Report Number : ICRR0020125

1. Project Data

Project ID P104794	Project Name TP-Health Sector Strategic Plan Support
Country Timor-Leste	Practice Area(Lead) Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
IDA-H3430,TF-91653	30-Jun-2013	38,000,000.00
Bank Approval Date	**Closing Date (Actual)**	
13-Dec-2007	15-Jun-2015	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	1,000,000.00	15,702,800.00
Revised Commitment	1,000,000.00	3,807,825.98
Actual	993,203.96	22,305,025.98

Sector(s)
Health(83%):Central Government(12%):Sub-National Government(5%)

Theme(s)
Health system performance(33%):Child health(17%):Malaria(17%):Nutrition and food security(17%):Population and reproductive health(16%)

Prepared by	Reviewed by	ICR Review Coordinator	Group
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Project ID P144520	Project Name HSSP-SP AF (P144520)
Country Timor-Leste	Practice Area(Lead) Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)

17,700,000.00

Bank Approval Date	Closing Date (Actual)
27-Feb-2013	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	0.00	0.00
Revised Commitment	0.00	0.00
Actual	0.00	0.00

Sector(s)
Public administration- Health(31%):Health(69%)

Theme(s)
Public expenditure, financial management and procurement(34%):Health system performance(66%)

2. Project Objectives and Components

a. Objectives

According to the Financing Agreement (p. 4) and the Project Appraisal Document (PAD, p. 7), the objective was "to improve the quality and coverage of preventive and curative health services, particularly for women and children, in order to accelerate overall progress toward the health Millennium Development Goals."

At a Level 1 restructuring in February 2013, the objectives were revised to: "support the Government of Timor-Leste to get more resources to where they are needed most to improve the delivery of health services in districts and sub-districts" (Project Paper, p. 6).

Because the objectives were materially revised in February 2013, this ICRR will perform a split rating. At this restructuring, US$ 16.24 million, or 73.2% of the total, had been disbursed. Some key targets were revised at an October 2014 restructuring, but because they were output targets, an additional split rating will not be performed.

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

Yes

Did the Board approve the revised objectives/key associated outcome targets?

Yes

Date of Board Approval

27-Feb-2013

c. Components

The original project consisted of four components, intended for implementation through a Sector-Wide Approach (SWAp):

1. Health Service Delivery (appraisal, US$ 12.0 million; actual US$ 4.0 million). This component was to support implementation of a Basic Service Package (BSP) for primary health care, improvements in district-level planning and management capacity, strengthened community nutrition and health services (including contracts with non-governmental organizations to deliver integrated community health events and technical support to MOH), improved hospital care and referral systems (through support for implementation of a Hospital Service Package and "twinning arrangements" to support sub-regional hospitals), and quality care assurance throughout the health system (including improvements in infrastructure and equipment, upgrading of existing Community Health Centers to include maternity rooms and equipment, and efforts to ensure appropriate disposal of biomedical waste).

2. Support Services, Human Resource Development, and Management (appraisal, US$ 4.0 million; actual, US$ 10.4 million). This component was to strengthen the capacity of the Institute of Health Sciences to provide technical and management training to health staff, provide direct support for priority local and international training for the health work force, strengthen procurement and distribution of essential drugs and supplies, and strengthen core Ministry of Health (MOH) support and fiduciary functions, all through technical assistance and training.

3. Coordination, Planning, and Monitoring (appraisal, US$ 2.0 million; US$ 1.7 million). This component was to support the establishment of a Department for Partnership Management (DPM) to strengthen MOH capacity for donor coordination, provision of technical assistance to strengthen the annual planning and budgeting process at the central and district levels, further strengthening of the MOH Health Management Information System (HMIS), the conduct of surveys and evaluations, and improved policy and research capacity within MOH.

4. Innovation and Program Development (appraisal, US$ 2.3 million; actual, US$ 1.3 million). This component was to provide flexible support for piloting new initiatives or further develop promising approaches that emerged during implementation, with likely priorities identified as promotion of community demand for health services, provision of incentives for service providers to attract and retain key health personnel in rural/remote areas, and establishment of effective public-private partnership options and contracting mechanisms. The Rapid Results Initiative approach was to be adapted as a methodology to pilot new initiatives and build local implementation capacity and strengthen focus on results. An MOH committee was to be established to provide oversight and vet proposals for this funding.

At the February 2013 restructuring, three components were added to move away from the SWAp and instead provide more targeted support. At this restructuring, funds from the original project financing continued to be allocated to the original four components, with the new components financed through US$ 17.7 million in Additional Financing (AF). Overall, the restructuring was intended to narrow the project's focus to district service delivery, institutional strengthening, and improved coordination of all development assistance to the health sector:

1. Improving Public Financial Management (PFM) and fund flows for Service Delivery (estimated US$ 12.2 million; actual, US$ 2.2 million). This component was intended to strengthen MOH planning and budgeting systems, advocate for an increase in health budget allocations, and provide flexible and innovative financing for service delivery.

2. Strengthening Pharmaceutical and Medical Supplies (estimated US$ 1.6 million; actual, US$ 0.6 million). This component was to strengthen clinical and logistics management capacity, regulatory capacity, and quality control.

3. Improving Evidence-Informed Decision Making and Health Sector Coordination (estimated US$ 3.9 million; actual, US$ 2.0 million). This component was to support the development and implementation of a monitoring and evaluation (M&E) framework, institutionalization of health sector coordination meetings and joint annual sector reviews, and strengthening of research capacity.

At the October 2014 restructuring, the project was focused on activities with greatest momentum and cancel activities not performing well. US$ 6.9 million in project financing was cancelled. The reduction in the work plan and revised estimated costs by component were:

1. Estimated cost revised from US$ 12.2 million to US$ 3.5 million. Activities to advocate for an increased health budget allocation were cancelled, as development of a Medium-Term Expenditure Framework was postponed to post-project in 2017.

2. Estimated cost revised from US$ 1.6 million to US$ 1.5 million. All activities were cancelled except the development of management capacity, with the remaining focus shifted to planning/forecasting and supply chain systems development.

3. Estimated cost revised from US$ 3.9 million to US$ 1.3 million. Activities on strengthening research capacity were cancelled, with the remaining focus shifted to strengthening M&E and institutionalizing sector coordination.

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

Project Cost: Of the original US$ US$ 20.3 million allocated to the project's original components, US$ 17.4 million was spent, with significantly less allocated than planned directly to health services delivery and significantly more to planning and management. Of the US$ 17.7 million originally allocated to the components that were added at restructuring, US$ 4.8 million was actually spent, with the focus shifted to planning and coordination activities. Total actual project costs were therefore US$ 22.2 million. The difference between planned and actual costs is largely due to narrowing of the project's focus from the point of the 2013 restructuring, in an attempt to strengthen activities with a higher likelihood of success.

Financing: The project was initially to be financed by a US$ 1.0 million International Development Association (IDA) Sector Investment Grant and a US$ 19.3 million contribution from the Australian Agency for International Development (AusAID), with the latter managed by IDA through a Trust Fund. It was anticipated that the proceeds from the IDA Grant and the Trust Fund would be pooled and allocated based on a health sector Medium Term Expenditure Framework and annual MOH work programs. It was also expected (PAD, p. 46) that AusAID would provide an additional US$ 3.5 million to support the project's fifth year, to be approved following a Mid-Term Review after the project's second year.

At the 2013 restructuring, the US$ 19.3 million (from AusAID) Trust Fund was increased to US$ 40.3 million (additional US$ 21.0 million: US$ 11.0 million from AusAID and US$ 10.0 million from the European Union). The ICR (fn 4, p. 3) provides further information that, of the US$ 21.0 million in AF, 1% was allocated to central unit cost recovery and 2.92% to management unit cost recovery, leaving US$ 20.2 million. Of that, US$ 17.7 million was used to finance the added components through a Recipient Executed Trust Fund (RETF). The other US$ 2.5 million was used to finance two Bank Executed Trust Funds, one (US$ 1.0 million) for analytical and advisory services, and the other (US$ 1.5 million) for implementation support. This left US$ 20.3 million in original financing (IDA plus AusAID) and US$ 17.7 million in AF, for a total of US$38.0 million available to the project.

AusAID cancelled US$ 6.9 million at the October 2014 restructuring. With exchange rate adjustments, this brought total project financing to US$ 28.3 million (ICR, p. 5, fn 7). At project closing, approximately US$ 5 million remained in the RETF account. With agreement from AusAID and the EC, that amount is to be transferred to the parent Trust Fund and will be used for technical assistance and advisory services to the government and MOH.

Borrower Contribution: No government contribution was expected or made.

Dates:
March 5, 2012: A Level 2 restructuring amended the Grant Agreement to enable the project to access funds that became available due to exchange rate gains and to reallocate funds across components.
February 27, 2013: A Level 1 restructuring revised the objectives, components, and results framework, extended the closing date from June 30, 2013 to June 15, 2015, and provided Additional Financing (an increased contribution from AusAID and a new contribution from the EU).
October 31, 2014: A Level 2 restructuring narrowed the range of activities and revised output targets accordingly, and the contribution from AusAID was reduced.

3. Relevance of Objectives & Design

a. Relevance of Objectives

The project's original objectives were highly relevant to country conditions at the time of appraisal, government strategy, and Bank strategy. At appraisal, key health sector challenges included high rates of communicable disease, poor health status (especially for women and children), inadequate utilization of low-quality health services, weak budgeting/planning/M&E for health systems, inefficient budget execution, and poor expenditure management. The first pillar of the Bank's Country Assistance Strategy at appraisal (covering FY 2006-2008) was the delivery of sustainable services, with an explicit focus on "improved access to and quality of health services" (p. 34). The current Country Partnership Strategy (2013-2017) stresses, as its first priority, "to help the government to invest in the quality of health and education services and the effectiveness of social protection programs" (p. ii), reflecting the first pillar of the country's 2011-2030 Strategic Development Plan, "to continue investing in human capital through improved access and quality of health, education, and skills development while protecting the vulnerable." The project also explicitly supported the government's Health Sector Strategic Plan (HSSP, 2008-2012), with key objectives of improved accessibility to and demand for quality health services, strengthened management and support systems, and strengthened coordination, planning, and monitoring.

The revised objectives dropped the emphasis on women and children, focusing the objectives on health system and resource management. Given the broad range of health issues in the country and the need to address shortcomings in management and planning as a prerequisite to improvements in sustainable service delivery, this revision remained highly relevant to country conditions and Bank/government strategy.

Rating	Revised Rating
High	High

b. Relevance of Design

Relevance of design under the original objectives is rated Modest. It is not clear that there was sufficient capacity at MOH for the level of sector coordination necessary for successful implementation of a SWAp, and therefore a SWAp may not have been the most appropriate instrument. At appraisal, the project contained a set of planned activities that were logically and plausibly connected to anticipated outcomes and therefore to achievement of objectives. However, as the ICR points out (p. 8), the activities "read like a 'shopping list' which was extensive, varied, and lacked focus." In the project's early years, the project received requests to finance regular MOH functions because it was perceived to be easier to access funds from the project than from the domestic budget (where budget release was late). As a result, governance and financial management were not strengthened, and the project's activities were not appropriately prioritized or sequenced in the service of its objectives. The exogenous factor of political instability and resultant variability in commitment to specific project activities was not taken adequately into account.

At the 2013 restructuring, the project's components were winnowed to a more manageable, prioritized set of activities, well aligned with the restated objectives. Relevance of design under the revised objectives is therefore rated Substantial.

Rating	Revised Rating
Modest	Substantial

4. Achievement of Objectives (Efficacy)

Objective 1

Objective
Improve the quality of preventive and curative health services, particularly for women and children, in order to accelerate overall progress toward the health Millennium Development Goals

Rationale
The ICR contains a discussion of attribution issues, given the existence of other donors in the sector. In 2011-2012, this project's spending was only 16% of total donor expenditure on health in the country. In this case, it is reasonable to examine funded inputs/activities and to make a judgment about plausibility of attribution of achievements to those activities.

Outputs
Technical assistance and capacity development was provided to MOH on financial management, procurement, and human resources management. It was reported that technical assistance activities did not always match the needs of staff, and that roles of technical advisors were not always well communicated to the districts. Nonetheless, the project financed development of a Public Financial Management Roadmap and Working Group, a Financial Instructions Manual, Standard Operating Procedures for budget implementation, and specific training on financial internal control. Joint annual sector review and planning meetings were held in 2013, 2014, and 2015, meeting the target. Two structured sector coordination meetings were held to progress toward one plan, one budget, and one sector monitoring and evaluation framework, meeting the target. Thirteen districts were submitting annual district plans/budgets to the central MOH by 2014, surpassing the target of nine, but there were indications that the planning and budgeting process still needed much improvement. By the end of the project, all health facilities were submitting completed Health Management Information System monitoring

reports within one month after the end of each quarter, exceeding the target of 90%, but data quality remained a concern. The number of districts implementing supportive supervision increased from 3 in 2014 to 13 in 2015, meeting the target of 13.

The percent of the state budget allocated to health increased from 4.3% in 2009 to 5.2% in 2015 (there was no target); however, execution of the health budget (implementing, monitoring, and reporting on the annual budget) decreased from 94% in 2011 to 89% in 2014 (there was no target). A planned health Medium-Term Expenditure Framework based on costing of the strategic plan was not prepared. The ICR (p. 8) found that, in the project's early years, requests to finance regular MOH functions were being submitted to the project (because the domestic budget was not released until the first quarter of the fiscal year), contradicting the project's intent of strengthening governance and financial management in the health sector.

The project financed a functional analysis of human resources at the central MOH, selected districts, and one national hospital. At the time of project closing, the findings of this analysis were just starting to be taken into account, and the ICR (p. 22) found that much more work remained to address issues of maldistribution of nurses and midwives.

As of 2012, the project had supported 475 outreach events across 442 integrated community health posts, servicing more than 300,000 participants, 93% of whom were pregnant women and children. Six NGO/private sector partnership contracts with MOH were signed to support these activities, not meeting the target of 10. All six contracts ended in June 2012. Early in the project period, the project supported operating costs at US$ 35 per event; this costing proved to be inadequate and therefore necessary transportation and equipment were not available. A rapid assessment of these activities in 2012 found large variations in the staff mix, implying variation in service availability and quality. After the 2013 restructuring, full financing of monthly outreach events at the 442 integrated community health posts (at a rate of US$ 120 per event) was provided, better ensuring consistency and adequacy of staffing, equipment, and transportation.

The project financed inputs at health facilities to support the rollout of the Basic Service Package: vehicles and motorbikes to enable access to community health programs, medical equipment, solar panels, training for midwives and nurses, and support for 119 scholarships in various disciplines. Suspected misuse was reported for the distribution of some vehicles, distribution of some medical equipment was delayed, and some equipment did not fit into health posts because of inappropriate specifications.

The number of districts receiving current expenditures consistent with their approved budgets (within 20%), and reporting expenditure against planned/approved budgets, was zero as of May 31, 2014, not meeting the original target of 8 districts. The number of requests from budget divisions receiving advances per quarter that were acquitted within 30 days following the end of the quarter increased from 9.5 in June 2014 to 18 in May 2015, exceeding the target of 15.

No targeted staff passed a competency test in financial management, procurement, and/or management, not reaching the original target of 60% or the revised target of 50%. The percentage of Commitment Payment Vouchers that were rejected remained at 7% throughout 2014, not reaching the targeted 5%.

None of the 13 targeted districts and six targeted hospitals developed a functional National Logistics Management Information System, not reaching the original target of 11 total places or the revised target of 15 places. A paper-based logistics management system was developed by project closing, but this system we not rolled out, contributing to continued poor supply chain management for medicines. A pharmaceutical management system (mSupply) was established at the central medicines warehouse and extended to three major hospitals, meeting the target of piloting the system at three sites. Overall, bottlenecks persisted in the supply chain: lack of strategic procurement and improper quantification, leading to over-supply of some drugs and stock-outs of others; late annual procurement processes leading to delayed deliveries of medicines; and a slow feedback loop between the MOH Department of Pharmacy and health facilities on stock levels.

None of the targeted 60% of research projects approved by the research cabinet were responsive to the national research priorities defined by the MOH.

Outcomes

The percentage of pregnant women receiving at least four antenatal visits increased from 36% in 2006 to 42% in 2014, not meeting the original target of 55%. The antenatal dropout rate (difference between the percentage of women receiving just one visit and percentage receiving four or more visits) remained essentially unchanged, at 22 points in 2008 and 23 points in 2014, not meeting the target of 10 points. (This dropout rate indicator and target were introduced by the ICR author to evaluate the quality aspect of the objectives.)

The percentage of health posts with resident midwives was 43% in 2014, not reaching the target of 65%, and with nurses was 54%, not reaching the target of 90%. These indicators/targets were introduced by the ICR author, and no baseline is available. The ICR (p. 22) hypothesizes that the main human resource issue is likely poor distribution of staff rather than a shortage in overall absolute numbers of

staff.

The percentage of stock-outs of tracer essential drugs in the Autonomous Medical Supply System decreased from 22% in 2012 to 20% in 2014, not meeting the original target of 2% or the revised target of 15%. The percentage of stock-outs of these drugs in health facilities was 40% in 2011 and 43% in 2014, not meeting the original target of 5% or the revised target of 30%.

13 districts undertook facility readiness surveys, meeting the target. The percentage of health facilities scoring at least 80% on this readiness assessment survey decreased from 54% in June 2014 to 2% of health posts and 17% of community health centers in December 2014, not meeting the target of 80%. The percentage of integrated community health posts functioning according to Category A standards (having human resources, equipment, and funding meeting established guidelines) was 31% in 2009, remained stagnant around 31% through 2012, and then increased to 44% in 2014, still not meeting the target of 60% (this indicator/target was introduced by the ICR author to measure the quality aspect of the original objectives).

Although the country made progress during the time period of the project toward achievement of the child mortality and maternal health MDGs, it is unlikely that the project made a significant contribution to those outcomes, given shortcomings in achieving both output and outcome targets.

Rating
Modest

Revised Objective
Get more resources to where they are needed most to improve the delivery of health services in districts and sub-districts

Revised Rationale
Outputs and outcomes are the same as for the original objective. Delivery is interpreted as both quality and coverage. The rating for quality of health services remains modest.

Revised Rating
Modest

Objective 2

Objective
Improve the coverage of preventive and curative health services, particularly for women and children, in order to accelerate overall progress toward the health Millennium Development Goals

Rationale
Outputs:
The average number of visits to outpatient health facilities per capita increased from 1.9 in 2009 to 2.9 in 2014, not reaching the target of 5 (this indicator/target was introduced by the ICR author). Attendance at project-supported monthly events held at integrated community health posts remained stagnant, at 0.7 visits per capita in 2009 and 0.65 in 2014.

Outcomes:
The percentage of children under one year of age vaccinated with DPT3 increased from 63% in 2006 to 76.8% in 2015, not meeting the original target of 90%, and with the measles vaccine increased from 61% in 2006 to 82% in 2014, not meeting the original target of 90%.

The percentage of births attended by skilled health personnel increased from 27% in 2006 to 57.7% in 2014, exceeding the original target of 45%.

The percentage of children ages 6-59 months receiving vitamin A supplements increased from 36% in 2003 to 66% in 2014, not meeting the original target of 80%.

The percentage of married or cohabitating women receiving modern contraceptives at outpatient visits increased from 10% in 2003 to 49.9% in 2014, exceeding the original target of 25%. However, it is not known whether these contraceptives were actually used.

Women and children were served primarily under the project by the monthly integrated health service post events. Attendance at these events remained essentially stagnant throughout the project period, even after the project began fully funding them. As a result, it is difficult to attribute to the project the observed outcomes related to increased childhood vaccines and supply of micronutrients, and increased coverage of childbirth with a skilled attendant.

Although the country made progress during the time period of the project toward achievement of the child mortality and maternal health MDGs, given the attribution challenges noted above, it is difficult to determine whether (or to what extent) this project contributed to those outcomes.

Rating
Modest

Revised Objective
Get more resources to where they are needed most to improve the delivery of health services in districts and sub-districts

Revised Rationale
Outputs and outcomes are the same as for the original objective. Delivery is interpreted as both quality and coverage. The rating for coverage of health services remains modest.

Revised Rating
Modest

5. Efficiency

The PAD's economic analysis (pp. 68-71) describes economic benefits to be derived from improvements in the primary and secondary care systems. It estimates a cost range of US$ 501 to US$ 822 per Disability Adjusted Life Year (DALY) averted, assuming a project cost of US$ 20 million and per capita income of US$ 750. The ICR (pp. 43-46) repeats that calculation, finding an actual cost per DALY averted of US$ 251 to US$ 412, which compares favorably to 2014 per capita Gross Domestic Product of US$ 1,070. The ICR's analysis is careful to preserve comparability with the PAD.
However, there were significant delays in project startup and in implementing the restructuring that had been recommended at the MTR. The project lost focus in its early phases due to a broad range of requests for it to fund various MOH activities; there was not prioritization of a manageable set of targeted activities. Staff shortages, delays in filling key positions, the need to re-orient government and MOH staff with several changes of government, lack of consistent in-country Bank supervision at the beginning of the project period, excessive delays in processing of payments (Borrower's ICR, p. 53), and weaknesses in financial management and procurement contributed to severe implementation inefficiencies throughout the project. The project's rating for financial management was Moderately Unsatisfactory for the majority of the duration of the project, including the most recent rating provided in the Bank's Financial Management Implementation Review Report in March 2015. Payments were made for potentially ineligible expenditures with no proper documentation. While the ICR states that financial management reviews found that the provisions made to address some of the weaknesses would provide reasonable assurance that policies and procedures would be complied with, the Moderately Unsatisfactory financial management rating persisted. There is no mention of whether external audits were conducted, whether they were unqualified, or, if not, what the nature of the qualifications was. With regard to procurement, although procurement ratings in the last four ISRs were Moderately Satisfactory, the rating had declined to a consistent Unsatisfactory/Moderately Unsatisfactory rating from 2010-2013.

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

Original objectives: The project's original objectives were highly relevant to country conditions, Bank strategy, and government strategy. The project's design under the original objectives was modestly relevant, as it encompassed a too-long and unprioritized list of activities and relied on a sector-wide approach that was beyond government coordination capacity. Achievement of all objectives is rated modest. Improvements in the quality of health services did not reach targets, especially for health facility readiness and staffing. Coverage of health services also improved only modestly. Although there were increases in access to some basic vaccination, micronutrient, and maternal health services, overall access to outpatient care did not reach targets. The majority of attendees at project-sponsored monthly events at integrated community health posts were women and children, but attendance at these events did not increase over the project's lifetime, making it difficult to attribute observed maternal and child health improvements to project interventions. Project efficiency is rated modest. Taken together, these ratings are indicative of significant shortcomings in the project's performance, and therefore an Outcome rating under the original objectives of Moderately Unsatisfactory.

Revised objectives: The revised objectives were also highly relevant to country conditions, government strategy, and Bank strategy. At the 2013 restructuring, the list of activities was streamlined to be more manageable and better focused on achievement of objectives, resulting in substantial relevance of design under the revised objectives. There was modest achievement of getting health resources to where they were needed the most to improve the delivery of health services, where "delivery" is interpreted as both quality and coverage. Project efficiency is rated modest. Taken together, these ratings are indicative of significant shortcomings in the project's performance, and therefore an Outcome rating under the revised objectives of Moderately Unsatisfactory.

Following IEG/OPCS guidelines on projects with revised objectives, the project's overall Outcome rating is determined by weighting according to the percentage of disbursements before and after restructuring. In this case, the Outcome rating under both the original and revised objectives is Moderately Unsatisfactory, and therefore the overall Outcome rating is Moderately Unsatisfactory.

a. Outcome Rating
Moderately Unsatisfactory

7. Rationale for Risk to Development Outcome Rating

Important capacity was built among MOH and district health administration staff, who are likely to remain in their positions. Although some support will continue from international donors, sustainability of key activities funded under the project will require support from MOH and the domestic budget. The MOH budget was reduced by 18% from FY 2015 to FY 2016, putting at particular risk funding for medicines. As of the writing of the ICR, the function of the project management team had closed, and the status of many project-financed activities was unclear. For example, the folding of the monthly integrated community health post events into the overall primary health care package was being discussed. It remains unclear how MOH priorities and project activities will be prioritized under a reduced budget envelope.

a. Risk to Development Outcome Rating
Substantial

8. Assessment of Bank Performance

a. Quality-at-Entry

The PAD articulated well the rationale for adopting a SWAp and for flexible financing that would respond to government needs and MOH annual plans. Project preparation benefited from lessons learned under predecessor projects: that project design should be straightforward and flexible, focused on a manageable set of priority objectives; and that a flexible design framework could allow resources to be shifted in line with the government's annual rolling plans. These two ideas, however, came into conflict with one another, as the built-in flexibility led to accommodation of MOH requests to finance a large range of activities and therefore a lack of appropriate prioritization. Implementation arrangements, which gave responsibility to MOH departments rather than a dedicated Project Management Unit (PMU), were concluded without a proper assessment of MOH's implementation and coordination capacity. Although limited capacity for planning and implementation was flagged as a substantial risk, the prescribed mitigation measures -- to minimize design complexity and reduce transaction costs -- were not adopted, given the broad and varied range of planned activities. In addition, inadequate attention was paid to the need for implementation staff familiar with Bank rules on eligible expenditures and procurement and with their responsibilities in executing a trust fund.

Quality-at-Entry Rating
Moderately Unsatisfactory

b. Quality of supervision

Although the PAD described partnership and coordination arrangements for the SWAp, including joint donor missions and the establishment of Joint Annual Sector Reviews and Planning Summits, joint sector meetings prior to the 2013 restructuring were often postponed or cancelled with no notice (ICR, p. 9). It was a significant shortcoming that the Bank team did not provide much earlier support for strengthening MOH capacity for implementation and coordination. Instead, over the project's first three years, there was no experienced, in-country Bank team dedicated full-time to project management (ICR, p. 28). Two other parallel, European Commission (EC)-financed health sector projects were being simultaneously implemented through Trust Fund grants managed by MOH and overseen by the Bank, consuming "already limited bandwidth" of both MOH and the Bank team (ICR, p. 9).

A highly participatory Mid-Term Review (MTR) was conducted in July 2010, resulting in the appropriate and proactive decision to scale down the project's scope of work. However, it took over two years before the MTR's recommendations were formalized in the February 2013 restructuring; the ICR (p. 10) notes that the 2012 change in government and resulting MOH reorganization in early 2013 were partially responsible for this delay.

After the 2013 restructuring, the quality and consistency of Bank supervision improved, with stronger oversight from a Task Team Leader based in the capital. Specialists were also recruited to support MOH on procurement and financial management. However, the ICR remains unclear on the quality of supervision with regard to safeguard policies and fiduciary oversight.

Quality of Supervision Rating
Moderately Unsatisfactory

Overall Bank Performance Rating
Moderately Unsatisfactory

9. Assessment of Borrower Performance

a. Government Performance

The government and MOH have been consistently committed to improvement in health sector outcomes, with a cohesive vision for the sector articulated in comprehensive strategy documents. However, the government's initial insistence on framing this project as a SWAp may have been too ambitious for MOH's coordination capacity, and, according to a co-financier, the MOH "never took real ownership of this programme" (ICR, p. 57). Institutional instability -- four ministers of health and three MOH reorganizations over the project's lifetime -- also hampered project performance. An assassination attempt on the President and Prime Minister in February 2008, resulting in a politically charged environment throughout the country, significantly delayed project start-up. A new Minister of Health came on board about a year before effectiveness, and by the time the project became effective in June 2008 the MOH had been reorganized with new Directorates and new staff teams. This change considerably decreased MOH's ownership of the sector strategy on which the project had been based and required extensive engagement to familiarize new staff with the project's goals and activities. A 2012 change in government, leading to another MOH reorganization in the first half of 2013, necessitated yet another period of re-engagement. It was only after the 2013 restructuring that a Project Steering Committee was established.

Government Performance Rating
Moderately Unsatisfactory

b. Implementing Agency Performance

Implementation responsibility initially rested with a newly created Directorate of Planning and Financing, subsumed under the Department of Partnership Management (DPM). These institutions were untested and understaffed for the first year of project implementation. Absence of a PMU (which had existed for the country's previous Bank-financed health sector projects) decreased capacity to understand Bank requirements and execute a Trust Fund. It was clear throughout the project's initial years that MOH did not have adequate capacity to manage a SWAp, resulting in a condition and legal covenant for the February 2013 restructuring to recruit a partnership management specialist. There were early delays in recruiting other key project staff, including a procurement advisor and an international support adviser to DPM. The two other EC-supported projects consumed staff time and attention from this project. After the 2013 restructuring, a Project Management Team (PMT) was established, and a dedicated Project Manager and eleven additional new staff (including a procurement specialist and accountant) were hired. Although these new hires led to improvements in project procurement and financial management, progress toward desired outcomes did not reach specified targets. There were major weaknesses in financial management and procurement.

Implementing Agency Performance Rating
Unsatisfactory

Overall Borrower Performance Rating
Unsatisfactory

10. M&E Design, Implementation, & Utilization

a. M&E Design

The project's M&E framework paralleled that of the MOH, with indicators drawn from the Health Sector Strategic Plan. However, some of the outcome indicators in the PAD did not reflect activities to be financed by the project (for example, immunization coverage was largely to be supported by the World Health Organization's Expanded Program for Immunization). These indicators were included under the logic that the project was designed as a SWAp, but it was challenging from the start to attribute achievement of broad health sector outcomes to project-financed activities. The PAD also specified 14 intermediate outcome indicators, some without baselines and targets. An HMIS was already functional as the project became effective, but there was a recognized need for strengthening of the timeliness, quality, and use of data, and the project planned to provide technical assistance and support for M&E-related hardware and software. Facility and household surveys, program evaluation, operational research, and community-level monitoring were also planned.

b. M&E Implementation

M&E was "patchy" in the project's early years (ICR, p. 11) due to multiple implementation challenges. At the February 2013 restructuring, the project's results framework was revised to introduce four new PDO-level indicators and eight new intermediate outcome indicators. At the October 2014 restructuring, three of the four PDO-level indicators from the previous restructuring were dropped because the MOH was not able adequately to collect and report relevant data, and two new ones were added to better reflect project-financed activities. Intermediate outcome indicators were dropped, revised, and some maintained at this point as well. However, because the project was using the MOH M&E framework throughout, all the original PDO-level indicators were tracked in the HMIS through project closing. It remained a shortcoming that some intermediate outcome indicators were not well defined. For example, a definition of "comprehensive" for the indicator "percentage of health clinics providing the comprehensive BSP" was not developed until after the 2013 restructuring. As a result, there was no usable information on many intermediate outcome indicators at project closing.

Overall, there was "a weak culture of reporting," and the multiple, closely-spaced restructurings shifted the project's activities and goalposts so often that it was "difficult to settle into a good momentum of implementation and monitoring of progress" (ICR, p. 12). Nonetheless, the hiring of a dedicated M&E Officer at MOH at the end of 2012, combined with a collaborative effort among development partners to support M&E, resulted in improvements in the project's last several years. MOH conducted a holistic review of M&E, and good indicators and scorecards were developed for use at the facility level.

c. M&E Utilization

The MOH's annual planning and budgeting framework was disconnected from data reported by its own M&E framework. The ICR (p. 12) reports that there are concerted efforts under way to correct this situation in crafting the FY 2016 budget. District Health Administrators have begun to follow data more closely in order to benchmark the quality of their health services against other districts. Other ministries (notably the Ministry of Agriculture) have asked for a presentation on the MOH framework, presumably to inform that for the agricultural sector, and the Office of the Prime Minister has provided comments on specific indicators to be incorporated into the health sector's national scorecard, indicating that a culture of M&E -- with contributions from the project -- is beginning to emerge in the country.

M&E Quality Rating

Modest

11. Other Issues

a. Safeguards

The project was rated environmental category C and triggered OP/BP 4.01, Environmental Assessment, as planned activities included rehabilitation of facilities and procurement of drugs and medical equipment. Prior to the 2013 restructuring, some health posts were to be maintained and upgraded, with anticipated environmental impacts judged to be minimal and temporary, and healthcare waste was to be generated. A Healthcare Waste Management Plan was disclosed in 2007. No additional environmental impacts were expected at the 2013 restructuring, but the trigger for Environmental Assessment remained in place due to civil works and procurement of drugs under the project's original components (ICR, p. 13). Throughout, the project supported the use of clinical waste gasifiers to manage healthcare waste, and training sessions on this equipment were conducted in mid-2014. The World Health Organization is continuing work on healthcare waste management after project closure. The ICR does not specify whether there was compliance with the Bank's safeguard policies. The project team later explained that, after the 2013 restructuring, the project was no longer undertaking activities that fell under the Environmental Assessment safeguard. It remains unclear whether there was compliance with safeguard policies prior to that restructuring.

b. Fiduciary Compliance

Financial Management: There were numerous shortcomings in the project's early years, including unreconciled advances and a lack of action on outstanding advances, inadequate registers for consultant contracts and financial commitments, delays in fund flows and errors in claims resulting from a lack of timely and regular submission of Withdrawal Applications, payments made for potentially ineligible expenditures without

proper documentation, and delays in submission of annual audits. The ICR (p. 14) states that the project's rating for financial management remained Moderately Unsatisfactory for the majority of its lifetime, including the most recent rating in March 2015. According to the ICR (p. 14), however, the situation improved after the 2013 restructuring with the creation of a dedicated Project Management Team and project accountant. A Finance Manual, including provisions on internal controls, was adopted in 2013 as part of the Project Operations Manual; although financial management reviews found these provisions to be acceptable, the ICR (p. 14) is not clear on whether they were adopted in practice, stating only that the provisions provided "reasonable assurance" that policies and procedures "would be complied with." Throughout, the project remained on an Excel-based accounting system rather than moving, as planned, to the government's accounting software (Freebalance); this impacted the timeliness and reliability of financial information (ICR, p. 14). Overall, it is not clear from the ICR whether the project complied with the Bank's financial management and fiduciary requirements.
Procurement: Initial procurements were hampered by limited understanding of Bank procedures and weak follow-up actions. The Bank had to issue several "objection" letters, requiring revisions to bid evaluation reports or other documentation. After the PMT began implementing the project in 2013, separately from MOH procurement, and with full-time assistance from a procurement specialist, procurement processes improved significantly. The last four Implementation Status Reports rated procurement Moderately Satisfactory, but rating had declined to a consistent Unsatisfactory/Moderately Unsatisfactory rating from 2010-2013. Timeliness was a challenge, as submissions from technical departments in MOH were inadequate.

c. Unintended impacts (Positive or Negative)
None reported.

d. Other
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12. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Moderately Unsatisfactory	Moderately Unsatisfactory	---
Risk to Development Outcome	Substantial	Substantial	---
Bank Performance	Moderately Unsatisfactory	Moderately Unsatisfactory	---
Borrower Performance	Moderately Unsatisfactory	Unsatisfactory	Major delays and weaknesses in financial management and procurement.
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 ICR (pp. 30-31) contains several insightful lessons, including:
Political and institutional instability can impede progress if not taken into account during project design. In this case, an ambitious SWAp and long list of potential activities proved too much for weak capacity that could not be fully rectified due to staff shortages and government turnover. Institutional reform is time-consuming, and a project's structure and level of ambition should take this into account.
There is a tradeoff between breadth and depth of project support. In this case, the focus on a sector-wide approach overshadowed the need for clarity on exactly what outcomes the project would specifically support (and for which outcomes the project should be held accountable).
While experienced, consistent, in-country Bank support can help strengthen implementation capacity even in low-capacity environments, in this

case, that support did not appear until the time of the first restructuring.

14. Assessment Recommended?

No

15. Comments on Quality of ICR

The ICR provides a remarkably clear and concise narrative on a very complicated project. It is appropriately outcome-oriented, drawing data from sources outside the project's formal results framework where necessary to assess achievement of objectives. Its lessons are insightful and incisive, and they should prove useful to other low-capacity countries attempting to reform service delivery. It presents clearly a very complex chain of events related to project financing and costs. However, although the ICR contains a brief discussion of attribution challenges, given the existence of other donors in the sector, it does not assess the entire results chain as tightly as might have been possible. It also does not contain straightforward statements about compliance with the Bank's safeguard and financial management/fiduciary policies.

a. Quality of ICR Rating
Substantial