2007–2011 and 2012–2016 in terms of priorities for the health sector, notably for strengthening social inclusion and assuring economic growth and social equity by improving social services to the poor and marginalized groups.

Relevance of objectives remained high at project closing. In 2016, the Vietnamese Government and the World Bank launched the "Vietnam 2035 Agenda," with which the project objectives are in line, and in particular, the objective of increasing access to quality health services for the poor. The Vietnam 2035 Agenda states that "the major policy challenge facing Vietnam's health system over the next 20 years will be to achieve universal health coverage, that is, to ensure that everyone has access to quality services without suffering financial hardship."

Rating
High

b. **Relevance of Design**

Relevance of project design was consistent with the stated objective to increase the utilization of district health services especially among the poor and ethnic minorities of the Northern Upland Provinces. The design of project interventions laid out a coherent results chain that reflected a plausible pathway leading to increased utilization and had a clear underlying logic linking funding and planned activities to outputs and intermediate outcomes to improved utilization of health services. The strengthening of district-level health services, including human resources, quality and management of hospital services, facility repair, and the provision of basic medical equipment, were expected to contribute to increased service utilization. Capacity building of Health Care Funds for the Poor, and increasing the financial capacity of the district hospitals to enroll beneficiaries, were reasonably expected to improve access to the poor and ethnic minorities. Information, education and communication were also expected to enhance health-seeking behavior and to promote the utilization of health services.

Rating
Substantial

4. Achievement of Objectives (Efficacy)

Objective 1
Objective
Increase the utilization of district health services especially among the poor and ethnic minorities population.

Rationale
Outputs
The project strengthened human resources development by providing long-term training to 1,058 assistant doctors, 377 specialist doctors, and 98 assistant pharmacists, out of whom ethnic minorities represented 54%, 48%, and 32% respectively. It provided short-term training to 3,414 medical doctors and 336 preventive care staff. 1,542 health staff were trained on Millennium Development Goals with a focus on maternal and child mortality. Under the project, 753 staff were trained on hospital management, 400 staff on health management information systems, 200 staff on maintenance of equipment, and 3,400 staff on medical waste management. Technical support was provided to district hospitals by 670 provincial doctors. The project allowed the recruiting of retired doctors in district hospitals and centers during the training periods of health staff to facilitate the continuity of services.

The project upgraded 18 district hospitals, and provided ambulances and 4,400 units of medical equipment in four areas: laboratory, treatment, monitoring devices and ventilators, and infection control.

The project provided capacity building at the district level to manage Health Care Funds for the Poor, and provided office equipment and incremental operating costs for the project management units at the center and in the districts, and to M&E activities and surveys. The project supported monetary allowances for nonmedical expenditures to poor and ethnic minority beneficiaries, covering the cost for travel and meals for those seeking health care at district hospitals. Information, education and communication activities were carried out in 880 communities.

Outcomes
Utilization rates of out-patient health services in district hospitals by the target population, which was qualified by the government as "Decision 139 beneficiaries", showed about a four-fold increase, from a baseline of 0.067% in 2009 to 0.247% in 2015, exceeding the target of 0.075% (The scale of the measures used was small because the denominator used was 100 inhabitants; a larger denominator could have been adopted to better illustrate the rate change). Utilization rates of in-patient services in district hospitals also showed a four-fold increase. The proportion of district hospitals that provided a full set of health services according to national norms increased from 39.1% in 2009 to 80.4% in 2015, surpassing the target of 71.4%. The percentage of households experiencing catastrophic healthcare expenditures in the preceding year was reduced from a baseline of 14.3% in 2008 to 2% in 2014, surpassing the target of 13.2%. However, the ICR did not provide contextual information on larger factors, such as the 2008 economic crisis, that may also have affected such expenditures. Progress in the intermediate indicators reflecting quality improvements was also noted, including health workers' knowledge, schedule and budget for maintenance, adherence to treatment protocols, and budget allocations for infrastructure and equipment. Patient satisfaction with health services in project areas increased from a baseline of 8.5% in 2009 to 84.4% in 2014, surpassing the target of 10.2%.
The information provided by the ICR supports the conclusion that the project achieved its intended outcomes, although relevant comparisons across the country would have been helpful to further illustrate the reported improvements.

Rating
Substantial

5. Efficiency

The PAD did not include a cost-benefit analysis, and stated that a quantitative economic analysis based on costs was not feasible because there was no empirical basis for estimating the project's health outcome costs. Neither an economic rate of return nor a net present value of the benefits of the project was calculated/forecasted during appraisal. The expected benefits were associated with health outcome improvements and the narrowing of the health spending gap between the poor and the average population. The PAD expected the benefits to be achieved by: (a) improved efficiency in service delivery by increasing

the supply of skilled human resources and refurbishing and equipping the district hospitals; (b) improved efficiency for the poor in accessing health services by removing financial barriers to increased service utilization; and (c) reduced risk of impoverishment for the poor and ethnic minority populations.

The ICR presents an economic analysis based on: (a) the rationale of the government investment in the region based on the unfavorable socioeconomic and health conditions; (b) efficiency in achieving access; (c) the project's contribution to increased health benefits; and (d) the impact of project interventions on equity in access, and health spending benefiting the poor and ethnic minorities. The ICR states that project investments improved the coverage and quality of health services, and increased efficiency on both the supply and demand side of health care. On the supply side, there were improvements in the outputs of district-level health services, and on the demand side, there was increased utilization of cost-effective health interventions by poor and ethnic minorities, whose previous levels of health care utilization were considerably lower than those of other social groups in the country. The ICR's economic analysis concludes that: (a) the project was efficient in delivering its outputs, reducing unitary costs for training, equipment installation, and civil works during implementation; and that (b) the project interventions and subsidies to the target population were efficient and contributed to reducing maternal, neonatal, and infant mortality, improved equity in access to health care, and reduced spending on health care by the poor and ethnic minorities.

Project resources were used to support important interventions that are known to be cost-effective. Improving access to mother and child health interventions is recognized by international experience as a cost-effective investment. A substantial part of the project's interventions was focused on reducing maternal, newborn, and child morbidity and mortality. A recent 2016 publication by the World Bank, *Disease Control Priorities: Reproductive, Maternal, Newborn, and Child Health*, shows high returns for interventions aimed at increasing coverage of services where good evidence exists for demand-side interventions to motivate service uptake. The project interventions contributed to the reduction in infant mortality and maternal mortality in the Northern Upland Provinces. Infant mortality decreased from 31.1 to 29.4 deaths per 1,000 live births, and maternal mortality from 178 to 106 deaths per 100,000 live births between 2008 and 2014. The targeting of resources on identified barriers, such as financial barriers and service quality, shows judicious use of resources. The equipment installed by the project achieved a satisfactory level of utilization, and the project results survey showed that 95% of the equipment was delivered, installed, and effectively used. Only 1.4% of the installed equipment was broken, and 3.9% was unused because of lack of technical skills or utility/infrastructure constraints.

Some shortcomings in the efficiency of implementation were observed, including slow initial implementation during the period 2008-2012, after which implementation improved and was largely on track till project closing in 2016. There was one project extension, and there were variable delays in M&E reporting at the provincial levels caused by delays at the weaker lower levels in the communes and districts (TTL clarifications, 9/21/2016).

Efficiency Rating
Substantial

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

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

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

6. Outcome

Relevance of objectives is rated High as they are responsive to the needs of the Northern Upland Provinces, which lagged behind the national average in health indicators. These provinces constitute the most disadvantaged region in Vietnam with the highest concentration of poor and ethnic minorities. The objectives are consistent with the strategies of the country and the Bank. Relevance of design is rated Substantial as the design of project interventions laid out a coherent results chain that reflected a convincing pathway leading to increased utilization of district health services with a clear underlying logic, linking funding and planned activities to outputs and intermediate outcomes to improved utilization of health services. The objective to increase utilization of district health services, especially among the poor and ethnic minorities, was achieved and is rated Substantial. Human resources development was extensive. Efficiency is rated Substantial as the project's interventions were cost-effective, but with some shortcomings in the efficiency of implementation. Taken together, these ratings are indicative of minor shortcomings in the project's preparation and implementation, and therefore an Outcome rating of Satisfactory.

a. Outcome Rating

Satisfactory

7. Rationale for Risk to Development Outcome Rating

The Risk that development outcomes will not be maintained is rated Modest for several reasons. Government ownership is strong, and the health care policies governing ethnic minorities are institutionalized. These policies have widespread social and stakeholder support, and are not likely to be reversed in the short run. Commitment is reflected in the budgets of the provincial governments to retain skilled human resources in district hospitals, to maintain facilities and equipment, and to implement policies addressing the needs of ethnic minorities. The provinces have committed to provide training support for doctors in the Northern Upland Provinces if they seek specialization in surgery and trauma care. District hospitals have developed plans to maintain regular training in the future. The government has created a supportive policy environment to sustain progress (see Section 9). The technical programs are sound, and the enhancement in human resources and in the delivery of district health care has been significant, hence the short-term and mid-term outlook for

continued progress appears to be favorable. However, despite government provisions, the localities still face limited budgets, creating some uncertainty regarding the future adequacy of financial resources to guarantee the continuation of outcomes after project closing (ICR, p. 24). These concerns are exacerbated when comparisons are made with national and provincial hospitals that have more flexibility to increase their revenues and to charge the real costs of services in contrast with the Northern Upland district hospitals that cater to a majority poor population. The ICR states that the government is introducing mechanisms to strengthen the financial sustainability of district services, including the use of government bonds. It also notes that Vietnam's rapid economic growth would contribute to enhancing the sustainability of provincial health budgets and district hospitals (ICR, p. 22).

a. Risk to Development Outcome Rating

Modest

8. Assessment of Bank Performance

a. Quality-at-Entry

The Bank performed effectively in collaborating with the government to identify, facilitate preparation, and appraise the operation. The strategic relevance was high as the thrust of the operation was to address health disparities and to meet the needs of disadvantaged populations. The Bank incorporated lessons learned from previous projects into the design, namely the Mekong Health Support Project and the National Health Support Project. Lessons included the importance of addressing capacity needs in the provinces, maintaining flexibility in blue print investments to adapt to local conditions, and providing attention to demand-side interventions. Project development was consistent with the Bank's fiduciary role. The Bank Team provided added focus on institutional arrangements to facilitate implementation, including a Central Project Management Unit and Provincial Project Management Units, although the Bank could have further addressed the low institutional capacity for M&E. Environmental aspects were adequately addressed through an assessment of health care waste management and the development of a related plan. Risks were identified and mitigation measures were prepared. Ethnic minority policies and poverty aspects were well addressed and were central to the project's thrust in deprived areas.

Quality-at-Entry Rating

Satisfactory

b. Quality of supervision

Supervision and implementation support were effective and pro-active with a focus on results. The task team conducted 11 implementation support missions during the project life. Financial management and safeguards implementation support missions were also performed effectively. The project had four Task Team Leaders (TTLs), and from 2010 onwards, the TTL was field-based. Thus the project benefited from the Bank's country

presence as the TTL and the Central Project Management Unit were in close communication. Fiduciary technical support was readily available to assist in identifying arising issues and exploring solutions. The Borrower's report (Annex 6) recognizes the responsiveness of the Bank's Team and its promptness. Reporting was adequate. Environmental and social safeguards were monitored.

Quality of Supervision Rating
Satisfactory

Overall Bank Performance Rating
Satisfactory

9. Assessment of Borrower Performance

a. Government Performance
Government commitment and ownership were substantial. The government created an enabling environment with favorable policies. Several provisions underlined this commitment: The government issued national norms to create Provincial Health Funds to establish incentives for keeping health care providers in mountainous provinces, as well as national norms on the provision of a full set of health services. Decision 14, issued by the Prime Minister, allowed the provinces to use their fiscal revenues to support transportation and meals to the poor. Decision 38, issued in 2012, allowed the use of district hospital revenues to maintain and buy new equipment. The government established a project steering committee that functioned effectively to solve arising issues facing the project. The Ministry of Health was fully involved in project preparation and implementation. Stakeholders were consulted and field visits were organized to establish links and networks with local government authorities. The Ministry of Health issued a handbook for guiding the implementation of the project at the onset of the project. It provided the required budget for communications, supervision, monitoring, evaluation, and travel during project implementation.

Government Performance Rating
Satisfactory

b. Implementing Agency Performance
The Central Project Management Unit and the Provincial Project Management Units were the main agencies responsible for day-to-day implementation. The Central Unit was established with sufficient human resources and capacity, and was effective in coordinating with the various departments of the Ministry of Health, the provinces, and the districts. The Central Unit was committed to achieving development objectives and pro-actively encouraged and enhanced the role of the provinces. It provided support and capacity building to the Provincial Units to enhance their performance in project management, including accounting, procurement, asset management, civil works, and M&E. It was responsive to arising needs through technical support. It was pro-active in facilitating the managerial autonomy of district hospitals and in assisting provincial health departments to improve local health systems in the project

areas. It ensured compliance with the project covenants and safeguards.

Some shortcomings in the performance of the implementing agencies were observed: During the early years of the project and until 2012, implementation was relatively slow, and there were some delays in procurement and in the delivery of procurement packages. Implementation subsequently improved and was on track during the latter years of the project. The performance of the Central Project Management Unit was adequate. The ICR noted mixed performance among the Provincial Project Management Units. The TTL clarified that only two out of seven Provincial Units had lower performance (TTL clarification, 9/21/2016). The main weakness consisted of delays in M&E reporting, which was also dependent on the reporting from the lower and weaker levels at the communes and districts. It is understood that the project covered economically and geographically difficult provinces, which were mountainous and remote. This contributed to weaker capacities and performance at the periphery, but which have improved over time (GP clarifications, 2/9/2017).

Implementing Agency Performance Rating
Moderately Satisfactory

Overall Borrower Performance Rating
Moderately Satisfactory

10. M&E Design, Implementation, & Utilization

a. M&E Design
The M&E design was sound. The indicators reflected the objectives. Since weaknesses in the capacity and quality of the existing health information system were noted at appraisal, the project supplemented the routine system with a survey methodology to provide more reliable information at the start-up, during the mid-course, and before the end of the operation. Apart from the survey plans, institutional arrangements for data collection were not fully addressed, and were dependent on concurrent capacity strengthening. The Bank and the government agreed to conduct the baseline survey during the initial stages of implementation, after which baselines would be either confirmed or adjusted. Hence, most of the baselines and targets were set during the first year of implementation. The ICR stated that the baseline survey should have been been undertaken during project preparation, but the TTL clarified that, while this would have been ideal, there were no funds available for this activity prior to project approval (TTL clarification, 9/21/2016).

b. M&E Implementation
During the implementation period, three surveys associated with project M&E were completed using the same methodology of the initial survey: (a) the baseline survey during the first semester of 2009; (b) the second survey for the mid-term review between November 2011 and May 2012; and (c) around the original project

closing date, in May and June 2014. The Baseline Survey was conducted in June 2009 and published in July 2009, and allowed reliable baselines to be identified and targets to be set. Data from routine information sources and from the surveys were collected and used. Concurrently, the project strengthened the existing system, which was deemed to be weak at appraisal. The Central Project Management Unit and the Provincial Project Management Units developed and maintained their own data records. Progress was monitored on most indicators, but a complete overview was available only after the mid-term survey in 2012. Some Provincial Units had difficulties in the use of definitions and in the calculation of some indicators. Support to M&E was enhanced after the mid-term review through technical assistance and the provision of qualified consultants to help the provinces in improving data reporting and in accurately measuring the indicators. At project closing, the data was reported regularly with the help of consultants, and contributed to the database for the final evaluation.

c. M&E Utilization

M&E findings, notably survey data, were effectively used by the government and the Bank to assess progress towards the attainment of development objectives. The findings were shared with stakeholders. The methodologies used by the project to undertake surveys were used by the government to strengthen its own surveys and its regular information system, centrally and in the districts.

M&E Quality Rating

Substantial

11. Other Issues

a. Safeguards

The project triggered two of the Bank's safeguard policies, and there was compliance with both policies.
Environmental Assessment (OP/BP/GP 4.01). The project was classified under Environmental Category B. At appraisal, health care waste management was identified as a possible area of concern since the project was expected to result in an increased level of activities in health facilities. A Health Care Waste Management Study was completed during project preparation and provided recommendations on mitigation measures to be undertaken during project implementation. The measures included the preparation of a Health Care Waste Management Plan with specific plans for each district hospital under the project; training and use of information, education, and communication materials on waste management for district hospital staff; procurement of related equipment and supplies; and the introduction of waste water treatment facilities at district hospitals.
Health Care Waste Management Plans were developed and implemented, and the project facilities achieved substantial improvements with reference to the 2007 baseline, when most facilities did not comply with waste management regulations. By the end of the project, most of the district hospitals had a well-prepared Health Care Waste Management Plan and a monitoring program. All project hospitals complied with the regulations on waste segregation and collection. Concerning waste storage, 45% fully complied, and 51% partly complied with the regulations. By project closing, 60% of project hospitals were treating

their hazardous waste. Out of the 65 project hospitals, 59 hospitals have trained their staff.
Some difficulties were encountered in the procurement of related equipment, including changes in the World Bank's policy on the procurement of incinerators.
Indigenous People (OP/BP 4.20). As the majority of project beneficiaries were ethnic minorities, the project itself was considered as an Ethnic Minority Development Plan, and no free-standing Ethnic Minorities Plan or Planning Framework was deemed necessary. A Social Assessment was undertaken. It focused on the cultural dimensions that would have a bearing on project design with regard to both improved service delivery and access to health services. The assessment obtained the views of stakeholders to improve project design and to establish a participatory process for implementation and monitoring. No issues were encountered in the execution of the project in terms of indigenous people, and the satisfaction rate among the beneficiaries was high (see Section 4).

b. Fiduciary Compliance

Financial management. A financial management assessment was conducted in June 2007, and updated in July 2007 and November 2007. The assessment found that financial management capacity at the Ministry of Health, the Provincial Departments of Health, and the district hospitals was low, and that the related risk was substantial. A financial management action plan was developed and included the following: (i) recruitment of capable financial staff at the central and provincial levels; (ii) development of an operations manual covering implementation guidelines and fiduciary requirements; (iii) training on fiduciary aspects; (iv) setting up a computerized accounting system; and (v) strengthening the internal controls and internal audit functions. The interventions resulted in strengthened financial management capacity. The Central Project Management Unit and the Provincial Project Management Units that were responsible for financial management functioned effectively. Financial reports were delivered with satisfactory quality. The audits were unqualified. The audits were delivered on time, except for one audit delay during the whole project period (TTL clarification, 9/21/2016).
Procurement. An assessment of the implementing agency was conducted at pre-appraisal and updated at appraisal. Although the Ministry of Health had previously implemented two Bank-supported projects, it had few experts in procurement of medical equipment through ICB procedures, or in the preparation of technical specifications. During the first three years of implementation, there were variable delays in procurement, many of which were caused by non-responsive bidders (TTL clarifications, 9/21/2016). Post review of procurement found no deviation or non-compliance. At project closing, procurement plans and actions were completed with no pending issues.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

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12. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Satisfactory	---
Risk to Development Outcome	Modest	Modest	---
Bank Performance	Satisfactory	Satisfactory	---
Borrower Performance	Satisfactory	Moderately Satisfactory	The ICRR rates Government Performance as Satisfactory, and Implementing Agency Performance as Moderately Satisfactory because of some shortcomings, including slow project implementation during the first four years, delays in M&E reporting, procurement delays, and mixed performance among the Provincial Project Management Units. The ICR also rates Government Performance as Satisfactory and Implementing Agency Performance as Moderately Satisfactory. If the ICR had aggregated the two ratings as per guidelines, the overall Borrower Performance rating in the ICR would also have been Moderately Satisfactory.
Quality of ICR		Substantial	---

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

13. Lessons

The project has provided a number of lessons (ICR, pp. 27-28), and the following lessons are drawn from the ICR and adapted by IEG:

- **Facilitating the retention of qualified staff at grassroots levels and in district hospitals strengthens the continuity of health services in disadvantaged areas.** Training under the project included a high proportion of ethnic minorities, thus increasing the likelihood that staff would remain in their communities. There was rotation of staff from provincial hospitals, and specialists benefited from supplemental salaries. Educational support was provided to staff who wanted to pursue specialized training. The project assisted the provinces to develop their own health and training plans, including preparatory steps to maintain activities after project closing. However, staff retention at district hospitals remained challenging, and the need for an assessment of existing incentives, and further exploration of innovative mechanisms and incentives to promote future retention, was noted.

- **Investing in district hospital strengthening, notably in medical equipment and human resources, increases the range of services offered in deprived areas and promotes the utilization of services.** The project increased the range of services from 35% to 80% through such investments.

- **Provisions for transportation and meals to the poor and ethnic minorities are effective mechanisms to increase utilization of health services since non-medical expenditures constitute key barriers to these population groups to seek health care.** Appropriate policies and allowances addressed this issue under the project, thus reducing the financial burden for seeking health care.

14. Assessment Recommended?

No

15. Comments on Quality of ICR

The ICR is clearly written, well organized, and captures the project experience. It is results-oriented. The quality of the evidence is adequate. The ICR is consistent, both internally and with the guidelines. It identifies useful lessons derived from project experience. The report could have been more concise. The quality of the ICR is rated Substantial.

a. Quality of ICR Rating

Substantial