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The World Bank

Report No: ICR00001497

IMPLEMENTATION COMPLETION AND RESULTS REPORT
(IDA-43050 TF-58152)

ON A

CREDIT

IN THE AMOUNT OF SDR6.7 MILLION
(US$ 10 MILLION EQUIVALENT)

TO THE

REPUBLIC OF MADAGASCAR

FOR A

SUSTAINABLE HEALTH SYSTEM DEVELOPMENT PROJECT

June 28, 2010

AFTHE
AFCS1
Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective May 30, 2010)

Currency Unit = Ariary

1.927 Ar = USD1

USD 1.55663 = SDR 1

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AFD	*Agence Française de Dévéloppement*	MDG	Millennium Development Goals
AfDB	African Development Bank	MOH	Ministry of Health, Family Planning and Social Protection
AIDS	Acquired Immuno Deficiency Syndrome	MMR	Maternal Mortality Rate
CAS	Country Assistance Strategy	MOU	Memorandum of Understanding
CRESAN II	Second Health Sector Support Project	MWMP	Medical Waste Management Plan
CSR	Country Status Report	OP/BP	Operational Policy/Business Policy
DHS	Demographic and Health Survey	NHA	National Health Accounts
EU	European Union	NGO	Non-Governmental Organization
FM	Financial Management	NTD	Neglected Tropical Diseases
GDP	Gross Domestic Product	PAD	Project Appraisal Document
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria	PDO	Project Development Objective
HMIS	Health Management Information System	PDSS	National Health Sector Development Plan
HIV	Human Immunodeficiency Virus	PCU	Project Coordination Unit
ICR	Implementation Completion Report	RAM	Regional Accounting Manager
IDA	International Development Association	PRMP	Person Responsible for Public Procurement
IEG	Independent Evaluation Group	SHSDP	Sustainable Health System Development Project
IHP+	International Health Partnership and related initiatives	SIL	Specific Investment Loan
ISR	Implementation Status Report	STI	Sexually Transmitted Infections
JAR	Joint Annual Review	SWAp	Sector Wide Approach
JICA	Japanese International Cooperation Agency	TTL	Task Team Leader
JHSSP	Joint Health Sector Support Project	UNDP	United Nations Development Programme
KfW	Kredit Anstalt fur Wiederaufbau	UNFPA	United Nations Fund for Population Activities
M&E	Monitoring and Evaluation	UNICEF	United Nations Children's Fund
MAP	Madagascar Action Plan		

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MADAGASCAR
Sustainable Health System Development Project

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MAP

A. Basic Information

Country:	Madagascar	Project Name:	Madagascar Sustainable Health System Development Project
Project ID:	P103606	L/C/TF Number(s):	IDA-43050,TF-58152
ICR Date:	06/26/2010	ICR Type:	Core ICR
Lending Instrument:	SIL	Borrower:	REPUBLIC OF MADAGASCAR
Original Total Commitment:	XDR 6.7M	Disbursed Amount:	XDR 6.4M
Revised Amount:	XDR 6.7M		
Environmental Category: B			
Implementing Agencies: Project Coordination Unit of SHSDP			
Cofinanciers and Other External Partners:			

B. Key Dates

Process	Date	Process	Original Date	Revised / Actual Date(s)
Concept Review:	02/12/2007	Effectiveness:	08/31/2007	08/31/2007
Appraisal:	03/27/2007	Restructuring(s):		
Approval:	05/22/2007	Mid-term Review:		
		Closing:	12/31/2009	12/31/2009

C. Ratings Summary

C.1 Performance Rating by ICR

Outcomes:	Satisfactory
Risk to Development Outcome:	Substantial
Bank Performance:	Satisfactory
Borrower Performance:	Satisfactory

C.2 Detailed Ratings of Bank and Borrower Performance (by ICR)

Bank	Ratings	Borrower	Ratings
Quality at Entry:	Satisfactory	Government:	Satisfactory
Quality of Supervision:	Satisfactory	Implementing Agency/Agencies:	Satisfactory
Overall Bank Performance:	Satisfactory	**Overall Borrower Performance:**	Satisfactory

C.3 Quality at Entry and Implementation Performance Indicators			
Implementation Performance	**Indicators**	**QAG Assessments (if any)**	**Rating**
Potential Problem Project at any time (Yes/No):	No	Quality at Entry (QEA):	None
Problem Project at any time (Yes/No):	No	Quality of Supervision (QSA):	None
DO rating before Closing/Inactive status:	Moderately Satisfactory		

D. Sector and Theme Codes		
	Original	**Actual**
Sector Code (as % of total Bank financing)		
Central government administration	20	20
Health	62	62
Other social services	7	7
Sub-national government administration	11	11
Theme Code (as % of total Bank financing)		
Child health	23	10
Health system performance	22	42
Other communicable diseases	22	18
Population and reproductive health	22	20
Social safety nets	11	10

E. Bank Staff		
Positions	**At ICR**	**At Approval**
Vice President:	Obiageli Katryn Ezekwesili	Hartwig Schafer
Country Director:	Ruth Kagia	Ritva S. Reinikka
Sector Manager:	Eva Jarawan	Laura Frigenti
Project Team Leader:	Maryanne Sharp	Mukesh Chawla
ICR Team Leader:	Jumana N. Qamruddin	
ICR Primary Author:	Jumana N. Qamruddin	

F. Results Framework Analysis

Project Development Objectives (from Project Appraisal Document**)**
The project development objective of Madagascar SHSDP is to contribute to the strengthening of the health system and enhance the institutional capacity of the Ministry

of Health to improve the access and utilization of health services, especially in rural and remote areas.

Revised Project Development Objectives (as approved by original approving authority)

(a) PDO Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	People with access to a basic package of health, nutrition, or population services (Number)			
Value quantitative or Qualitative)	7,680,000 (PAD)	11,520,00 (MOH)		11,077,000
Date achieved	12/30/2005	06/01/2007		12/31/2008
Comments (incl. % achievement)	This is an IDA retrofitted indicator and does not directly related to project objectives. There is not enough information on how "basic package" is defined.			
Indicator 2 :	Children immunized			
Value quantitative or Qualitative)	83,510 (MOH)			358,592 (MOH)
Date achieved	12/30/2005			12/31/2008
Comments (incl. % achievement)	This is an IDA retrofitted indicator. Percentage increase would have been more relevant.			
Indicator 3 :	Health sector budget execution rate (recurrent and investment)			
Value quantitative or Qualitative)	65% (MOH)	100% (PAD)		86% (MOH)
Date achieved	12/30/2005	06/01/2007		12/31/2009
Comments (incl. % achievement)	The original target value was set for 2011.			
Indicator 4 :	Two Joint Health Sector Reviews per year are held with all development partners			
Value quantitative or Qualitative)	N/A	Two/year (PAD)		1(2007) 2(2008) 0(2009)
Date achieved	06/01/2007	06/01/2007		12/31/2009
Comments (incl. % achievement)	Three joint health sector reviews were held by the end of the project (September 2007, May 2008, and December 2008). No review was held in 2009 due to the political crisis.			
Indicator 5 :	Health Sector MTEF 2009-2012 is updated and validated			

Value quantitative or Qualitative)	N/A			Validated MTEF available (MOH)
Date achieved	06/01/2007			12/31/2009
Comments (incl. % achievement)				

(b) Intermediate Outcome Indicator(s)

Indicator	Baseline Value	Original Target Values (from approval documents)	Formally Revised Target Values	Actual Value Achieved at Completion or Target Years
Indicator 1 :	Number of primary and secondary health care facilities in line with technical norms of Ministry			
Value (quantitative or Qualitative)	N/A	47 (PAD)		48 (MOH)
Date achieved	06/01/2007	06/01/2007		12/31/2009
Comments (incl. % achievement)				
Indicator 2 :	Number of packages of drugs and consumables distributed to primary and secondary health facilities			
Value (quantitative or Qualitative)	N/A	25 (PAD)		25 (MOH)
Date achieved	06/01/2007	06/01/2007		12/31/2008
Comments (incl. % achievement)				
Indicator 3 :	Number of safe delivery kits provided free of charge to primary health centers			
Value (quantitative or Qualitative)	N/A	100,000 (PAD)		393,833 (MOH)
Date achieved	06/01/2007	06/01/2007		12/31/2009
Comments (incl. % achievement)				
Indicator 4 :	Number of maternal kits distributed			
Value (quantitative or Qualitative)		10,000 (PAD)		
Date achieved		06/01/2007		
Comments (incl. % achievement)	This indicator was integrated with the safe delivery kits indicator above.			

Indicator 5 :	Percentage of completed integrated workplans submitted			
Value (quantitative or Qualitative)		100% (PAD)		100% (MOH)
Date achieved		06/01/2007		12/31/2008
Comments (incl. % achievement)				
Indicator 6 :	Number of cesarean delivery kits provided			
Value (quantitative or Qualitative)		870 (MOH)		1,267 (MOH)
Date achieved		06/01/2007		12/31/2009
Comments (incl. % achievement)				
Indicator 7 :	Number of health personnel trained in the provision of delivery of quality services			
Value (quantitative or Qualitative)				10,355 (MOH)
Date achieved				12/31/2008
Comments (incl. % achievement)				
Indicator 8 :	Number of contraceptives distributed			
Value (quantitative or Qualitative)				33,000 (MOH)
Date achieved				12/31/2008
Comments (incl. % achievement)				
Indicator 9 :	Number of TB cases treated			
Value (quantitative or Qualitative)				3,103 (MOH)
Date achieved				12/31/2009
Comments (incl. % achievement)				

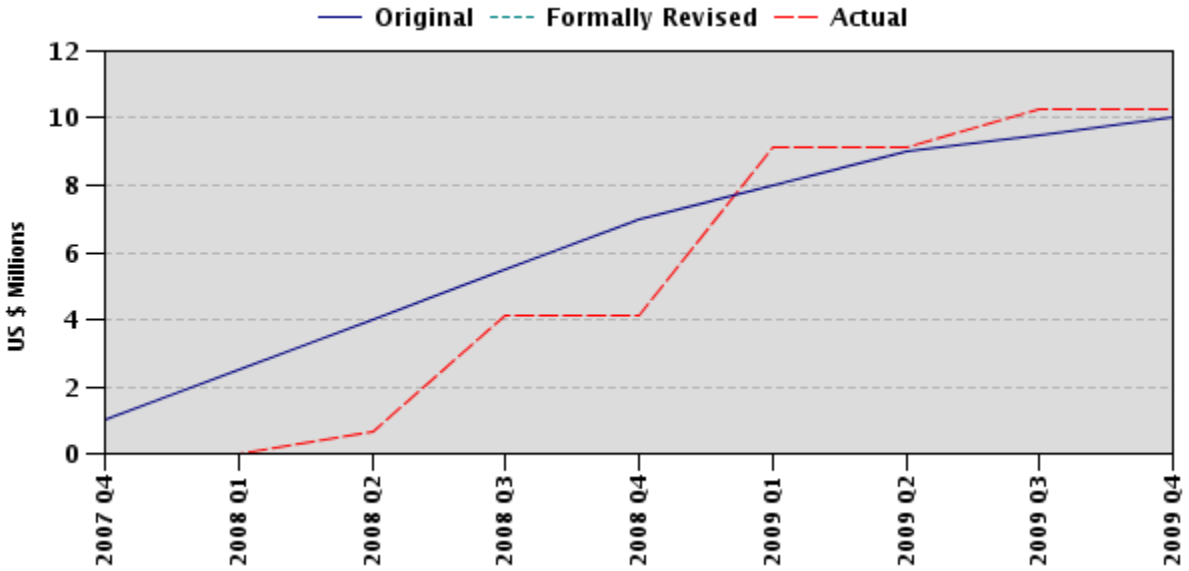
G. Ratings of Project Performance in ISRs

No.	Date ISR Archived	DO	IP	Actual Disbursements (USD millions)
1	12/04/2007	Satisfactory	Satisfactory	0.65
2	03/26/2008	Satisfactory	Satisfactory	4.11
3	08/31/2008	Satisfactory	Satisfactory	9.16
4	02/26/2009	Satisfactory	Satisfactory	10.28
5	06/15/2009	Moderately Satisfactory	Moderately Satisfactory	10.28
6	11/11/2009	Moderately Unsatisfactory	Moderately Satisfactory	10.28
7	12/28/2009	Moderately Satisfactory	Moderately Satisfactory	10.28

H. Restructuring (if any)

Not Applicable

I. Disbursement Profile



1. Project Context, Development Objectives and Design

1.1 Context at Appraisal

1. At the time of appraisal in early 2007, Madagascar had made good progress since the political and economic crisis of 2002. Immunization rates had improved, the infant and child mortality rates had declined significantly over the last decade and chronic malnutrition had decreased. Similarly, progress had been made on reducing poverty, which declined to 70 percent from its peak level of 80 percent at the time of the 2002 crisis.

2. Despite progress in some areas, the rates of infectious diseases were still very high and were disproportionately affecting the poor. The tuberculosis (TB) prevalence rate[1] had increased from 359 to 417 by 2007, and incidence rate[2] reached 251 from 217. The maternal mortality ratio[3] (MMR) had decreased only slightly from 488 in 1997 to 469 in 2003. Some estimates suggest that there was a slight increase to 510[4] in 2005. This stagnation and possible worsening was in part attributable to lack of access to skilled staff at delivery and a poorly functional referral system that did not comprise all elements of emergency obstetric care. Given that a large percentage of women did not give birth in a health center, post-natal care interventions were all the more critical for the health of the newborn and the mother yet referral and emergency services were generally difficult for women to access, particularly in rural areas, further amplifying some of these differences.

3. In addition, there were large income inequalities in access and utilization of health services across the country. The inequality in the supply of health services was closely linked to the unequal distribution of human resources as well as varying levels of training and competence of the medical staff. A few hospitals in major cities had an inordinately high of number doctors and specialists, while there were huge needs for specialized staff in areas such as gynecology, surgery and pediatrics at the regional level. Similarly, the distribution of doctors across rural and urban areas showed serious imbalances. While health centers in urban areas had, on average, more personnel than required by the national standard, health centers in rural areas had much less staff[5]. This issue was highlighted in the National Health Sector Development Plan (PDSS) as a key bottleneck in access to and delivery of health services, especially in rural and remote areas.

4. Health policy issues featured prominently in the country's development plans as evident in its Madagascar Action Plan (MAP), 2007-2011. The Ministry of Health, Family Planning and Social Protection (henceforth: MOH) formulated a comprehensive

[1] (per 100,000 population)
[2] (per 100,000 population)
[3] (per 100,000 live births)
[4] UNICEF/WHO
[5] For example, 46 percent of all doctors working in the public sector in Madagascar were located in the former province Antananarivo, serving only 28 percent of the population of the country.

PDSS identifying a number of key bottlenecks to increased access and utilization of health services and improvement in health indicators. Despite this prioritization in policy, the country was spending very little on health at about US$12 per capita[6], corresponding to about 3.5 percent of GDP. These numbers were well below the US$30 to US$40 per person per year recommended by the WHO[7] to finance a package of essential services. At these levels of expenditures, the country would not be able to achieve the health related Millennium Development Goals (MDGs). At the time, it was estimated that an additional US$5.40 per capita per year would be needed for three years to achieve a 41 percent reduction in child mortality and a 35 percent reduction in neonatal and maternal mortality[8] required to sustain progress in achieving these MDGs.

5. External assistance was the main source of financing in the sector, representing about 37 percent[9] of total spending on health, with a number of development partners[10] working in the country. This funding was extremely fragmented because partners were supporting the Government through parallel financing streams to address the dysfunctions and bottlenecks within the health care system. In addition, the high volatility and unpredictability of these funds and the complexity of managing projects with different procurement and monitoring mechanisms made budget planning and execution in the Ministry difficult. Moreover, a number of health projects that had been active in the country since the 1990s were coming to an end and the Government was unlikely to sustain the levels of expenditures on health without additional financial aid from the donor community.

6. The rationale for continuing[11] Bank assistance was strong at the time of appraisal. It was seen as essential for sustained and gradually enhanced IDA financing as well as being important for leveraging other donor financing for the health sector in Madagascar. This was in line with IDA-14 goals on leveraging and partnerships. The World Bank had been supporting the health sector in Madagascar as a lead donor through a number of health-specific and multi-sectoral projects in the past decade. It was also a key agency in a consortium[12] that was being created to support the health sector via the sector-wide approach. The Sustainable Health System Development Project (SHSDP) represented the next stage with respect to the World Bank and other development partners' support for the health sector. It was consistent with the Bank's strategy for long term engagement in

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[6] National Health Accounts (NHA) 2003
[7] Commission for Health and Macroeconomics, WHO, 2002
[8] MOH, with the support of UNICEF.2005
[9] NHA,2003
[10] African Development Bank (AfDB), Agence Française de Dévéloppement (AFD), European Union (EU), Japanese International Cooperation Agency (JICA), United Nations Children's Fund (UNICEF), United Nations Fund for Population Activities (UNFPA), United Nations Development Programme (UNDP), United States Agency for International Development (USAID) and World Health Organization (WHO)
[11] The World Bank has been supporting the health sector through a number of health-specific and multi-sectoral projects since the 1990s. These included the Second Health Sector Support Project (CRESAN 2), which was approved in November 1999 and closed in December 31, 2007. Other projects included the Multisectoral STI/HIV/AIDS Project (US$20 million, closing date: December 2007), Community Development Fund (US$176 million, closing date: June 2008), Second Community Nutrition Project (US$47.6 million, closing date: December 2009), and the ongoing Second Multisectoral STI/HIV/AIDS Project (US$30 million, closing date: December 2010).
[12] The consortium included the AfDB, AFD, the EU, the French Cooperation, JICA, UNICEF, UNFPA, USAID, WHO, and the World Bank.

the sector for supporting the Government's move toward a more harmonized and better functioning health system that focused on results.

7. The SHSDP was included in the Country Assistance Strategy (CAS) and directly supported the objectives under Pillar 2 which included "improving services to people" and "achieving better outcomes in education and health." The project was consistent with the CAS principles and approach of alignment with the government program as outlined in the MAP and PDSS, harmonization and coordination with other donors, and preparation of a sector-wide approach (SWAp) to the health sector aimed at bettering health outcomes.

1.2 Original Project Development Objectives (PDO) and Key Indicators (*as approved*)

8. The PDO of the SHSDP is to contribute to the strengthening of the health system and enhance the institutional capacity of MOH to improve the access and utilization of health services, especially in rural and remote areas. The key indicators are listed above in the datasheet.

1.3 Revised PDO (as approved by original approving authority) and Key Indicators, and reasons/justification

9. The PDO and key indicators did not change.

1.4 Main Beneficiaries

10. The project was intended to benefit the entire population of Madagascar accessing public health services. There was an added focus on the population in rural areas which was estimated to be about 73 percent of the population (13.6 million people).

1.5 Original Components (*as approved*)

11. The total amount of financing was US$10 million implemented over 2.5 years and the original components were as follows:

12. **Component 1: Strengthening Delivery of Health Services (US$5.3 million):** This component sought to strengthen health service delivery and quality of services at the primary and first referral levels in districts through capacity building of districts to better organize, manage and deliver health goods and services, and provision of goods and services to strengthen health centers, including drugs, medical supplies and equipment.

13. **Component 2: Development and Management of Human Resources in the Health Sector (US$0.9 million):** The objective of this component was to improve human resource management in the health sector with particular emphasis on rural areas. To this end, this component financed the development of innovative mechanisms to provide incentives to rural based personnel and promote enhanced performance of such personnel. It also supported training of all health personnel on basic health service

delivery, such as diagnosis and treatment of infectious diseases, pregnancy and delivery management, as well as health care-for children and new-born babies.

14. **Component 3: Innovations in Health Financing Management (US$0.6 million):** This component sought to support creative resource mobilization and strengthen health resource allocation, through the development of a variety of mechanisms designed to mobilize additional health resources through programs such as social insurance, and through improved management of existing private and public funds for the health system.

15. **Component 4: Improving Demand and Utilization of Health Services (US$1.05 million):** This component endeavored to stimulate demand for quality health services through community education and awareness campaigns, and developing mechanisms for conditional cash transfers.

16. **Component 5: Institutional Strengthening (US$2.15 million):** This component supported a number of system development and institutional strengthening activities, such as procurement and financial management and program oversight. In addition, the component financed a number of monitoring and evaluation (M&E) activities, including development of an M&E plan, support to the National Health Information System and strengthening of Government's analytical capacity for better use and management of data.

1.6 Revised Components

17. Project components were not revised.

1.7 Other significant changes

18. There were no significant changes in the implementation arrangements or funding allocations during the life of the project.

2. Key Factors Affecting Implementation and Outcomes

2.1 Project Preparation, Design and Quality at Entry

19. ***Project Preparation.*** The SHSDP was prepared in the context of the World Bank's commitment to supporting the Government of Madagascar in implementing its long term strategy in the health sector. The project preparation phase was short but was a collaborative process with both the Government and partners participating in project development from the outset. The preparation of the project benefitted from:

- **Implementation experience from previous operations.** The SHSDP was the logical next stage with respect to the World Bank's support for the health sector. As the previous operation, the Second Health Sector Support project (CRESAN II), benefitted from the implementation experiences of the Bank supported CRESAN I and other donor programs, so did SHSDP benefit from the

implementation experience and lessons learned[13] from CRESAN II as well as other programs in the health sector.

- **Supporting the National Health Sector Development Plan through a participatory approach.** The project preparation process[14] involved active collaboration between the Bank, the MOH, and development partners. The operation promoted a harmonized approach in the sector by supporting the achievement of key outcomes and indicators as outlined in the health sector strategy formulated by the MOH in the PDSS. The objectives of the project supported the achievement of key interventions highlighted in MAP[15]. This ensured that there was Government ownership and partner buy-in from the start.

20. ***Project Design.*** From the outset, the SHSDP was envisioned to be an essential step[16] in strengthening the health sector for better service delivery by focusing on addressing key systems and institutional capacity issues such as fragmentation of support from donors and budget planning and execution. This was coupled with supporting health interventions and testing innovative solutions to address health challenges that were disproportionately affecting the poor in more rural and remote areas of the country. It was envisioned that the gains made under the SHSDP would be supported and furthered through subsequently larger investments, starting with a planned follow-on Bank operation[17] to help meet the objectives outlined in the country's MAP and PDSS.

21. The initial modest investment of the SHSDP (US$10 million) and short timeline (30 months) was appropriate as it allowed the Government to further ensure that the principles of a more efficient and effective system were in place by increasing harmonization and coordination in the health sector and enhancing the institutional capacity of the MOH to more effectively deliver health services as a primary objective

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[13]lessons: 1) The project was able to reach its goals despite all obstacles thanks to the flexibility of the project design and implementation. 2) The decentralization of the activities financed by the project, and particularly the technical assistance offered to the decentralized levels of the Ministry, allowed a smoother implementation of activities and the achievement of the PDO. However, technical assistance to the central level was also needed to ensure a sustainable development of the health system. 3) Close coordination with other partners under the leadership of the Government is important for success. 4) To increase service utilization, it is important to make sure that all causes of non-utilization are dealt with. This project only aimed at improving geographical access by trying to build new facilities. However, the main cause of non-utilization of health services has always been their cost. 6) As the project changes, it is important to formally revise the monitoring and evaluation framework to ensure that the project's progress is correctly monitored. CRESAN II changed significantly across the years but the M&E framework did not, making it difficult to follow its progress in achieving the PDO or to correct any problem in time.

[14] The project preparation period was four months long.

[15] The MAP – which sets very ambitious targets in the areas of maternal and child mortality, fertility rate, malaria, tuberculosis, sexually transmitted diseases and HIV/AIDS control, and reduction of malnutrition in children under the age of five – is multi-sectoral in nature and recognizes the importance of system and institution strengthening.

[16] The World Bank's Independent Evaluation Group (which completed a country assistance evaluation in July 2006 of IDA's involvement in Madagascar for 1995-2005) also recommended limiting the role of budget support until there was a sustained improvement in collecting and managing public resources.

[17] The Project Appraisal Document and Aide Memoires outline the aim of this project in strengthening the sector for a larger investment. The discussions and preparations for the follow-on project with partners and the Government began during the first supervision mission for the SHSDP in September of 2007, right after the effectiveness of the project. The follow-on project was fully prepared and negotiated by January 2009 for a total program cost of US$ 85 million. The project was pulled from the Board due to the political crisis.

and secondly to prepare the sector to better manage and utilize more resources starting with a planned larger investment. In the longer term, the activities under the SHSDP were designed contribute to the Government's vision to implement a SWAp tied to results in health. This two-step financing model (a smaller investment to resolve some critical systems and institutional challenges and to implement key health interventions followed by a larger investment) best responded to the country context at the time of project preparation.

22. The health systems activities were complemented by support to strengthen the delivery of key health interventions and implementation of supply and demand side activities aimed at increasing utilization of health services especially in rural and remote areas. In this context, the human resource focus was appropriate[18] as was the focus on strengthening and/or upgrading facilities in rural and remote areas. The project design supported the implementation of innovative approaches and key activities to boost progress on pro-poor and potentially high impact interventions[19] related to maternal and child health and communicable diseases. In this respect, the project was ambitious and aimed to do a lot with a relatively small amount of financing. There could have been a potential benefit to narrowing the health intervention focus instead of including financing for so many different activities.

23. ***Design of Implementation Arrangements***. The implementation arrangements for the project were designed well and aimed to take advantage of capacities already built in the sector while providing support key areas[20] that needed to be strengthened. The arrangements also ensured that the Project Coordination Unit (PCU) for SHSDP was firmly embedded in the structure of the MOH and supported the overall objectives of the sector while ensuring the implementation of the project (as described in more detail below). The design of the implementation arrangements was also appreciated by other partners and projects as evidenced by the fact that the PCU is currently managing Global Fund and Bank HIV/AIDS resources.

24. The implementation of the country's PDSS was overseen by the MOH, through its relevant directorates and services. Decisions were made by a management team which was responsible for closely monitoring project activities (including the tracking of performance indicators, sector issues and health status/epidemic trends), donor coordination, and making concrete recommendations of ways to improve overall program and project implementation.

25. Within this structure, responsibility for the SHSDP coordination rested with the PCU and was essentially made up of staff from the project unit of CRESAN II[21]. The

[18] Addressing one of the key issues to equitable delivery of services in the country
[19] E.g. DOTs for tuberculosis, drugs for NTDs, family planning, and obstetric care
[20] Aspects of FM, budget planning and execution, and procurement
[21] This unit has performed its duties satisfactorily and acquired experience in managing IDA funded activities, coordinating donors, NGOs, various MOH services and district health authorities. At appraisal, the PCU's current capacity, daily working arrangements, procurement and financial management mechanisms and partnerships with other MOH directorates and services were reviewed to ensure confirm capacity. Other donors have expressed interest in using this PCU for the execution of their activities (e.g., AFD); thus the PCU will be staffed accordingly.

coordinator of the PCU reported to the Secretary General and the Minister of Health, and participated in the MOH management team together with the other central directors, and the senior staff of the health districts. The project staff benefitted from having an internal controller to oversee all administrative and financial transactions; a highly qualified accountant with at least one assistant; two procurement specialists; and a procurement assistant. Implementation of project activities was the responsibility of key MOH Directorates who collaborated closely with the decentralized health districts.

26. ***Lending Instrument***. The lending instrument, a Specific Investment Loan (SIL), was appropriate to the project objectives as the financing was helping to ensure that the sector was sufficiently prepared for implementing the larger operation.

27. On the basis of the above, the design of the project was appropriate for achieving project outcomes.

28. ***Risks.*** There were a number of risks[22] outlined in the PAD with adequate mitigation measures overall. However, potential risks associated with health system and institutional strengthening activities as well as partnerships could have been better elaborated. For example, the team did not identify the risk associated with donors agreeing to move forward in a more harmonized and coordinated manner as a risk. Given that this was one of the aims of the project, it would have been useful to have included it in the table.

29. The most significant risk to the project and related development outcomes was the political crisis. This was an unforeseeable event and could not have been planned for at the outset of the project. That said, the task team worked with partners and the MOH to mitigate the potential negative effects of the crisis during implementation of the project by playing a key role in ensuring that there was at least a small amount of financing (through AFD) to carry on critical activities after project closing and in the absence of the envisioned Bank financing.

2.2 Implementation

30. The detailed implementation summary highlighting achievements and challenges can be found in annex 6. Implementation can be divided into two distinct phases:

- ***Phase One: Pre-political Crisis*** (October 2007-January 2009)

  The project achieved a lot in a short period of time. The majority of project activities were completed within this phase with 96 percent of the credit being disbursed. There was positive progress toward the achievement of project indicators. Overall,

[22] The risks were: 1) Health personnel do not want to move to rural areas, 2) Project time is too short and resources too limited to have a measurable impact, 3) Health service strengthening does not result in utilization of health services, 4) Ministry moves away from agreed activities and redirects own budget resources away from agreed priorities, 5) Demand for basic health services is stimulated but supply cannot respond, 6) Conditional cash transfers do not reach the intended target population targeting issues, and 7) Risk of delays in the production of financial reports, and audit may not be conducted in compliance with international auditing standards.

implementation went smoothly with a very quick start-up after effectiveness[23]. The larger follow-on project, the Joint Health Sector Support Project (JHSSP) was prepared and negotiated with pooled financing from AFD. Madagascar was also successful in becoming a member country of the International Health Partnership and related initiatives (IHP+), another positive step towards the sector's eventual move to a SWAp.

- ***Phase Two: Political crisis*** (January 2009-December 2009)

In January 2009, Madagascar suffered severe civil unrest. As result of the change in Government, the Bank portfolio was subject to OP/BP 7.30 *Dealing with De Facto Governments* as of March 17, 2009 whereby disbursements were stopped. Given that most of the project funds had been disbursed, only US$453,900 was unable to be disbursed. The balance of the special account had been fully committed and spent by the end of the project[24].

31. While there were some delays, the crisis did not have much impact on the activities being implemented under the SHSDP and the project was able to achieve its objectives with support of the resources in the special account.

32. The crisis did, however, put the achievement of the project achievements at risk and had a negative impact on the progress made in the health sector more broadly[25]. As a result, and following management guidance on the need to downgrade the project ratings of all projects in the portfolio given the situation, the PDO was downgraded to Moderately Unsatisfactory in the Implementation Status Report (ISR) of November 2009 as a precautionary measure given the country situation at the time. This rating was upgraded to Moderately Satisfactory in the final ISR in recognition of the project's strong performance in mitigating the negative effects of the crisis on implementation. The decision not to downgrade the IP from Moderately Satisfactory was appropriate given the efforts of the project in completing all activities despite the political crisis and the lack of financing.

33. OP/BP 7.30 has continued to be applied across the portfolio as of the time of this ICR. With regard to SHSDP, this presented unique challenges to implementation. OP/BP 7.30 is not designed to be used for such a continuously long period of time and there is no operational guidance on how to manage the portfolio under such

[23] Within the first two months, the first supervision mission was held along with a joint annual review (one of the key indicators of the project). The work plan and procurement plan were approved and the first deposit to the special account was requested.

[24] Focused on closing activities and necessary evaluations during the last six months of the project

[25] A key example was the decision by the new Government in June 2009 to replace the majority of the staff in the health sector, including at the regional levels. Out of the 22 regional directors, only three remained. This resulted in a loss of knowledge, institutional memory and capacity built over the years, given that most of the staff had been implicated in more than one Bank-financed project.

circumstances. In this context, the Bank team managed to find practical solutions to ensure that the project continued implementation. The PCU staff continued their work with the same amount of efficiency and diligence despite delays in salaries and other resources for administrative tasks. While the broader development outcomes were at risk as described above, the project performed well despite the politically challenging circumstances. Therefore, there is clear justification that the project should be rated as Satisfactory[26].

2.3 Monitoring and Evaluation (M&E) Design, Implementation and Utilization

34. ***Design of the Results Framework*:** There were three dimensions to the monitoring of the achievement of the PDO: i) monitoring of project indicators as defined in the credit agreement; ii) monitoring of key additional output and process indicators that were relevant to the PDO; and iii) monitoring of key sector indicators related to the PDSS to which the project was contributing to but could not claim full attribution.

35. The design of the Results Framework for the project was ambitious and very complex in an attempt to link the system strengthening support by the project to the MAP objectives to create an integrated framework to monitor and evaluate progress across multiple dimensions. Within in this framework, a group of indicators were used to monitor the performance of the SHSDP. While the complexity was necessary given that the project was part of a longer term strategy for the health sector, it made the Results Framework for this particular operation bulky. Moreover, while the process and output indicators were clearly linked to the intermediate indicators[27] in the Result Framework, the link from the intermediate indicators to the high level outcome indicators could have been illustrated more clearly.

36. On the positive side, the Bank's results indicators for the project were clearly outlined in a table and were restricted to output and process indicators which were relevant to what the project was trying to achieve given its scope.

37. During the August 2008 supervision mission, the ISR was revised to include core common indicators for IDA 14 reporting. While this was a Bank-wide mandatory initiative, the indicators for health were high level outcomes that were not directly related to the objectives of the project. Although the task team monitored these indicators, a better process should have been used to select those core indicators relative to the specific objectives and activities of projects.

38. The project financed training for the MOH on the Health Management Information System (HMIS) and provided resources for the implementation of the DHS. The support provided under the project for M&E was incremental given that these

[26] There is a difference between the ICR rating for the project and the ISR ratings. The ISR ratings review the last 6 months of a project whereas the ICR is reflecting on the entire project. In this regard, the project performed very well before the political crisis.

[27] This project focused on achievement of output and intermediate outcome indicators.

aspects were sufficiently funded by other donors. This was appropriate to ensure that the funding for M&E activities was complementary not duplicative.

39. ***Implementation and utilization***: M&E went smoothly during the life of the project and was satisfactory overall. The PCU had one full-time M&E coordinator supported by four technical specialists and an assistant. Given the many activities that were being implemented, the capacity was appropriate and as a result, the PCU was able to effectively monitor the project at central level. In addition:

- Activities under Component 5 on M&E were adequately implemented as highlighted in Implementation Summary in annex 6.
- There was also project funding set aside for evaluating the pilots under the project to learn what worked, what didn't, and why. This indicated that the pilots[28] were regarded as a learning opportunity for finding innovative approaches for improving health outcomes that had the potential of being scaled-up. Two of the pilots were evaluated but one was unable to be evaluated due to the political crisis.
- In October 2008, there was a decision to amend the credit agreement to include indicators that more accurately reflected objectives of project. While this was a good decision given that the indicators selected for inclusion into the credit agreement did not capture the objectives of the project comprehensively, the amendment was not signed because of the political crisis.
- As a result of the crisis, the rating for M&E was appropriately downgraded to a Moderately Satisfactory because regular supervision missions were not possible by the PCU.

2.4 Safeguard and Fiduciary Compliance

A. Fiduciary

40. There were no significant issues with the fiduciary aspects of the project.

41. ***Financial Management (FM).*** During project preparation, the FM assessment of the previous health project (CRESAN II) and related operating units of the MOH satisfied the Bank's minimum requirements specified in OP/BP 10.02. A FM plan was developed and carried forward with the MOH outlining key measures to further strengthen the financial management system to allow for efficient use of report-based disbursements. The project made significant progress in strengthening the system vis-à-vis FM and continued to remain compliant with OP/BP 10.2. This was highlighted in Aide Memoires and ISRs of the project. This was a good approach and ensured that the project took advantage of capacities already built in the sector while providing financing to strengthen identified weaknesses during project preparation.

42. To mitigate risks raised by the limited capacity of the Auditor General (*Chambre des Comptes*), the partners and Government agreed that, as an interim measure, an international private auditing firm would carry out the audit of the program accounts

[28] Results from pilot are discussed in the Implementation Summary Annex 6 and Achievement of PDO section.

jointly with the Auditor General. These audits were performed bi-annually and all audit reports were received in a timely manner. The project continued to make adjustments to strengthen the FM aspects throughout the life of the project through Component 5 in order to ensure that there was an adequate system in place for the follow-on investment. As a result of the above, FM was appropriately rated as Satisfactory with a Low Risk rating.

43. ***Procurement.*** A Procurement Capacity Assessment of MOH, including training needs and arrangements, was conducted as part of the project preparation and it was agreed with MOH that the existing procurement unit of CRESAN II would continue to function as the procurement unit for SHSDP. The procurement staff of the MOH were twinned and housed with the SHSDP procurement unit to ensure transfer of capacity and knowledge. There were some delays during project implementation[29] in this area.

B. Safeguard policies

44. ***Medical Waste Management Plan***. The only safeguard triggered was the environmental assessment, because a Medical Waste Management Plan (MWMP) was required[30]. The proposed project was classified as environment "category B" for environmental screening purposes, given the risks associated with the handling and disposal of medical wastes. During the first six months of supervision, the Bank had the opportunity to evaluate the implementation of the Medical Waste Management Policy. Although some progress had been made, the performance was rated Unsatisfactory because of the lack of sufficient equipment and infrastructure as well as operating budget.

45. A series of key actions were agreed to and implemented to address the issues of lack of infrastructure and insufficient supervision. At the end of the first year of implementation, environment safeguards were deemed Moderately Satisfactory with the understanding that on-going work and attention to this issue was needed. This was justified given that, despite the political crisis in the country, most of the actions[31] agreed to in 2008 were completed satisfactorily. Those activities requiring a specific budget by the follow-on Bank operation were unable to move forward due to the crisis. However, these activities have subsequently been financed by the Bank-financed Multi-sectoral STI/HIV/AIDS Prevention Project, which is on-going.

2.5 Post-completion Operation/Next Phase

46. A follow-on operation, the JHSSP, was prepared and negotiated by January 30, 2009. This project leveraged additional resources through a pooled financing effort under the JSSP with US$63 million from IDA and US$19.5 million in co-financing from AFD (in silent partnership with KfW). The project responded to the remaining gaps in the sector and was complementary to other activities with a design that integrated lessons

[29] Elaborated in Implementation Summary Annex 6
[30] The Project did not trigger any of the Banks social safeguard's policies, since land was not expected to be acquired and work was limited to rehabilitation of existing infrastructures
[31] Detailed action plan can be found in Annex 3 of the May 2008 Aide Memoire

learned and implementation experience from the previous operations. The design also incorporated some key findings from the evaluation of SHSDP by AFD to identify potential activities for funding. The pilots that were implemented under the SHSDP were to be adjusted based on the results of their evaluations and scaled up under the JHSSP and by various partners, such as UNFPA.

47. The partnership arrangements under the JHSSP clearly outlined a way forward with respect to the pooled financing[32]. A MOU outlining the Guiding Principles for a SWAp laying out the coordination, financing and monitoring principles governing the implementation of the PDSS was signed by the MOH and 22 development partners during the third Joint Health Sector Review in December 2008. These Guiding Principles were to serve as the foundation for the development of a Country Compact, a critical milestone of IHP+ to be prepared in 2009; however, this did not move forward because of the crisis.

48. Due to the political crisis, the JHSSP was pulled from the Board and most partners in the sector moved toward funding emergency needs of the country. AFD is putting in place an interim project of €5 million for 12 months to move forward some of the key activities envisioned under the JHSSP and as a stopgap measure until the Bank re-engages in the sector. While there have been setbacks in the health sector due to the political crisis, the PDO is protected to some extent given that AFD, KfW, and the Bank are committed to continuing the pooled funding mechanism as a way to support the sector once the political situation normalizes.

3. Assessment of Outcomes

3.1 Relevance of Objectives, Design and Implementation

49. The political crisis in Madagascar was an unforeseen event and has negatively impacted the overall health sector. This must be taken into consideration when looking at the relevance of the project and its performance, which should largely be assessed within the country context before the crisis.

50. ***Objectives (Substantial):*** The operation provided modest financing as part of a longer term health sector strategy to achieve key health outcomes but it had too short of a timeline with the added challenge of the crisis to link the health system and institutional strengthening activities to improved access and utilization of health services in all areas. However, the project did have a number of output indicators that were successfully achieved well before the closing date of the project and would have likely been linked to the improvement in access and utilization of services had the political situation in the country remained stable.

[32] It was envisioned that a separate Collaboration Agreement outlining the organizational, institutional and coordination arrangements for implementation, the roles and responsibilities of each partner pooling their resources as well as and arrangements for adding new partners during implementation, would be signed initially by the Government, AFD and the World Bank. The goal was that participating donors would gradually expand the share of their support to be pooled and that other donors would switch from parallel to pooled funding as projects closed

51. The main aims of the project are still relevant and are firmly embedded in the country development plans, including the MAP. The project also clearly responds to the bottlenecks outlined in the country's PDSS. The project supports the objective of the Madagascar CAS Pillar II (2007-2011) which focuses on strengthening delivery of health services. The Bank's CAS 2007-2011 aims at contributing to these goals by helping to improve access and quality of services. In summary, the objectives of the operation were supporting the longer term objectives of the health sector in Madagascar.

52. ***Design (Substantial):*** The design of the project is still relevant today. It focused on health system and institutional strengthening activities (Components 1, 3 and 5) and aimed to address some of the following gaps as outlined in the PDSS as a first step in resolving them:

- poorly equipped health centers and low levels of capacity to produce and deliver health services, especially in rural and remote areas (Components 1 and 3);
- uneven staffing of health facilities, especially in rural and remote areas (Component 2) ;
- low levels of health financing and inefficiencies in resource allocation (Component 3); and
- inadequate demand for health services and low levels of utilization (Component 4).

53. The SHSDP was recognized as an essential part of a longer term engagement of the Bank in supporting the evolution of a more harmonized health sector that would produce better health outcomes in Madagascar.

54. ***Implementation (Substantial):*** The implementation strategy is still relevant today, despite the political crisis and the Bank's current inability to finance the envisioned larger follow-on project. AFD is financing priority activities in the interim through the same implementation mechanisms envisioned under the JHSSP. This is in line with the long term strategy of the health sector in functioning through a SWAp mechanism.

3.2 Achievement of Project Development Objectives

55. Rating: **Substantial.** The PDO for the project is to contribute to the strengthening of the health system and enhance the institutional capacity of MOH to improve the access and utilization of health services, especially in rural and remote areas.

56. ***Indicators.*** The table in section F of the data sheet provides baseline and follow-up estimates for indicators listed in the Results Framework, monitored in the ISR, and additional relevant indicators. The following section highlights some of these indicators to illustrate the achievement of the PDO. Key process indicators have been linked to higher level indicators where appropriate.

57. ***Pilots.*** The project supported three pilots[33] that directly responded to priority health issues and bottlenecks and gave an indication of what the follow-on operation aimed to do. Moreover, they focused on three issues that disproportionately affect the poor in Madagascar with a potential impact on resolving the issues of geographic and financial equity in delivery of health services. These are discussed in greater detail below in the context of the achievement of the PDO. Each pilot had a planned evaluation (the pilots for TB and Emergency Obstetric and Neonatal care were completed but the evaluation of the HR pilot could not be carried out due to the political crisis) from the outset with a view to learning from implementation, adjusting the models, and scaling up the interventions. The evaluations can inform the Government and partners in the health sector as they scale up these interventions once the political situation in the country has normalized.

58. ***Sustainability***. While the impact of the political crisis on the health sector is significant, some gains made under the project will likely be sustained through the short and medium term. For example, the Bank's leadership role in supporting the Government in harmonizing the sector and the institutional strengthening for better delivery of services for has been appreciated by partners on the ground as noted during the ICR mission. The Bank continues to play a leadership role in the health policy dialogue as illustrated by the joint AFD and Bank mission in April 2010 to agree on the priority areas of the AFD interim financing to the sector. Partners remain committed to moving towards working together and with a longer term view of supporting the Government through a SWAp approach to reach the objectives under the MAP and PDSS. The strong analytical work done by the Bank including the comprehensive CSR that was finalized in June 2010 as well as the evaluations done under the SHSDP will provide the basis and rationale for moving forward once the political situation in the country stabilizes.

59. The PDO can be broken into two parts:[34]

a) **Strengthen the health system and enhance institutional capacity of the MOH (High)**

60. A number of actions needed to take place in order to prepare the health sector to manage and implement resources for more effective service delivery. In this context, process and output indicators were equally significant to those indicators defined as output or intermediate outcome indicators. Two important areas that SHSDP supported were:

61. ***Harmonization and coordination***. As discussed above, the health investment budget is predominantly financed by donors (around 80 percent between 2000 and 2005)[35]. This aid was fragmented and put a lot of administrative pressure on the MOH.

[33] Tuberculosis, Emergency Obstetric and Neonatal care, and Human Resources
[34] The health systems and institutional strengthening component has a higher weight than the service delivery component.
[35] Health Expenditure Review 2006/2007

In this regard, improved donor harmonization and coordination was critical to the achievement of the PDO.

62. The Joint Annual Reviews (JARs) initiated under the project in 2007 provided a venue for partners and the Government to come to consensus on how to move forward on key issues related to the broader vision for the health sector through a common approach. These reviews were also the key platform used to move forward on initiatives such as signing of the partner MOU by twenty two partners as a first step to signing the Country Compact for IHP+. These meetings also served to address the allocative efficiency in donor funding as partners agreed on financing specific activities in a complementary manner. The JARs were successful in facilitating a constructive dialogue around bottlenecks and capacity constraints to service delivery. Because of their effectiveness, it was decided that the reviews would be institutionalized to provide a mechanism for monitoring progress on implementation of the PDSS and serve as one of the country's health sector coordination mechanisms.

63. ***Budget Execution***. The low budget execution rate in the MOH had been identified as a significant weakness. The project financed activities that contributed to the increase in the budget execution rate in a relatively short period of time:

- The continuation of funding of the RAMs[36] resulted in a 100 percent completion of annual workplans by all districts in a timely manner.
- The project also provided technical support (two consultants) to the DAAF to help resolve any bottlenecks efficiently[37].
- The MTEF[38] put in place a guiding framework for more effective planning and budgeting and fed into decentralized processes for planning.

64. These combined interventions led to substantial increase in the budget execution rate from 65 percent to 86 percent[39] by the end of the project.

65. ***Human Resources.*** The project supported a pilot that redeployed health personnel in three regions of Madagascar[40] with a package of financial and non-financial incentives. Although planned for, the results of the pilot were not able to be evaluated because of the political crisis. However, the final report of the pilot indicated that there was an increase

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[36]Given the success of the RAMs, AFD will be supporting these roles in the interim financing to the sector. An evaluation of the RAMs took place in October 2009. The report showed that of the 17 RAMS funded by PDSSP, five were rated as highly competent, five were rated as competent, five had average skill and two below average skill and professionalism. These two were supported heavily by the project to ensure that the AWPs were completed in a timely manner

[37] As an example, during the 2008 fiscal year, supported by financing of the SHSDP, the MOH identified several errors in its budget that inflated the budget envelope, thereby reducing the execution rate. The Ministry identified a number of projects financed by AFD, the EU and GTZ that had been already closed in previous years and should not have been included in the budget. Second, the MOH found that its 2008 budget had inadvertently included the AfDB's multi-year budget for MOH instead of just the 2008 planned disbursements. Correction for these two errors resulted in an overall smaller investment budget envelope for 2008

[38] This was an important element of the reform of the budgetary system undertaken by the Government and stressed the importance of increasing efficiency and the efficiency of the actions of public health by streamlining of the use of public resources

[39] MOH 2008

[40] Two of the regions were extremely remote and one served as a proxy of a less remote region.

in the number of health personnel in the targeted areas. As a result, the MOH was able to meet 70 percent[41] of it human resource needs in the three regions.

b) Improving the access and utilization of health services, especially in rural and remote areas (Substantial)

66. The project funded a mix of proven interventions with testing innovative approaches for better health outcomes focusing on health issues that disproportionately affect the poor in Madagascar.

67. It is important to note that that data collection for the 2008/09 DHS took place in 2008. The period covered during this particular survey was useful for general trends in health outcomes in the country but could not be used to provide evidence for attribution between the activities supported by this operation and higher health outcomes (such as MMR) as these indicators take time to show change. Linkages of output indicators and intermediate outcome indicators in the DHS to project activities can be made as described in relation to some indicators below.

68. ***Infrastructure for effective service delivery:*** This project built on progress made under CRESAN and surpassed its target of upgrading of existing primary and first referral health centers. A total of 48 health centers were chosen (12 primary health centers and 36 first referral health centers) to be upgraded. There was a specific focus on ensuring that these centers were in rural and remote areas of the country. As shown in Table I below, these levels of the health system are frequented most by the poorest quintiles in both urban and rural populations. It was thus critical to ensure that the health centers frequented by the poorer segment of the population were upgraded to ensure that the population had access to good quality health services.

Table I. Place of consultation across income quintiles and urban and rural areas

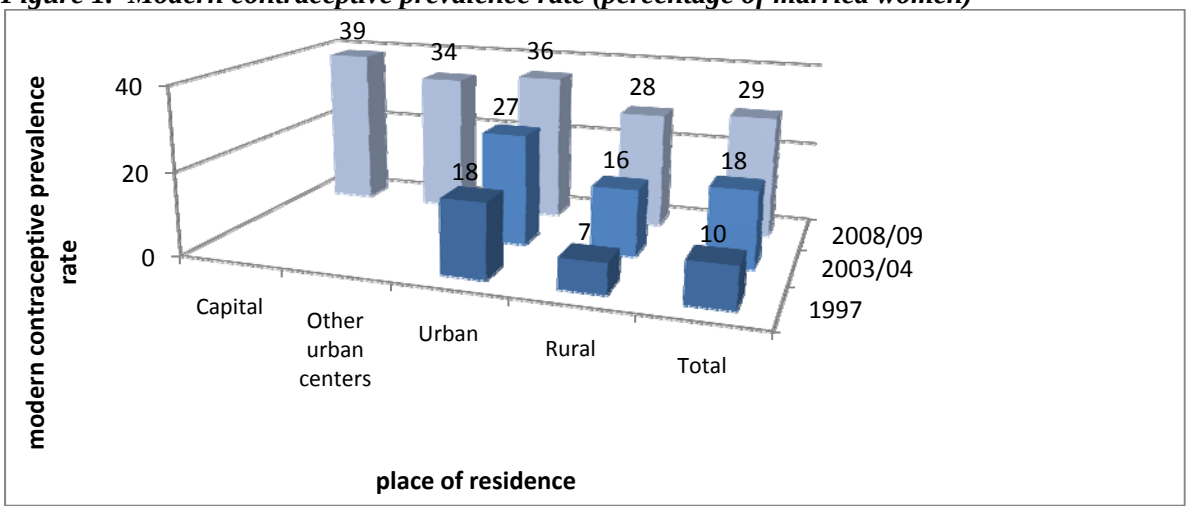
	CH*	CSB 1	CSB 2	Private clinic	Private doctor	Other	Total
Urban							
Poorest	20.1	18.6	38.8	3.1	3.2	16.2	100.0
II	14.9	11.3	31.6	5.9	24.3	12.1	100.0
III	20.4	14.7	25.4	16.3	13.2	10.0	100.0
IV	11.2	10.5	29.4	8.1	31.9	8.9	100.0
Richest	23.3	4.9	20.6	7.5	32.7	11.0	100.0
Total	19.0	9.5	26.2	8.3	26.0	11.0	100.0
Rural							
Poorest	5.1	25.5	58.0	0.9	6.2	4.1	100.0
II	4.9	19.0	53.9	2.1	7.0	13.0	100.0
III	3.5	12.9	56.9	3.0	12.6	11.3	100.0
IV	1.2	11.6	66.9	2.1	11.4	6.9	100.0
Richest	5.7	10.0	50.8	3.6	20.4	9.4	100.0
Total	4.0	15.1	57.3	2.5	12.2	9.1	100.0

Source: Enquête Prioritaire auprès des Ménages(EMP) 2005

[41] MOH 2009

69. ***Reproductive health***. It is relevant to examine the trends in contraceptive prevalence rates in the country because some of the interventions[42] under the project aimed to contribute to the improvement of these indicators. Overall, the modern contraceptive prevalence rate is increasing, especially in rural areas. According to the DHS, the increased attention on family planning translated into improved behaviors over the past five years. The use of modern methods of contraception, to which the project contributed, has increased by 60 percent (from 18 percent of all married women to 29 percent), mostly due to remarkable improvements in the rural areas, albeit from a very low prevalence of 16 percent in 2003 to 28 percent in 2008[43] .

Figure 1. Modern contraceptive prevalence rate (percentage of married women)



Source: Madagascar Country Status Report, 2010

70. **Maternal mortality.** The Government sought to find innovative solutions to some of the most critical issues contributing to the high MMR in the country with support from the SHSDP:

71. **Issue: Assisted Deliveries**. Assisted deliveries[44] in Madagascar decreased from 51 percent to 44 percent in the past five years. According to the preliminary results of the 2008/09 DHS, a smaller percentage of women sought medically trained assistance during childbirth than in the previous five-year period (. Unlike for all other behavioral changes for which indicators in rural areas have improved, the decrease in childbirth assistance is

[42] During 2008, the project was one of the major financing sources the MOH in terms of family planning and related interventions[42]. Project funding supported the following activities: 1) broadcasting of Family Planning messages through 324 television ads and 579 radio ads, 2) Distribution of 33,000 Units of Implanon with consumables[42] and accessories Delivery of consumables to 534 sites to ensured within the standardized PF norms, 3) Training district Implanon officials and 52 health workers in 19 districts that do not have previous training in the usage of Implanon, 4) stocked 211 sites with PF equipment and techniques, 5) Reproduction of 29, 500 management tools for Family Planning, 6) two workshops to update the forecasting of contraceptives supplies, 7) Support to the district of Antananarivo Renivohitra in the implementation of awareness and FP services campaign.

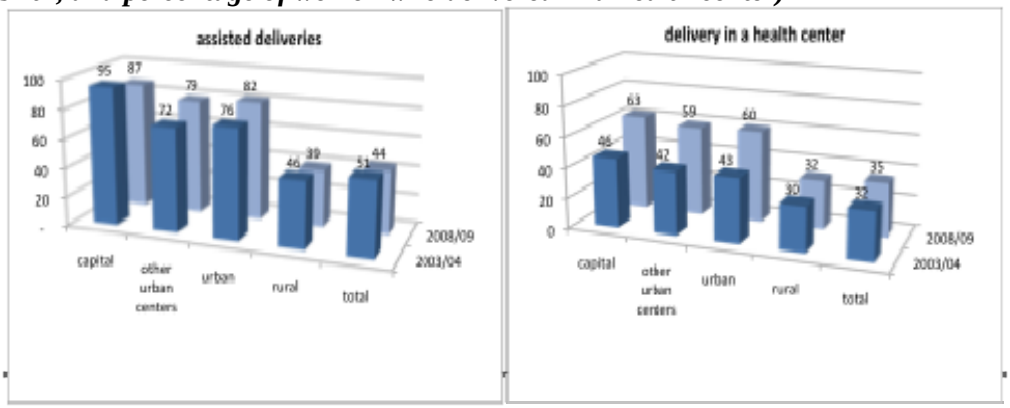
[43] Madagascar Country Status Report

[44] Medically trained assistance during delivery improves the health outcomes of the mother by preventing or treating postpartum hemorrhage and that of the newborn in the immediate postnatal period.

attributable to poorer coverage in rural areas and in the capital. However, more women delivered in a health center but this percentage remains alarmingly low, especially in rural areas (35 percent overall, 32 percent among rural residents, and 60 percent in urban areas). This is also linked to the inequitable distribution of human resources in the country, financial barriers to accessing health care, and lack of knowledge of services by the population, especially in rural and remote areas.

72. ***Figure* 2**). Unlike for all other behavioral changes for which indicators in rural areas have improved, the decrease in childbirth assistance is attributable to poorer coverage in rural areas and in the capital. However, more women delivered in a health center but this percentage remains alarmingly low, especially in rural areas (35 percent overall, 32 percent among rural residents, and 60 percent in urban areas). This is also linked to the inequitable distribution of human resources in the country, financial barriers to accessing health care, and lack of knowledge of services by the population, especially in rural and remote areas.

Figure 2. Assistance at delivery (percentage of women who had medically trained assistance at birth, and percentage of women who delivered in a health center)



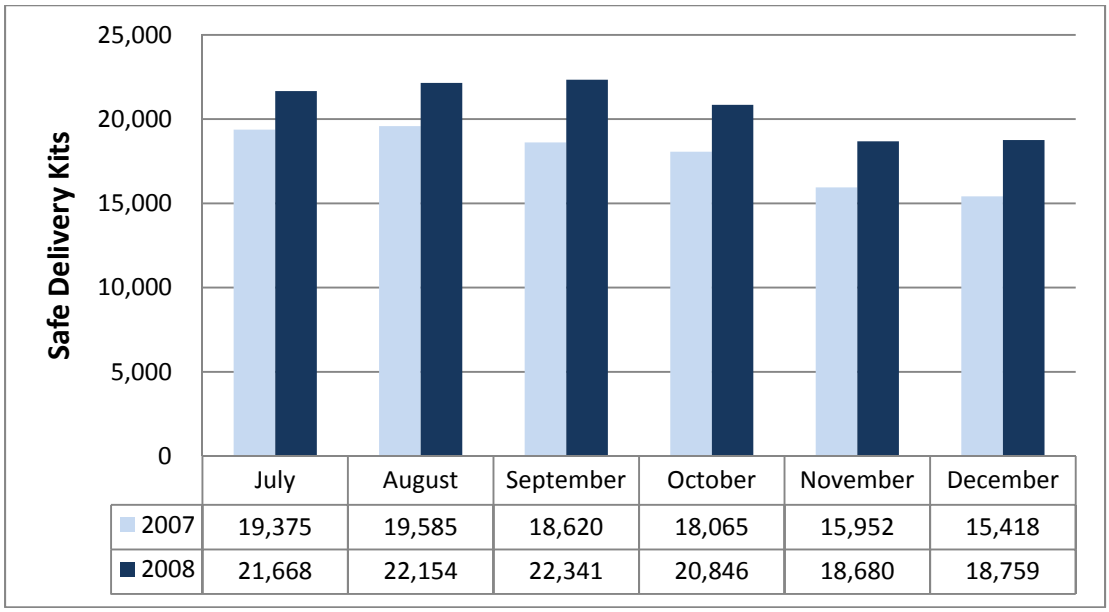
Source: Madagascar Country Status Report, 2010

73. ***Response: Safe delivery kits.*** In July 2008, primarily supported by the SHSDP[45], the MOH introduced safe delivery kits, a demand-side intervention that resulted in deliveries becoming free-of-charge at the health center level with the aim to incentivize the poorer quintiles of the population to access this service.

74. With regard to the impact of this activity, the client Implementation Completion Report (ICR) showed there was an increase in the number of births in health facilities for the period of July through December 2008 when compared with the corresponding period in 2007. The monthly comparison as illustrated in the graph below, shows an average increase of 16 percent in the second half of 2008, ranging from 12 percent to 22 percent with a peak in December (22 percent) and in September (20 percent). Additionally, anecdotal evidence during the ICR field visit to three regions suggested a very high demand for these kits in health centers by beneficiaries.

[45] These kits were distributed nationally to all primary level public health facilities. In 2008, the SHSDP financed a total of 397, 566 kits; UNFPA financed 52,000; and Marie Stopes International financed 19,693.

Figure 3. Number of Births in Health Facilities (2007, 2008)



	July	August	September	October	November	December
2007	19,375	19,585	18,620	18,065	15,952	15,418
2008	21,668	22,154	22,341	20,846	18,680	18,759

Source: Client ICR

75. **Issue: Emergency Obstetric and Neonatal Care**. Given that 65 percent of women do not give birth in a health center, post-natal care interventions are all the more critical for the health of the newborn and the mother. Referral and emergency services are generally difficult for women to access, particularly in rural areas, further amplifying some of these differences. Health centers manned by a doctor are not always accessible and distances to district level hospitals are even greater. In addition to the physical inaccessibility, the costs associated with the visit (direct costs, medicines, transport and lodging for family members) constitute a barrier to access.

76. ***Response*:** As an innovative response to maternal and neonatal mortality, a pilot project supported care related to obstetric and neonatal emergencies free of charge in the regions of Boeny and DIANA[46]. The pilot was implemented with a view to scaling up so as to address the financial barriers in accessing these services. The specific objectives of the pilot were to: (i) cover costs related to dystocic deliveries, cesarean surgeries, and pediatric emergencies for infants 0 to 6 months of age; (ii) increase the number of assisted deliveries; (iii) increase the revenues of the targeted hospitals; and (iv) improve the quality of obstetric and neonatal emergency care in the targeted facilities. The pilot covered all patients needing emergency obstetrical and neonatal care through a third-party payer system.

77. An NGO was sub-contracted to manage the funds necessary to run the payment system. The patient sought the approval of the NGO prior to the care and presented this

[46] The University Hospital in Majunga, the regional reference hospital in Diana, the Type II district hospitals in Nosy Be and in Marovoay

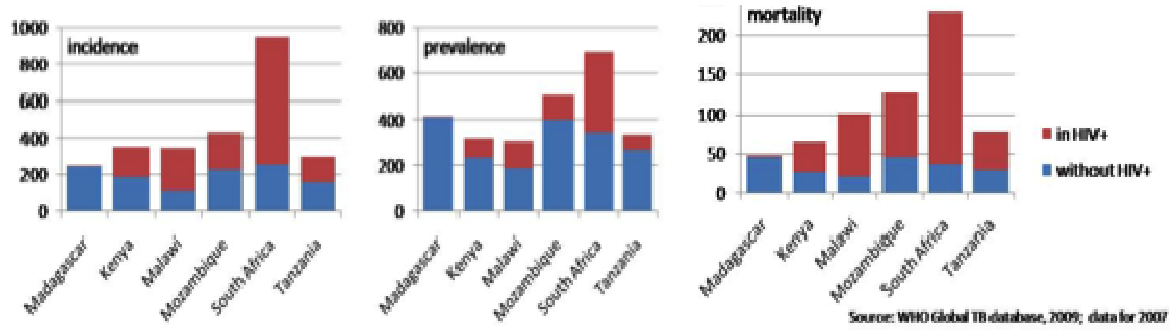
information to the hospital at the time of service. After the services were delivered, the hospital presented the receipts to the NGO for payment of fees. The pilot was evaluated and found that in the first year, the program covered 1,754 women in Boeny region and 1,030 in DIANA region for a total of 2,784 women. This represented a 15 percent increase in the number of women in both regions[47]. The evaluation of the pilot revealed that despite the fact that all treatment charges were covered, patients continued to have significant out of pocket expenditures[48.] However, the review also revealed that patient satisfaction with services was very high for the pilot (around 90 percent in Majunga and Marovoay, and 100 percent in DIANA and Nosy Be). The evaluation concluded that while the model needed some adjustments, the intervention was successful. The findings of the evaluation were used to adjust the model for a larger scale roll-out in the country.

78. ***Tuberculosis.*** While TB incidence and mortality in Madagascar is significantly lower than in most neighboring countries where the HIV/AIDS epidemic has increased the number of new TB cases. Figure 4 shows the prevalence rate in comparison to the other countries in the region. TB disproportionately affects the poor in Madagascar.

79. There are a couple of intertwining explanations for these findings as highlighted in the Country Status Report (CSR). The sustained increase in TB incidence, which is the rate of new cases being identified, can be attributed to worsening poverty in Madagascar as well as to implementation of a more successful TB program which translates into more cases being detected.

80. Adherence is a critical issue in the context of TB treatment. Madagascar has 141 diagnostic and treatment Centers at type II health centers and at the district hospital levels, and 800 treatment centers at the public and private health facility level.

Figure 4. TB incidence, prevalence, and mortality, all forms with and without HIV+



81. The SHSDP supported the MOH in implementing a pilot program that aimed at increasing the treatment rate and reducing the number of patients lost to follow-up. The program started in April 2008 and fully subsidized TB treatment costs for DOTS and

[47] Baseline was 2,370 (for both regions and combined for obstructed deliveries and cesarean). USAID, 2007

[48] between Ariary 40,000 on average (US$20) in Marovoay and Ariary 100,000 Ariary (US$50) on average in Nosy Be. Most of the out of pocket expenditure (64 percent) is for drugs and supplies purchased within the hospital or a private pharmacy.

transportation, lodging, and room/board for all patients in 11 diagnostic and treatment centers. The evaluation showed that in June 2009 1,508 patients had enrolled in the program, of which 351 were in treatment. The number of patients lost to treatment was significantly lower than the national average of 17 percent (Table II).

Table II. Tuberculosis treatment, pilot program indicators

Diagnostic and treatment centers	Enrolled patients	Currently in treatment	Treated	Percentage Treated	Lost to follow-up	Percentage lost to follow-up
Itaosy	182	41	112	62	22	12
Manjakandriana	46	10	33	72	0	0
Betafo	104	21	54	52	22	21
Tsiroanomandidy	123	45	74	60	1	1
Ambatondrazaka	174	45	126	72	0	0
Ihosy	48	36	12	25	0	0
Maevatanana	219	33	182	83	1	0
Marovoay	258	51	191	74	7	3
Mahabibo	207	31	168	81	0	0
Sakaraha	78	12	50	64	10	13
Toliara	69	26	35	51	6	9
Total	1508	351	1037	69	69	5

Source: SHSDP data

Efficiency

Rating: **Modest**

82. For a small amount of financing and short timeline, the project played an essential role in enhancing institutional capacity at the MOH, strengthening decentralized levels of the health system in financial management and budgeting and planning, and improving allocative efficiency of resources with the aim to contribute to better service delivery improve health outcomes. As a direct result of this financing, a follow-on operation of US$85 million was leveraged to move the sector forward. Unfortunately, many of the efficiency gains in the sector were not able to be fully realized as a result of the political crisis and there will be a cost of restarting the system once the country stabilizes. This contextual reality has resulted in the above rating of Modest.

83. ***Efficiency of project implementation:*** The efficiency of implementation is illustrated by the project disbursement profile[49]. The project had a very quick start to implementation right after effectiveness and was 96 percent disbursed of funds during the first 15 months with the majority of activities implemented. The remaining 4 percent of financing was not disbursed do to the political situation.

[49] See data sheet

84. ***Efficiency in the MOH:*** The project enhanced the capacity of the MOH in a number of areas. As a result of the financing under the project, there was improved efficiency of budget execution in the MOH and through strengthened capacity for budgeting and planning at all levels. In addition, the project contributed to the institutional strengthening of the MOH in the areas of procurement, project management, financial management, and monitoring and evaluation. This in turn contributed to the MOH's ability to more efficiently and effectively manage and utilize both public and donor resources. The capacity to manage donor projects is demonstrated by the PCU's mandate to manage the implementation of Global Fund resources and the World Bank Multi-sectoral STI/HIV/AIDS Prevention Project. The assessments during project preparation identified areas that needed to be strengthened so that resources were spent on priority activities, as described in previous sections, avoiding unnecessary duplication of roles and ensured that the capacity that was already built was fully utilized.

85. ***Efficiency of the returns to the investment:*** The project contributed to significant progress on donor coordination and harmonization. This financing helped to address the fragmentation and parallel financing issues as donors moved toward a more complementary approach to supporting the sector. As a result of increased coordination and harmonization, AFD and the World Bank had committed to a pooled financing approach over a four-year period to finance the health sector. The broader partnership was moving toward harmonized implementation procedures, including audits, financial management and procurement so as to reduce transaction costs for the Government.

86. A significant part of the financing under service delivery was used to test new and more efficient mechanisms for addressing key public health issues and the lessons learned from implementation and scale-up of these models would have likely had large efficiency gains for the sector in the longer term.

87. These efficiency gains were not able to be fully realized due to the political crisis.

3.4 Justification of Overall Outcome Rating

88. The ratings of ***substantial*** relevance, ***substantial*** efficacy and ***modest*** efficiency, result in an overall project outcome rating of ***Satisfactory.***

3.5 Overarching Themes, Other Outcomes and Impacts

(if any, where not previously covered or to amplify discussion above)

(a) Poverty Impacts, Gender Aspects, and Social Development

89. As part of the PDO, the project aimed to strengthen the overall health system for more effective delivery of interventions to rural and remote areas, and as such, the selection of interventions aimed to meet this objective. The selection criteria for upgrading health centers prioritized rural and remote areas. There was a focus on Neglected Tropical Diseases and TB given the burden of these diseases on poorer quintiles of the population in Madagascar. The project also aimed to find innovative solutions to increasing access to quality services by addressing health systems challenges

related to distribution of qualified health personnel across the country. Finally, the project focused on implementing demand side interventions to address some key barriers to access of services predominately affecting poorer segments of the population.

(b) Institutional Change/Strengthening

90. As institutional strengthening was one of the key objectives of the project, the impact has been discussed above.

(c) Other Unintended Outcomes and Impacts (positive or negative)

91. The project had positive impacts at various levels of the health system:

i. **Project management:** As a direct result of the effective implementation of the SHSDP, the PCU is now managing the World Bank financed Second Multi-sectoral STI/HIV/AIDS Prevention Project and the Global Fund grant for the health sector. This is clear evidence that management capacity has been built at central level.

ii. **Planning:** During the field visits for the ICR, it was evident that there had been a positive behavioral shift in planning despite the fact that the project funds were no longer available and the RAMs were no longer being financed. Comprehensive annual work plans had been completed with prioritized interventions at regional, district, and health center levels, identifying all sources of funding and gaps in financing.

3.6 Summary of Findings of Beneficiary Survey and/or Stakeholder Workshops

(optional for Core ICR, required for ILI, details in annexes)

4. Assessment of Risk to Development Outcome

Rating: **Substantial**

92. The main development outcome of the project was to strengthen the health system to deliver health services more effectively. The most important potential risks to this outcome are (i) further political instability, and (ii) insufficient financing in the sector to protect the progress made. The political crisis in the country has lasted over a year and continues to negatively impact the country as a whole. This is largely an exogenous risk but is directly linked to the level of sectoral financing for the medium to long term. While AFD has provided short term gap financing for the sector in line with the JHSSP, if longer term financing does not come through, the gains made during the project as part of the evolutionary process of the health sector toward a more efficient health system that produces results, is severely threatened.

5. Assessment of Bank and Borrower Performance

5.1 Bank Performance

(a) Bank Performance in Ensuring Quality at Entry
Rating: **Satisfactory**

93. The project did not go through a formal Quality at Entry review. The preparation of the project was a joint process involving all relevant partners in the health sector and was country-led. The design integrated the lessons learned and best practices from previous Bank projects in the health sector to develop a project that supported mechanisms that worked while addressing critical gaps, such as the fragmentation of donor financing in the sector. The project was seen as the next phase of financing to set the stage for a comprehensive sector wide approach in the health sector.

94. A few issues could have been better addressed in the context of the project design (as discussed in previous sections). In summary, the Results framework was a bit bulky and the on the health interventions side, the project was ambitious and aimed to do a lot with a relatively small amount of financing. There could have been a benefit to reducing the number of health interventions rather than trying to include financing for so many different activities.

(b) Quality of Supervision
Rating: **Satisfactory**

95. The supervision of the project was consistent and of high quality throughout the life of the project. The quality of supervision was essential to the project's success and has the following salient features:

i. **Comprehensive**: The project benefitted from a strong decentralized team at the country level with strong leadership of a Task Team Leader (TTL) based in Washington DC. All key units of the Bank including FM and procurement were actively involved from the beginning of the project and participated in all supervision missions. This gave the fiduciary team members a comprehensive view of the project and allowed them to respond proactively to resolving any issues that arose during the implementation of the project.
ii. **Responsive**: The Bank team was highly responsive during the implementation of the project. One example was responding to all requests for No Objections within a 48 hour period, a policy put in place by the TTL at the start of implementation.
iii. **Strategic:** The Bank team was successful in providing effective implementation support while at the same time ensuring that the follow-on project was prepared. The team kept the focus on the longer term engagement of the Bank in the health sector and helped partners gain confidence in the approach. This was clearly evident in the large amount of co-financing that AFD committed to put into the follow-on project. In addition, donors appreciated the Bank's leadership role in catalyzing efforts to bring the sector together around the PDSS.

iv. **Analytical Work:** The team ensured that there was a focus on producing analytical work during implementation of the project. A number of studies and reports were completed in the areas of human resources, community participation, and health service delivery with an aim to inform future operations and health policy. These studies fed into the CSR which was just finalized in 2010.

(c) Justification of Rating for Overall Bank Performance
Rating: **Satisfactory**

96. While there were minor shortcomings in the preparation of the project, these shortcomings did not have an impact on the Bank's performance during implementation which is rated at satisfactory. This results in an overall rating of ***Satisfactory.***

5.2 Borrower Performance
(a) Government Performance
Rating: **Satisfactory**

97. The performance of the Government should be assessed before the political crisis given that 96 percent of the project was already implemented. The Government that was in place before the political crisis and during most of the implementation period was committed to a longer term strategy in the health sector and there were no major shortcomings in performance during that time. With the support of the SHSDP, the Government took a leadership position in beginning to systematically address critical health systems and institutional capacity issues and in the process built the foundation for a more significant investment. The Government benefitted from having high-level staff that had been in the sector since the beginning of the Bank's involvement and had worked either indirectly or directly on Bank projects. This allowed for continuity and first-hand experience in the evolution of the sector over the long-term. While there were some minor issues with the technical units of the MOH coming fully on board conceptually at the beginning of implementation, the strong leadership at the highest levels in the MOH resolved any issues at technical level by ensuring that the strategic vision the guiding framework for policy and implementation.

(b) Implementing Agency or Agencies Performance
Rating: **Satisfactory**

98. The coordination of the project was the responsibility of the PCU. Its performance was excellent as noted in both the Aide Memoires and ISRs. In the areas of FM and Procurement, the PCU worked very closely within the MOH and project was part and parcel of providing technical assistance to strengthen key units of the MOH such as procurement and financial management and utilizing these units to achieve the objectives of the project. The PCU played an instrumental role in the successful implementation of this project. The team benefitted from the following:

i. **Experience.** The PCU had a number of technical staff that had been directly involved in the implementation of previous Bank projects and had been in the health sector for a number of years. This experience, coupled with the

appreciation for the long term strategy of the health sector, was one of the key reasons for efficient and successful project implementation.

ii. **Integration.** The PCU was integrated within the MOH and participated fully in the MOH's policy and technical discussions resulting in implementation of activities under a comprehensive and cohesive strategic framework.

iii. **Proactive Approach.** As noted in the Aide Memoires and ISRs, the PCU consistently approached issues with an action-oriented, problem solving approach. The PCU and World Bank team worked in close collaboration and any issues in implementation were addressed efficiently and effectively.

(c) Justification of Rating for Overall Borrower Performance
Rating: **Satisfactory**

99. More weight was given to the contribution of the PCU in assessing this rating given that the PCU was responsible for the management and day-to-day implementation of the project.

6. Lessons Learned

100. **Effective project management.** Project management on the Bank side needs to be sufficiently thought through and adequately funded to ensure that there is sufficient support to implementation. An important contributing factor to the success of project implementation was the strong management of the project by the Bank and the Implementing Agency. On the ground presence of Bank staff dedicated to the project as well as availability of the TTL and the task team working in close collaboration with a dedicated PCU made a critical difference in ensuring the successful and efficient implementation of the project.

101. **Supporting a long term strategic vision in the sector.** One of the strong points of this project was its role in supporting the broader long term strategic vision of the health sector in Madagascar. With the Government firmly in the driver seat, the investment was seen as the next logical step in Bank support and was tailored with a comprehensive view of the sector in mind. Because of the long term engagement in the sector, the Bank was able to utilize one of its key strengths as a convener to play the lead role in bringing together partners to support the Government. As a result, the relatively small Bank investment prepared the sector and leveraged a significantly larger amount of financial investment for the sector.

102. **Building and utilizing country systems.** The project was able to jump start implementation right after effectiveness because it took advantage of the capacity built in the areas of procurement and financial management. The implementation arrangements took advantage of MOH staff in these areas that had been working on Bank projects. In addition, the PCU was seen as part of the MOH, not as operating outside of it. This allowed for a pragmatic and strategic approach to technical assistance to ensure that capacity was built for the sector more broadly.

103. **Harmonization/coordination processes linked to results.** Harmonization and coordination were not seen as an end but rather as a means to support the Government in reaching the health outcome objectives of the MAP and the PDSS.

104. **Protecting progress.** Madagascar was on its way to successful example of implementing a SWAp for results in the longer term. As a consequence of the political crisis, all planned funding from the Bank did not move forward. At present, the sector is in danger of losing many of the gains that it has made over the past ten years. Human Development and the health sector in particular is unique in that there needs to be a sustained effort in ensuring that fragile gains are not lost. This is an issue for many countries in Africa given the political realities on the ground. In the case of Madagascar, the PCU and the technical units of the MOH have the capacity to implement but the resources did not materialize. There needs to be a critical look at weighing the risks of financing operations against the risk of losing the progress made in these types of contexts.

105. **Learning.** The project implemented pilots as a strategic way to test interventions with the intention of scaling-up models that worked. Therefore, baseline data was collected and there was financing for proper evaluations. This should be considered good practice in the context of Bank operations. Pilots that are not implemented in a strategic manner (contributing to objectives of the overall project and with proper evaluations) are difficult to assess and therefore can lose their intended purpose of testing an approach that is meant to be assessed for a decision on whether or not it can be scaled up.

7. Comments on Issues Raised by Borrower/Implementing Agencies/Partners

(a) Borrower/implementing agencies

106. The ICR mission interviewed all of the relevant PCU members. There were no significant issues raised by the implementing agency.

(b) Co-financiers

(c) Other partners and stakeholders

107. The ICR mission interviewed key partners on the ground. Those interviewed appreciated the Bank's leadership in bring the partners together to more effectively support the health sector.

Annex 1. Project Costs and Financing

(a) Project Cost by Component (in USD Million equivalent)

Components	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
Strengthening Delivery of Health Services	4.9	4.5	92
Development and Management of Human Resources	1.2	0.9	75
Innovations in Health Financing Management	.4	0.3	75
Improving Demand and Utilization of Health Services	1.0	0.9	90
Institutional Strengthening	2.5	3.0	120
Total Baseline Cost	10.00	9.6	96%
Physical Contingencies	0.00	0.00	0.00
Price Contingencies	0.00	0.00	0.00
Total Project Costs	0.00	10.00	
Front-end fee PPF	0.00	0.00	.00
Front-end fee IBRD	0.00	0.00	.00
Total Financing Required	0.00	10.00	

(b) Financing

Source of Funds	Type of Cofinancing	Appraisal Estimate (USD millions)	Actual/Latest Estimate (USD millions)	Percentage of Appraisal
Borrower		5.00	0.00	0.00
International Development Association (IDA)		10.00	10.00	100.00

Annex 2. Outputs by Component

COMPONENT 1: Improving Health Service Delivery	
Support in improving functionality of existing primary and first referral health centers at the district and community level	Procurement of equipment and materials for 10 operating blocks
	Procurement of initial drug supply for 25 health centers
	Contract with SALAMA for distribution of drugs
	Procure of equipment and materials for 48 health centers
Contribute to the fight against priority infectious diseases	Rabies vaccine supply in the 12 treatment centers
	Purchase of 500 boxes of 50 of streptomycin, 600 kg Propoxur, and 3 tons of Delthaméthrine to control plague
	The provision of medicines and awareness materials from 41 districts and 12 regions of plague outbreaks
	The provision of insecticides 41 districts at risk for plague outbreaks
	The implementation of interventions and responses to four 'emergency Ankazobe (2fois), Fianarantsoa II Mandritsara
	8 retrospective epidemiological investigations and control of monitoring indicators plague Ambohimahasoa, Ambositra, Antsirabe II Manjakandriana, Bealanana, Faratsiho, and Fandriana Tsiroanomandidy.
	Provide two campaigns Mass Distribution of Drugs (DMM) to combat filariasis in 30 districts most affected by the disease
Support of Maternal and Child Health and Family Planning	Roadmap Workshop to revise roadmap on maternal mortality
	Purchase and delivery of safe delivery kits
	Delivery of consumables to 534 sites to ensured within the standardize FP norms.
	Purchase of 33,000 units of Implanon including supplies
	Train providers in proper insertion of Implanon
COMPONENT 2 :Development and Management of Human Resources in the Health Sector	
Pilot for redeployment and retention of health professionals of Melaky of Androy and Vakinankaratra	rehabilitation of health centers and housing for health professionals
	9 mobile phones, 18 sets, kits, housing (furniture, kitchen utensils) and 31 motorcycles
Coaching capacity and management and service delivery training	52 teams trained on results based management at district level after their performance of predefined.
	Coaching and training of health personnel to strengthen capacity to enhance skills at regional and district level
	Support a pool of 30 coaches at central level and 85 coaches at regional level.
Strengthen the management of obstetric and surgical emergencies at the CHRR and CHD2	20 surgeons trained in essential surgery
COMPONENT 3: Innovations in Health Financing Management	
Developing the Medium Term Expenditure Framework	Four development and validation workshops

Improve Budget Planning and Execution	Support technical assistance of a consultant to prepare the budget program and workshops
	Support two assistants to DAAF
COMPONENT 4: Improving Demand and Utilization of Health Services	
Harmonization of Community Approaches	22 regional leaders trained on the new vision of Kominina Mendrika .
	28 Kominina Mendrikas put in place
	340 officials were trained on the process of Kominina Mendrika implementation
Obstetric and Neonatal Care Pilot	Treatment, including drugs, consumables, imaging and laboratory analysis for patients in 4 sites
	Food and lodging for patients during hospital stay
Tuberculosis Pilot	Support to all pilot activities in 11 sites (transport, lodging, food and costs of testing for patients)
COMPONENT 5: Institutional Strengthening	Support of 17 Regional Accounting Managers
	support of PRMP (central) and regional PRMPs
	Financial support to regions for work program planning and management
	Support to updating health map of 22 regions and 111 districts
	Training at regional and district levels on use of health map
	Communications network implemented in 4 Regional Offices and Directorates and 4 CHR
	Staff trained on new communications network
	Supervision support at regional level to resolve communications issues
	Telemedicine pilot in Manjakandriana which was to develop a computerized system for medical records with appropriate software
	Support to 2008/2009 DHS

Annex 3. Economic and Financial Analysis

A separate economic and financial analysis was not done as part of this ICR. It was not deemed necessary given that the Country Status Report was recently finalized and provides a comprehensive economic and financial analysis of the health sector in Madagascar.

Annex 4. Bank Lending and Implementation Support/Supervision Processes

(vi) **Task Team members**

Names	Title	Unit	Responsibility/ Specialty
Lending			
Mukesh Chawla	Sector Manager	HDNHE	TTL
Maryanne Sharp	Senior Operations Officer	LCSHH	Implementation & Operations
Paul-Jean Feno	Environmental Spec.	AFTEN	Safeguards
Anne-Claire Haye	Consultant	MNSHD	Technical and M&E
Gervais Rakotoarimanana	Sr Financial Management Specialist	AFTFM	Financial Management
Sylvain Auguste Rambeloson	Senior Procurement Specialist	AFTPC	Procurement
Norosoa Andrianaivo	Language Program Assistant	AFTED	Admin support
Supervision/ICR			
Mukesh Chawla	Sector Manager	HDNHE	TTL (until end 2007)
Maryanne Sharp	Senior Operations Officer	LCSHH	TTL (until closing)
Ando Tiana Raobelison	Consultant	AFTHE	Public Health
Paul-Jean Feno	Environmental Spec.	AFTEN	Safeguards
Gervais Rakotoarimanana	Sr Financial Management Specialist	AFTFM	Financial management (until Aug 2009)
Jean Charles Amon Kra	Sr Financial Management Specialist	AFTFM	Financial management (until closing)
Sylvain Auguste Rambeloson	Senior Procurement Specialist	AFTPC	Procurement
Lova Niaina Ravaoarimino	Procurement Analyst	AFTPC	Procurement
Lubna Bhayani	Consultant	AFTH3 – HIS	Health Economist

(b) Staff Time and Cost

Stage of Project Cycle	Staff Time and Cost (Bank Budget Only)	
	No. of staff weeks	USD Thousands (including travel and consultant costs)
Lending		
FY07		210.58
FY08		0.00
Total:		210.58
Supervision/ICR		
FY07		0.00
FY08		142.85
Total:		142.85

Annex 5. Summary of Borrower's ICR and/or Comments on Draft ICR

L'objectif de développement du PDSSP est de contribuer au renforcement du système de santé et d'améliorer la capacité institutionnelle du Ministère de Santé Publique et du Planning Familiale (MSPF) afin d'améliorer l'accès aux services de santé et leur utilisation, surtout dans les zones rurales et reculées. Au-delà des résultats attendus en termes d'amélioration de la performance du secteur sur certaines domaines techniques spécifiques, l'appui institutionnel octroyé par le projet tient une importance capitale dans la pérennisation des acquis.

Bien qu'il y ait eu une crise politique qui paralysait l'ensemble du territoire national au cours de l'année 2008, les impacts négatifs sur la performance du secteur semblent être relativement maîtrisés. Ce rapport d'évaluation comporte une triple évaluation : technique, institutionnelle et financière. Il comporte également les prévisions pour la pérennisation du Projet, les leçons apprises et l'opinion du Gouvernement sur l'IDA.

(vi) ***Evaluation Technique:*** Force est de constater que le projet a largement procedu ses objectifs. C'est au cours de l'année 2008 qua la majorité des activités a été menée. Les indicateurs du projet, détaillés dans ce rapport montre clairement.

(ii) Une Evaluation Institutionnelle*:* Les pprocédures institutionnelles de la Vice-Primature proced de la santé Publique ont bénéficié d'un renforcement soutenu dans le cadre du PDSSP. Le pprocédures santé actuel est à un top niveau par rapport à l'échelle Gouvernementale car seuls deux autres pprocédures se trouvent au proc niveau : les Affaires Etrangères et l'Intérieur. Malgré la crise politique et ses sur la stabilité de l'équipe, la performance générale semble être maintenue pour l'année 2009, sin on juge à travers les en programmation et budgétaire.

(iii) Une Analyse financière : Le coôu total du projet est de USD 10.000.000, avec quelques dues à la fluctuation des taux de changes. Environ 90% des dépenses ont été effectuées au cours de l'année 2008 et le reste est totalement décaissé en fin de projet, sans aucun reliquat. Aucun majeur n'a été constaté la mise en œuvre du projet et le Gouvernement pose un bilan très positif sur les système adopté par la Banque Mondiale en matière de gestion financière et de portefeuille du projet.

(iv) Un plan d'action pour la pérennisation du Projet : Au moment de l'écriture du rapport d'évaluation, quasiment impossible de prédire le dans lequel le Pays va vivre dans les prochains mois. Par contre, on peut affirmer que les 34procédures34 mises en place à travers le projet donnent toutes les chances dès que la situation le permette. La progression vers l'IHP+, enclenché au cours du PDSSP est parmi les aspects les plus importants pour l'efficacité des assistance extérieures.

(v) Leçons apprises : Le consultant aura pour tâche d'analyser les points forts et points faibles afin de mesurer chacune des composantes du projet ou tout au moins des aspects transversaux que financier, institutionnel et technique.

(vi) Opinion sur l'IDA : L'appréciation de la Banque Mondiale lors de la conception et l'exécution du Projet est très positive, notamment dans le sens de la convivialité des relations, la richesse et la fluidité des dialogues et le professionnalisme de l'équipe de la Banque. En plus, le système et les procédures de gestion spécifiquement conçus et mis en oeuvre pour le PDSSP satisfait le Gouvernement dans sa globalité.

Annex 6. Implementation Summary

This section highlights some of the activities that were supported by the project. The list is not exhaustive and gives some examples of the achievements and challenges during implementation. Key interventions not included in this section have been discussed in other sections of this ICR.

a) Health Systems and Institutional Strengthening

Budget Planning and Execution. The project supported a number of activities that aimed to strengthen budget planning and execution at all levels of the health system: i) recruitment of two technical assistants to the Department of Administrative and Financial Affairs (DAAF) to support the MOH is resolving budget execution bottlenecks, ii) resources at regional level for work planning and budgeting exercises, and iii) technical assistance and development workshops for the Medium Term Expenditure Framework (MTEF). Some of the achievements of this support include: a) increase in the budget execution rate[50], b) 100 percent of regional and district costed annual workplans developed, and c) development and finalization of MTEF for 2009-2011[51].

A key challenge was a six-month delay in the installation and training of SIGFP software which was designed to connect the MOH, the Commissioner of Financial Control and the Treasury, which was recommended in the Public Expenditure Review of the health sector. The software was an essential mechanism to facilitate the adjustment of external disbursements and data exchange between partners, the Ministry of Finance and Budget (MFB), and the MOH in a systematic and standardized manner. In addition, this contributed to the relatively slow progress on budget execution during the first four to six months of the project.

Financial Management. With financing from the project, 17 regional accounting managers (RAMs) were supported[52] to provide and help regions in ensuring that costed workplan were developed comprehensively from the health center level up to higher levels. The financial management report template was also revisited procedures were put into place for preparation and submission of reports. As a result of these activities, costed workplans were developed and reports were submitted in a timely manner.

The FM aspects of the project at central level were consistently rated ***Satisfactory.*** In contrast, there were some challenges with FM[53] at health center levels as indicated by the auditors. To address this problem, the regional accounting managers (RAMs) were given

[50] 65 percent (2007) to 86 percent (2009)
[51] Because of the political crisis, the MTEF will need to be fully reviewed and revised.
[52] These positions were created under CRESAN2 and were successful in supporting the regions. As a result, it was deemed essential that they were supported under SHSDP.
[53] Unregistered log books, missing receipts, unbalanced financial ledgers

the responsibility to identify the origins of the problems related to fund management at health facilities and to establish a plan of action to resolve them to improve financial management and accounting at the level of health facilities.

Procurement. The project supported an international technical assistant which had the following tasks: (i) development of an internal audit manual, including procurement, ii) training at all levels on this manual, (iii) the launch of an institutional audit to keep the role of the Person Responsible for Public Procurement (PRMP) and management units of the procurement according to the Department's activities and identify problems related to staffing, iv) financing of PRMP at central level and 13 PRMP posts at regional levels. This contributed to the timely preparation and submission of audit reports and facilitated procurement at all levels. One of the key challenges was delayed recruitment of the technical assistant. The Bank team worked with the PCU to resolve the issue given that the weaknesses noted in this area could have jeopardized all the gains in other areas of the department.

Harmonization and coordination. One of the key contributions of the project was in the area of harmonization and coordination. The project financing supported three Joint Annual Sector Reviews[54]. Some of the key achievements of this support included: i) increased information sharing among donors and the MOH, ii) agreement on key priority actions such as completion of the MTEF and updating the PDSS and iii) development of a joint prioritized action plan that was updated every six months outlining key areas of support by partner to provide financing through a more complementary approach as well as identifying priority actions to improve sectoral performance[55] to reach the MDGs. It was through this platform that the partner Memorandum of Understanding (MOU) for the IHP+ was discussed and signed by partners. Finally, these meetings were central to the discussion around the SWAp and the move towards a pooled financing mechanism in the sector.

Monitoring and Evaluation. The project supported a number of activities, including: i) updating the national health map, ii) trainings on the use of software for the health map, iii) supervision and management resources for M&E at central and regional levels, and iv) financial support to the DHS. As a result: a) the updated health map of 22 regions and 111 districts is available from the Department of health statistics, b) aggregated up-to-date data on the project was available at central level, and c) the Demographic and Health Survey (DHS) results are available.

Human Resources. The project supported a pilot that redeployed health personnel to two remote and rural areas of Madagascar to address the issue of uneven distribution of qualified personnel in the country. The financing supported an incentive package for

[54] The Joint Health Sector Reviews had three components: (i) joint preparation of critical questions in a number of thematic areas; (ii) a joint field visit to a number of different regions to better understand the problems in the field and undertake discussions with stakeholders at the regional, district and community levels on the critical questions; and (iii) a plenary session of two days to consolidate the field work and prepare a prioritized action plan for the following six-month period.

[55] i) improving access to health services; ii) human resources; iii) improving budgetary processes; iv) decentralization; 5) M&E and auditing; and 6) alignment/harmonization.

qualified health personnel to move three regions for the pilot (two regions were very remote and one used as a proxy). The incentive package included the provision of: (i) means of transport, (ii) means of reliable communication, (iii) adequate modernized housing, (iv) rehabilitated health center, and (v) compensation for redeployment.

While some of these aspects moved efficiently (29 mobile phones, 18 sets, kits, housing, furniture, kitchen utensils and 31 motorcycles were procured), there were some procurement and contracting delays. As a result, only twenty-one of a planned thirty-one health centers were fully operational (i.e. upgraded and sufficient qualified personnel redeployed). In addition, due to the political crisis, the planned evaluation of the pilot was not able to be carried out.

(b) Service Delivery

Upgrading of Public Health Facilities. The project financed: i) procurement of equipment and materials[56] for ten operating centers (CHRR), ii) initial procurement of drug supply for 25 health facilities, and iii) purchase of medical, biomedical, and technical equipment for 48 health facilities. This contributed to strengthening capacity at decentralized level to deliver key public health interventions. While the component was rated an overall satisfactory, there were some minor delays in delivery of equipment and materials to the CHRRs and biomedical materials to the 48 health facilities.

Demand for services. One of the critical areas that needed to be strengthened, as indicated in the PAD, was increasing demand for services, especially in more rural and remote areas and among the poorer quintiles of the population to address the challenges of inequitable access to services. Two examples looking at this aspect were:

- *Tuberculosis.* This pilot [57] was focused on increasing the rates of patients coming into health centers to be tested and treated and increasing the number of patients that adhered to the full course treatment of TB. The pilot was implemented in two remote and rural regions of the country, Boeny and DIANA. Activities that were financed included i) support for food, lodging and transport costs for participants, ii) testing costs for TB, and iii) contracting of NGOs to administer payment. Overall, the pilot was administered efficiently with the evaluation taking place as planned. The results[58] of the evaluation were going to be integrated in the model for scale-up under the follow-on operation.

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[56] consisting of regional reference hospital emergency incubator and monitors, echographs, curettage.

[57] The constraints related to treatment modalities resulting in costs related to patient non-adherence leads to treatment, thus losing sight of the sick. Indeed, although these are free, is often abandoned because of financial inability of the patient to assume the costs of travel expenses and accommodation that require treatment over a period of eight months minimum. In addition, TB patients are essentially groups of poor, marginalized and highly vulnerable.
The project worked in collaboration with the TB Department in the MOH who was responsible for the technical design of the pilot activities were funded by SHSDP.

[58] The recommendations had four main points: (i) the high relevance of the initiative was universally recognized by program managers, health care providers and beneficiaries themselves; (ii) the allowances rates were too low and needed to be adjusted, (iii) extending the initiative to other diseases should be considered, and (iv) there could be a great benefit to bringing TB treatment to health facilities near the homes of patients. The evaluation also highlighted the following: (i) the need for mapping structures of TB care that are more accessible and efficient, thereby reducing

- *Kominina Mendrika*[59] *(KM, or Champion Communes).* Expansion of KM is an example of one of the interventions that the project supported with regards to increasing community demand and ownership for health services. Specifically the project supported: i) updating of community monitoring tools, ii) training of 22 regional leaders on the KM concept, iii) 28 KMs put in place, and iv) 340 managers trained on processes of establishing a KM. All activities were implemented in a timely manner.

Neglected Tropical Diseases (NTD). The project supported interventions for combating three[60] NTDs. This was important as the funding under the SHSDP was one of the only sources of financing to address these diseases. As an example, the project supported two campaigns for the mass distribution of drugs to combat filariasis in endemic areas. All activities were implemented in a timely manner and resulted in a significant decrease in the prevalence of the disease in targeted areas. Due to the political crisis, a third, essential campaign needed to eliminate the disease, was unable to be carried out.

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the dropout rate; (ii) maximizing the use of community leaders is essential in the context of the implementation of the policy of with support and buy-in from communities; (iii) more education and awareness raising of initiative among the public as well as health professional health professionals to avoid misunderstandings and misinterpretations, especially with regard to the rates of allowances; (iv) a "single window" that provides for delivery of TB drugs and benefits; (v) while TB patients are recruited mainly among the poor and, in this case, rural populations, the equity aspects could be further strengthened. For examples, adjustment in the rates of allowances between rural and urban as well as the distance to treatment.

[59] Initiated in Madagascar by USAID over a decade ago as a means of mobilizing communities (at the fokontany, or village, level) to improve vaccination coverage rates.
The basic principle beyond USAID's KM approach is to engage all community stakeholders in achieving short-term health goals related to child and maternal health. This approach has produced good results in reducing diarrheal disease and malaria incidence, increasing child immunization rates and antenatal care visits, and promoting family planning activities.

[60] Rabies, Filariasis, and Plague.

Annex 7. List of Supporting Documents

1. Madagascar Health Expenditure Review (2006/2007)
2. Madagascar Demographic and Health Survey (2008/2009)
3. Madagascar Demographic and Health Survey (2003/2004) Madagascar (2005) Enquête Prioritaire auprès des Ménages
4. Madagascar (2005) National Health Accounts
5. Madagascar (2005) Enquête Prioritaire auprès des Ménages
6. Madagascar (2005) National Health Accounts
7. Ministry of Health (2007-2009) Sustainable Health System Development Project Data
8. Ministry of Health (2009) Rapport de Cloture: Project de Developpement d'un Systeme de Sante Perenne (PDSSP)
9. Ministry of Health (2009) Evaluation Finale du FPCU
10. World Bank (2007-2009) Aide Memoires
11. World Bank (2008) CRESAN II ICR
12. World Bank (2007-2009) Implementation Status Reports
13. World Bank, IEG (2009) "Improving Effectiveness and Outcomes for the Poor in Health Nutrition and Population"
14. World Bank (2010) "Madagascar: A Country Status Report on Health, Nutrition, and Population"
15. World Bank (2007) Project Appraisal Document "Sustainable Health System Development Project"

IBRD 33439

Mayotte (France)

Mozambique Channel

INDIAN OCEAN

45°E

50°E

15°S

20°S

25°S

Antsiranana
Ambilobe
Vohimarina
Ambanja
ANTSIRANANA
Maromokotro (2,876 m)
Massif Tsaratanana
Sambava
Bealanana
Andapa
Antalaha
Antsohihy
Befandriana
Maroantsetra
Mahajanga
Soha
Mandritsara
Mampikony
Soalala
Bemarivo
Mananara
Mahajamba
Besalampy
MAHAJANGA
Cliff of Bongolava
Cliff of Angavo
Maevatanana
Andilamena
Soanierana-Ivongo
Betsiboka
Kandreho
Andriamena
Lake Alaotra
Fenoarivo-Atsinanana
Manambaho
Mahavavy
Vohidiala
Maintirano
Ankazobe
Toamasina
TOAMASINA
Ambaravaranala
ANTANANARIVO
Antsalova
ANTANANARIVO
Moramanga
Soavinandriana
Tsiafajovona (2,642 m)
Vatomandry
Miandrivazo
Belo Tsiribihina
Antanifotsy
Ankaratra
Mangoro
Isiribihina
Antsirabe
Mahanoro
Morondava
Malaimbandy
Mania
Ambatofinan-drahana
Ambositra
Varika
Mandabe
Ambohimahasoa
Manja
Fianarantsoa
Mananjary
Morombe
Beroroha
Mangoky
FIANARANTSOA
Manakara
Ankazoabo
Ihosy
Pic Boby (2,658 m)
TOLIARA
Farafangana
Sakaraha
Mananara
Fiherenana
Toliara
Betroka
Onilahy
Betioky
Midongy-Atsimo
Tsivory
Berakete
Mandrare
Ampanihy
Androy Plateau
Amboasary
Androka
Menarandra
Ambovombe
Tolanaro
Beloha

0 40 80 120 160 200 Kilometers
0 40 80 120 Miles

MADAGASCAR

- SELECTED CITIES AND TOWNS
- PROVINCE (FARITANY) CAPITALS
- NATIONAL CAPITAL
- RIVERS
- MAIN ROADS
- RAILROADS
- PROVINCE (FARITANY) BOUNDARIES
- INTERNATIONAL BOUNDARIES

NOVEMBER 2004