Report Number : ICRR13456

IEG ICR Review
Independent Evaluation Group

1. Project Data:		Date Posted : 03/17/2011		
PROJ ID :	P103606		Appraisal	Actual
Project Name :	Madagascar Sustainable Health System Development Project	Project Costs (US$M):	10.00	9.60
Country :	Madagascar	Loan/Credit (US$M):	10.00	9.60
Sector Board :	HE	Cofinancing (US$M):		
Sector(s):	Health (62%) Central government administration (20%) Sub-national government administration (11%) Other social services (7%)			
Theme(s):	Child health (23% - P) Health system performance (22% - P) Population and reproductive health (22% - P) Other communicable diseases (22% - P) Social safety nets (11% - S)			
L/C Number:	C4305			
		Board Approval Date :		05/22/2007
Partners involved :		Closing Date :	12/31/2009	12/31/2009

Evaluator :	Panel Reviewer :	Group Manager :	Group :
Judyth L. Twigg	John R. Eriksson	IEG ICR Review 1	IEGPS1

2. Project Objectives and Components:

a. Objectives:

According to the Loan Agreement (p. 5) and the PAD (p. 5), the objective of the project was "to contribute to the strengthening of the Recipient's health system, and enhance the institutional capacity of the Ministry of Health, Family Planning, and Social Protection (MOH) to improve the access and utilization of health services, especially in rural and remote areas."

This project was to be the first phase of a longer-term program that, over time, would aim at results-based financing. At the end of the 2.5 years of implementation of the project, additional financing was to be sought to continue support to the medium-term objectives of the Borrower's poverty reduction strategy, the Madagascar Action Plan (MAP) (2007-2011), which included ambitious targets in the areas of maternal and child mortality; fertility; malaria, tuberculosis, sexually transmitted infections, and HIV/AIDS control; and malnutrition in children under five; and the Borrower's National Health Sector Development Plan, 2007-2011 (PDSS).

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

No

c. Components (or Key Conditions in the case of DPLs, as appropriate):

The project had five components:

A. Delivery of Health Services (planned US$ 5.3 million, according to PAD; planned US$ 4.9 million, according to ICR [costs approved in annual work plans]; actual US$ 4.5 million)

1. Support in improving the delivery of health services at the District and community level, through (a) rehabilitation works and the provision of drugs, equipment, and medical supplies for Primary Health Centers; and (b) provision of drugs, equipment, technical assistance, and training to support implementation of innovative strategies to meet the health needs of populations in remote areas.
2. Provision of technical assistance and equipment to MOH to: (a) review needs for essential drugs and update the list of essential drugs to be available nationally; (b) undertake an assessment of the institutional and organizational performance of the Recipient's hospitals, and subsequently implement hospital management pilots; and (c) develop tools for the fight against priority infectious diseases and subsequently implement such tools.

B. Development and Management of Human Resources (planned US$ 0.9 million, according to PAD, 1.2 million, according to ICR [costs approved in annual work plans]; actual US$ 0.9 million)

1. Development and selective implementation, through provision of technical assistance to MOH, for: (a) incentive, performance-based and contracting mechanisms for the redeployment of medical personnel to rural areas; (b) protocols for improving the working conditions of medical personnel in rural areas; (c) new training strategies for basic and continuing education; and (d) management of career plans and the development of effective human resources management tools.
2. Provision of training and coaching to health personnel to strengthen capacity to deliver quality services.

C. Innovations in Health Financing Management (planned US$ 0.6 million, according to PAD, 0.4 million, according to ICR [costs approved in annual work plans]; actual US$ 0.3 million)

1. Provision of technical assistance to MOH for the development and selective implementation of: (a) innovative resource mobilization mechanisms to ensure sustainability of priority programs; (b) mechanisms for better management of available public and private funds; and (c) innovative provider payment mechanisms.

D. Improving Demand and Utilization of Health Services (planned US$ 1.05 million, according to PAD, 1.0 million, according to ICR [costs approved in annual work plans]; actual US$ 0.9 million)

1. Promote awareness of health needs and available services at the community level and support increased utilization rates of health services, through carrying out of campaigns, and provision of technical assistance, training, and equipment for the implementation of selective innovative pilot experiences.
2. Provision of technical assistance for the development and selective implementation of innovative financial mechanisms to increase demand for priority health services.

E. Institutional strengthening (planned US$ 2.15 million, according to PAD, 2.5 million, according to ICR [costs approved in annual work plans]; actual US$ 3.0 million)

1. Support strengthening the capacity of the MOH in planning and programming, procurement, financial management, and budget management, and strengthen supervisory and implementation capacity of Districts and support to the preparation and implementation of work plans, through the provision of technical assistance and equipment, as well as carrying out audits and implementing social and environmental mitigation measures related to the Project.
2. Provision of technical assistance and training to MOH for: (a) the development and implementation of a monitoring and evaluation plan; (b) strengthening capacity to collect and analyze health information and data; and (c) contribute to the preparation and implementation of the national demographic and health survey (DHS).
3. Support operating costs for the Project Coordination Unit (PCU).

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

The ICR (p. 28) indicates that total planned project costs were US$ 15.0 million, with a planned US$ 5.0 million contribution from the Borrower. However, the TTL clarified that planned project costs were US$ 10.0 million, with no planned contribution from the Borrower.

In January 2009, Madagascar suffered severe civil unrest. As a result of a change in Government, the project was

subject to Operational Policy/Business Policy (OP/BP) 7.30 Dealing with De Facto Governments as of March 17, 2009, and disbursements were stopped. Most of the project funds had been disbursed at that time, with US$ 453,900 unable to be disbursed. OP/BP 7.30 continued to be applied across the portfolio in Madagascar at the time the ICR was written.

The ICR (p. 28) gives figures for appraisal estimates for each of the components that differ from those in the PAD (p. 54). These differences cannot be accounted for by changes in the dollar /XDR exchange rate, as the PAD estimate is higher than the ICR estimate for some components and lower for others. The TTL clarified that the estimates presented in the ICR were those approved in annual work plans. The final expenditures differed from estimates (for Components A, C, and D, actual costs were lower than estimated costs; for Component E, actual costs were higher than estimated costs) because of changing needs, overestimates of costs for some equipment and packages of medicines, and the political crisis and associated civil unrest.

According to the PAD (p. 5), Bank financing was to be pooled with contributions from the French Development Agency (AFD) (US$ 15 million [PAD p.5] or US$ 18 million [PAD p. 58] to begin in January 2008), and supported through parallel financing by other development partners, including the African Development Bank (AfDB) (US$ 10 million), Japan International Cooperation Agency (JICA) (US$ 2 million); United Nations Children's Fund (UNICEF) (US$ 14 million); United Nations Family Planning Association (UNFPA) (US$ 2 million), United States Agency for International Development (USAID) (US$ 15 million), and World Health Organization (WHO) (US$ 10 million). The European Union was to continue to provide direct budget support to the Government of Madagascar, which would indirectly support the health sector. The ICR does not provide information on actual spending or activities by the other partners from whom parallel financing was anticipated. The ICR (p. 22) briefly notes the pooled financing approach with AFD, but it does not provide additional information on implementation of this arrangement. The TTL clarified that there was some parallel (not pooled) financing with AFD for this project, in preparation for a pooled financing arrangement that was to begin with a follow-on project; this arrangement was a change from what had been planned in the PAD.

3. Relevance of Objectives & Design:

Relevance of Objectives is rated Substantial. At appraisal, there were large inequalities in access and utilization of health services across the country, closely linked to unequal distribution of human resources as well as varying levels of training and competence of medical staff. These inequalities severely disadvantaged rural and remote areas, with the PDSS highlighting four critical areas of weakness: poorly equipped health centers and low levels of capacity to produce health services, especially in rural and remote areas; uneven staffing of health facilities, especially in rural and remote areas; low levels of health financing and inefficiencies in resource allocation; and inadequate demand for health services and low levels of utilization. At the time of appraisal, only 10 percent of the population reported an illness annually, and of those, only 40 percent sought care from qualified medical personnel. Health policy issues were also featured prominently in the MAP. The project was included in the Country Assistance Strategy (CAS) for 2007-2011, directly supporting the Pillar 2 objectives of improving services to people and achieving better outcomes in education and health.

Relevance of Design is rated Modest. The PAD contains an excellent mapping of the relationship between project activities related to strengthening of the health system and broader MAP /PDSS objectives (p. 6). While project components and planned activities were strongly linked to key objectives, the project was extremely complex and involved a large number of activities over a relatively short period of time.

4. Achievement of Objectives (Efficacy):

Contribute to the strengthening of the Recipient 's health system is rated Substantial.

Outputs:

Two technical assistants were recruited to the Department of Administrative and Financial Affairs to support the MOH in resolving budget execution bottlenecks. Planning and budgeting exercises were held at the regional level, and 17 Regional Accounting Managers were funded, resulting in 100% completion of annual work plans by all districts in a timely manner. The health sector MTEF 2009-2012 was updated and validated as of December 2009.

Joint health sector reviews were initiated and held with all development partners (one in 2007 and two in 2008, none in 2009).

Outcomes:

The health sector budget execution rate increased from 65% in December 2005 to 86% in December 2009 (no data are provided for the budget execution rate at the beginning of the project period).

Enhance the institutional capacity of the Ministry of Health, Family Planning, and Social Protection (MOH) to improve access and utilization of health services, especially in rural and remote areas is rated Modest .

Outputs:

48 primary and secondary health care facilities were upgraded in line with technical norms of the MOH, against a target of 47. These health centers (12 primary health centers and 36 first referral health centers) were chosen with a "specific focus on ensuring that these centers were in rural and remote areas of the country " (ICR, p. 16). According to the TTL, all of these centers were in rural and remote areas .

For the following indicators, no information is provided in the ICR on coverage or geographic distribution :

- 25 packages of drugs and consumables were distributed to primary and secondary health facilities, meeting the target of 25. The TTL clarified that 100% of these packages went to rural and remote areas .
- 393,833 maternal/safe delivery kits were provided free of charge to primary health centers, almost quadrupling the target of 100,000. 1,267 cesarean delivery kits were provided, exceeding the target of 870. The TTL clarified that the maternal/safe delivery kits went to all health centers in the country .
- 10,355 health personnel were trained in the provision of delivery of quality services (no target given).
- 33,000 contraceptives (Implanon), along with appropriate consumables and training of personnel, were distributed. 324 television ads and 579 radio ads broadcasting family planning messages were supported . 211 sites were stocked with unspecified family planning equipment and techniques . 29,500 unspecified management tools for family planning were reproduced . No targets are given for these indicators . The TTL clarified that 50% of contraceptives went to rural areas, because many rural health centers do not have qualified staff to insert them .
- 3,103 tuberculosis (TB) cases were treated (no target given).

Three pilots (TB, emergency obstetric and neonatal care, and human resources) were conducted; these three issues, according to the ICR (p. 13), disproportionately affect the poor and had potential to resolve issues of geographic and financial inequity in delivery of health services . The pilots for the first two were evaluated, but the planned evaluation of the human resources pilot was not carried out due to the political crisis . The human resources pilot, which supported an incentive package for qualified health personnel to move to remote areas and upgraded housing and health centers, was carried out in two extremely remote regions, and in one region that, according to the ICR, "served as a proxy of a less remote region ."

Kominina Mendrika (KM), or Champion Communes, established over a decade ago as a means of engaging community stakeholders in achieving short-term goals related to maternal and child health, were supported with updating of community monitoring tools, training of 22 regional leaders on the KM concept, establishing of 28 KMs, and training of 340 managers on the process of establishing a KM .

The project supported two campaigns for the mass distribution of drugs to combat filariasis in 30 endemic districts, and interventions for combating rabies (vaccine supply in the 12 upgraded primary health centers) and plague (provision of drugs, insecticides, and awareness materials).

Outcomes:

For the following key indicators, data are not provided specifically for the dates of the project, making it difficult to attribute the results to Bank-sponsored interventions . Also, no data are provided on coverage or geographic distribution, and so outcomes in rural and remote areas are unknown :

- The number of people with access to a basic package of health, nutrition, or population services increased from 7.68 million in December 2005 to 11.077 million in December 2008, against a target of 11.52 million. The TTL later clarified that this target of 11.52 million was not for the end of the project, but for the National Health Sector Plan for 2011. "Basic package" is not defined. Data for 2009 are not available because of the political crisis .
- The number of children immunized increased from 83,510 in 2007 (the TTL clarified that the December 2005 baseline in the ICR is an error) to 358,592 in December 2008. The ICR does not specify which immunizations are included in these figures . Data for 2009 are not available because of the political crisis .

As a result of the human resources pilot, 70% of human resource needs were met in the three pilot regions . The ICR does not specify what percentage of human resource needs was being met before the pilot was implemented, but the

TTL clarified that 49% of needs were being met before the pilot.

As a result of the emergency obstetric and neonatal care pilot, there was a 15% increase in the number of women receiving such care in the two pilot regions. Patient satisfaction was high, ranging between 90-100%. However, the evaluation of the pilot indicated that patients continued to have significant out-of-pocket expenses for drugs and supplies, despite treatment charges being completely covered.

As a result of the TB pilot, implemented in 11 of 141 diagnostic and treatment centers in the country, the number of patients lost to follow-up in those 11 centers was 5%, compared to the national average of 17%.

The use of modern methods of contraception increased among married women from 18% in 2003 to 29% in 2008, and among rural married women from 16% to 28% over the same time period. No data are provided specifically for the dates of the project.

The number of births in health facilities, plausibly attributable to the distribution of free-of-charge safe delivery kits, increased between 2007 and 2008. However, assisted deliveries decreased from 51% to 44% "in the past five years" (ICR, p. 17, presumably meaning from 2005 to 2010). According to the ICR (p. 17), this decrease in childbirth assistance "is attributable to poorer coverage in rural areas and in the capital."

5. Efficiency (not applicable to DPLs):

Efficiency is rated Modest.

96% of funds were disbursed during the first 15 months of implementation, with the majority of planned activities implemented. According to the ICR (p. 22), resources were spent on priority activities. The successful implementation of the three pilots, and completed evaluation of two of the three pilots, was an efficient way to test new mechanisms to address issues of service delivery and access. The PCU's integration with MOH, and resulting participation in all MOH technical and policy discussions, facilitated efficient PCU work flow.

However, the ICR does not offer detailed evidence or analysis on the efficiency of use of project resources. There is no information provided on cost-effectiveness of health services, and little attributable evidence on the cost-effectiveness of institutional strengthening activities.

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

	Rate Available?	Point Value	Coverage/Scope*
Appraisal	No		
ICR estimate	No		

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

6. Outcome:

Relevance of objectives and achievement of one of the development objectives were substantial, but efficiency, design relevance, and the achievement of the second objective were modest, amounting overall to moderate shortcomings.

a. Outcome Rating: Moderately Satisfactory

7. Rationale for Risk to Development Outcome Rating:

The political crisis in Madagascar has lasted for over one year. The Borrower's ICR notes that "it is almost impossible to predict where the country will be in the coming months" (p. 34). It was originally envisioned that the gains made under the project would be supported and furthered through subsequently larger investments, including a follow-on Bank operation (Joint Health Sector Support Project, fully prepared and negotiated by January 2009, US$ 85 million with contributions from the bank and AFD) to help meet the objectives outlined in the MAP/PDSS. However, this project was pulled from the Board due to the political crisis. AFD is supporting an interim 12-month project as a stopgap measure until the Bank re-engages in the sector, and the Bank and AFD are committed to implementing the pooled funding mechanism to support the health sector once the political situation normalizes. The TTL added that the Bank continues to participate in joint supervision with AFD, even though the Bank is not currently providing financing. The ICR (p. 23) notes that, in the absence of longer-term financing, gains realized by the project will be severely threatened. Strong analytical work done by the Bank, including a comprehensive Country Status

Report (CSR) finalized in June 2010 and the pilot evaluations done under the project, could provide a basis for movement forward after the country stabilizes.

In June 2009, the new Government decided to replace the majority of staff in the health sector at both the central and regional levels, including 19 of 22 regional health directors. This decision resulted in a loss of knowledge, institutional memory, and capacity that had been built in previous years, with most of the replaced staff having been involved in one or more previous Bank-supported projects.

a. Risk to Development Outcome Rating : Significant

8. Assessment of Bank Performance:

Ensuring Quality-at-Entry is rated Moderately Satisfactory .

The preparation process involved active collaboration between the Bank, MOH, and development partners. The embedding of the Project Coordination Unit (PCU) within the MOH supported both the overall objectives of the health sector and project implementation. Detailed lessons were drawn from the experience of previous health projects in the country, including the need for clear development goals acceptable to all stakeholders, the importance of a comprehensive and harmonized approach to the health sector, the importance of technical assistance and capacity building in the MOH, and the need to improve processes of analysis and use of data for decision making.

Key risks – that health personnel would not want to move to rural areas; that the project time was too short and resources too limited for measurable impact; that health service strengthening would not result in increased utilization of health services; that MOH would not remain committed to stated priorities; that supply of basic health services would not be able to meet stimulated demand; that conditional cash transfers would not reach the intended target population; and risks related to financial reporting and auditing – were identified, and mitigation measures briefly outlined but not elaborated in detail. Some additional potential risks were not identified, including risks to efficiency associated with donor harmonization. The political crisis was unforeseen and could not have been planned for at the outset of the project.

Importantly, the project's key performance indicators did not reflect its stated objectives, nor did they reflect additional objectives listed in the PAD. The performance indicators listed in the Loan Agreement are output indicators and do not reflect outcomes related to access and utilization of health services in rural and remote areas. The PAD, while not highlighting the key performance indicators listed in the Loan Agreement, does contain a detailed results framework for the full MAP/PDSS (pp. 39-41) and a set of quantitative and qualitative indicators to be used specifically to track the results of Bank interventions (pp. 42-43). However, these indicators contain few baselines or targets and are exclusively output- and process-oriented, with no outcome indicators related to access and utilization of health services in rural and remote areas. The output and process indicators intended specifically to track the results of Bank interventions also do not reference rural and remote areas.

Quality of Supervision is rated Satisfactory .

The Bank team was highly responsive during implementation. Financial management and procurement staff were involved from the beginning of the project and participated in all supervision missions, allowing them to respond proactively to issues that arose during implementation. Under the challenging circumstances of the political crisis, the Bank team managed to find practical solutions to ensure that the project continued implementation. The follow-on project was strategically prepared while the current project was being implemented, providing a focus on the Bank's longer-term engagement and helping partners to gain confidence in the Bank's approach. The Bank played a leadership role in bringing partners together around the PDSS. The Bank team provided a focus on producing appropriate analytical work, with a number of studies and reports completed in the areas of human resources, community participation, and health service delivery, all of which informed the recently-finalized CSR. However, regarding environmental safeguards, there was an understanding that although at the end of the first year of implementation, environmental safeguards had improved to being moderately satisfactory, ongoing work and attention to the issue were required; according to the ICR, it is not known if all safeguard issues were satisfactorily resolved. The Region later confirmed that there was a Safeguards Specialist as part of the team on all project supervision missions, and that all safeguard-related activities were completed by the end of the project period. According to the Region, all incinerators financed by the project are fully operational and in use.

The deficiencies in M&E design could have been better addressed during supervision. While supervision aimed to retrofit indicators, the proposed retrofitted indicators had shortcomings. For example, the ICR notes on page (iii), the retrofitted indicator "people with access to a basic package of health, nutrition, or population" services

does not "directly relate to project objectives" and not enough information is provided on how "basis package" is defined. The ICR further notes on the same page that the retrofitted indicator "children immunized" was not as relevant as "percentage increase" would have been. Furthermore, the proposed retrofitted indicators did not reference rural and remote areas, which were explicitly referred to in the statement of objectives .

a. Ensuring Quality -at-Entry: Moderately Satisfactory

b. Quality of Supervision : Satisfactory

c. Overall Bank Performance : Moderately Satisfactory

9. Assessment of Borrower Performance:

Government Performance is rated Satisfactory . Given that 96% of planned disbursements were completed before the political crisis, Government Performance will be assessed based on the performance of the Government before the crisis. There was strong Government ownership and buy-in from the start, and the project benefited from the presence of high-level staff who had been in the sector since the beginning of the Bank's involvement and had worked either indirectly or directly on previous Bank health projects . This allowed for continuity in the sector over the long term. Strong leadership at the highest levels of the MOH resolved minor technical issues by ensuring the continuity of the strategic vision guiding policy and implementation . The ICR (p. 28) indicates that there was a planned US$ 5.0 million contribution from the Government, but the TTL explained that there was no such planned contribution.

Implementing Agency Performance is rated Highly Satisfactory . The PCU had a number of technical staff with experience in previous Bank-sponsored health projects, resulting in efficient implementation. PCU staff, integrated within the MOH, participated fully in the MOH's policy and technical discussions, resulting in implementation of activities under a comprehensive and cohesive framework . The PCU staff approached issues with an action-oriented, problem-solving approach, worked in close collaboration with the Bank supervision team, and continued their work during the political crisis, despite delays in salaries and other resources for administrative tasks, with diligence and efficiency. The PCU now manages resources of the Global Fund to Fight AIDS, Tuberculosis, and Malaria, as well as Bank HIV/AIDS resources.

a. Government Performance : Satisfactory

b. Implementing Agency Performance : Highly Satisfactory

c. Overall Borrower Performance : Satisfactory

10. M&E Design, Implementation, & Utilization:

M&E Design. The PAD (pp. 11-12) specifies a results framework for the five-year PDSS and three broad sets of indicators (availability and use of resources; effectiveness of system processes; outputs resulting from these processes) as well as a set of outcome indicators to measure progress . The PAD (pp. 11-12) also specifies a parallel but related system to track inputs and results specifically attributable to Bank-sponsored interventions. There is detailed discussion of roles and responsibilities related to data collection . However, baselines and targets are absent for many indicators, and there are no indicators to measure the main objectives of the project (access and utilization, especially in rural and remote areas) in the original project design, and only two indicators to measure these objectives added in October 2008 (with even those proposed retrofitted indicators not addressing access and utilization in rural and remote areas -- see next para).

M&E Implementation . The deficiencies in M&E design could have been better addressed during supervision . While supervision aimed to retrofit indicators, the proposed retrofitted indicators had shortcomings . For example, the ICR notes on page (iii), the retrofitted indicator "people with access to a basic package of health, nutrition, or population " services does not "directly relate to project objectives" and not enough information is provided on how "basis package" is defined. The ICR further notes on the same page that the retrofitted indicator "children immunized" was not as relevant as "percentage increase" would have been. Furthermore, the proposed retrofitted indicators did not reference rural and remote areas, which were explicitly referred to in the statement of objectives .

The project financed training on the Health Management Information System (HMIS) and provided resources for the implementation of a DHS. Project support for M&E was incremental, given that M&E was largely funded by other donors; this was appropriate, to ensure that funding for M&E activities was not duplicative . The PCU had one full-time M&E coordinator supported by four technical specialists and an assistant . Two of the three pilots were

evaluated, with the failure to evaluate the third due to the political crisis; it was intended that these evaluations inform the Government and development partners as they scaled up future activities . The project supported updating the national health map and training on the use of software for the health map .

During the August 2008 supervision mission, the Implementation Status Report was revised to include core common indicators for IDA 14 reporting. While this was a Bank-wide mandatory initiative, the indicators were for high-level outcomes that were not directly related to the objectives of the project . According to the ICR (p. 9), a better process could have been used to select core indicators relative to the specific objectives and activities of projects .

M&E Utilization . Because of the political crisis in January 2009, it is unclear that there has been opportunity to use data and analysis generated by the project to inform future policy and interventions . The ICR does not present evidence that M&E was used to fine-tune implementation of the project prior to the political unrest .

a. M&E Quality Rating : Modest

11. Other Issues (Safeguards, Fiduciary, Unintended Positive and Negative Impacts):

Safeguards: This was an environmental category B project . The only safeguard triggered was the environmental assessment, because a Medical Waste Management Plan (MWMP) was required. During the first six months of supervision, the Bank evaluated the implementation of the MWMP, issuing a rating of Unsatisfactory because of lack of sufficient equipment and infrastructure as well as operating budget . A series of key actions were agreed to and implemented to address these issues . At the end of the first year of implementation, environmental safeguards were deemed Moderately Satisfactory, with the understanding that ongoing work and attention to this issue was required . Agreed-upon actions in this area have subsequently been financed by the Bank 's Multi-sectoral STI/HIV/AIDS Prevention Project, which is ongoing . The ICR does not discuss whether these issues have been resolved . The Region later stated that all safeguard issues were resolved by the end of the project .

Fiduciary: There were no significant financial management or procurement issues .

Unintended Positive Impact: Despite the political crisis and subsequent lack of availability of project funds, planning activities at the regional, district, and health center levels continued, with annual work plans completed, prioritized interventions specified, and sources of funding and gaps in financing identified . The ICR (p. 23) cites this as evidence of a positive behavioral shift .

12. Ratings:	ICR	IEG Review	Reason for Disagreement /Comments
Outcome:	Satisfactory	Moderately Satisfactory	Relevance of objectives and achievement of one of the development objectives were substantial, but efficiency, design relevance, and the achievement of the second objective were modest, amounting overall to moderate shortcomings.
Risk to Development Outcome:	Significant	Significant	
Bank Performance :	Satisfactory	Moderately Satisfactory	Some key risks were not properly accounted for during preparation, and there were shortcomings in M&E design, which supervision could have handled better. See Sections 8 and 10.
Borrower Performance :	Satisfactory	Satisfactory	
Quality of ICR :		Satisfactory	

NOTES:
- 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:

It is critically important to build indicators directly measuring project objectives into the project 's results chain and M&E framework. In this case, despite great success in implementing a large and complex number of outputs in a relatively short period of time, it is not possible to assess the project as fully satisfactory because of the lack of evidence on achievement of the project 's specifically stated objectives .

Proper attention to constructing pilots that are directly relevant to the objectives of the project, and to effective and prompt evaluation of those pilots, is essential for a successful contribution to long -term strategic objectives . In this case, baseline data were collected, and financing was provided for proper evaluation, enabling an informed decision on whether or not to scale up .

14. Assessment Recommended? ○ Yes ● No

15. Comments on Quality of ICR:

The ICR is concise, results-oriented, and contains lessons based on evidence and analysis . It presents data on process, output, and outcome indicators related to the project, although many important data are put in footnotes . For many key indicators, data are not provided specifically for the time period of the project . The ICR does not provide sufficient information on the pooled financing arrangement with AFD, and it does not report on access and utilization of services in rural and remote areas even though this was part of the development objectives . There was an understanding that although at the end of the first year of implementation, environmental safeguards had improved to being moderately satisfactory, ongoing work and attention to the issue were required --the ICR does not discuss if all safeguard issues were satisfactorily resolved .

a.Quality of ICR Rating : Satisfactory