Report Number: ICRR14423

IEG ICR Review
Independent Evaluation Group

1. Project Data:			Date Posted: 09/08/2014	
Country:	Romania			
Project ID:	P078971		Appraisal	Actual
Project Name:	Health Sector Reform 2 Project (apl #2)	Project Costs (US$M):	206.5	198.5
L/C Number:	L4760	Loan/Credit (US$M):	80.0	78.89
Sector Board:	Health, Nutrition and Population	Cofinancing (US$M):	81.72	75.12
Cofinanciers:	European Investment Bank	Board Approval Date:		12/16/2004
		Closing Date:	12/31/2009	12/31/2013
Sector(s):	Health (96%); Central government administration (3%); Sub-national government administration (1%)			
Theme(s):	Population and reproductive health (29% - P); Health system performance (29% - P); Child health (28% - P); Rural services and infrastructure (14% - S)			

Prepared by:	Reviewed by:	ICR Review Coordinator:	Group:
Judyth L. Twigg	Denise A. Vaillancourt	Lourdes N. Pagaran	IEGPS2

2. Project Objectives and Components:

a. Objectives:

According to the Loan Agreement (LA, p. 15) and the Project Appraisal Document (PAD, p. 6), the project's objective was "to provide more accessible services of increased quality and with improved health outcomes for those requiring maternity and newborn care, emergency medical care, and rural primary health care."

At a November 2008 restructuring, the objectives were revised, with an additional objective added. The new objectives were: "(i) to provide more accessible services of increased quality and with improved health outcomes for those requiring maternity and newborn care and emergency medical care; and (ii) to provide support for the preparation of the primary health care strategy." This revision dropped the objective to provide more accessible services of increased quality and with improved health outcomes for those requiring rural primary health care. At this restructuring, US$ 36.27 million in Bank funds, or 46% of total Bank financing, had been disbursed.

At a December 2011 restructuring, a key associated outcome target (24-hour death rate for patients treated in emergency rooms) was revised. At this restructuring, US$ 69.48 million in Bank funds, or 88.1% of total Bank financing, had been disbursed.

The project was the second phase of an agreed two-phase Adaptable Program Loan (APL) whose overall objectives, as stated in the PAD, were to:
1. improve efficiency and equity in the planning and regulation of the health service delivery system;
2. reduce preventable deaths among emergency medical cases;
3. improve access and quality in primary health care in poor and remote areas; and
4. help the Romanian health sector to better focus on priority public health problems, thereby reducing preventable illness and deaths.

The LA (p. 15) states the overall objectives of the APL differently: "lowering morbidity and premature deaths, providing equitable access to health services and improving efficiency of the health sector."

All of the triggers to move from APL I to APL 2 had been achieved at the time the project was approved.

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

Yes
If yes, did the Board approve the revised objectives/key associated outcome targets?
Yes
Date of Board Approval: 11/26/2008

c. Components:

The project contained five components:

1. Maternity and Neonatal Care (appraisal: US$ 129.0 million; actual: US$ 133.8 million). This component was to finance the rehabilitation of maternity and neonatal care units and provide medical and other equipment to increase the quality of neonatal and maternity services. Technical assistance and training were to be provided to support implementation of best international practices and the monitoring of service quality and access.

2. Emergency Care Services (appraisal: US$ 58.1 million; actual: US$ 52.0 million). This component was to upgrade hospital emergency areas and development and implement an integrated ambulance dispatch capability.

3. Primary Health Care and Rural Medical Services (appraisal: US$ 14.0 million; actual: US$ 6.9 million). This component was to focus on improving the accessibility and quality of basic medical services in rural and small urban areas. Its main activities included support for multipurpose health centers and micro-credit lines to support family physicians and practices.

4. National Health Accounts and Planning (appraisal: US$ 0.64 million; actual: US$ 0.26 million). This component was to support the development of National Health Accounts and prepare proposals for rationalization and service development projects.

5. Project Management (appraisal: US$ 4.72 million; actual: US$ 5.48 million). This component was to support the operation of the Project Management Unit (PMU), and to ensure appropriate monitoring and evaluation of project activities.

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

Project Cost: The planned total project cost was EUR 167.88 million (US$ 206.49 million). Actual final costs were EUR 161.36 million (US$ 198.47 million). The project spent less than planned on the third and fourth components (parts of the third component were cancelled as part of a November 2008 restructuring detailed below), and more than planned on project management.

Financing: The project was financed by a planned EUR 65.1 million (US$ 80.0 million) loan from the International Bank for Reconstruction and Development. Actual Bank financing was EUR 64.14 million (US$ 78.89 million). The European Investment Bank (EIB) financed civil works. No formal agreement was established between EIB and the Bank, though the Bank provided supervision and procurement services on behalf of EIB. The planned EIB contribution was EUR 66.4 million (US$ 81.72 million); the actual EIB contribution was EUR 61.07 million (US$ 75.12 million).

Borrower Contribution: There was a planned counterpart contribution of EUR 36.4 million (US$ 44.77 million), of which EUR 36.2 million (US$ 44.46 million) was actually provided.

Dates:

In November 2008, the project was restructured to revise the objectives as noted above, and to cancel parts of the third component (the rural multifunctional health centers and the micro-credit lines for general practitioners) and reallocate those funds (EUR 9.52 million) to other components to support the procurement of additional medical equipment, the physical rehabilitation of maternity facilities, and the functioning of the PMU. These changes were necessitated by changes in the legislation governing health sect or financing, which no longer allowed the Ministry of Health (MOH) to finance investments in primary health care infrastructure, and developments in capital markets that gave group practices better access to private loans. The results framework

was revised accordingly, with some indicators added and others dropped . This restructuring also consolidated loan categories into a single category to permit greater flexibility in loan allocations .

In November 2009, the project's closing date was extended from December 31, 2009 to December 31, 2010.

In December 2010, the project's closing date was again extended from December 31, 2010 to February 28, 2011; two months later, in February 2011, the closing date was extended by another ten months (as part of a Level II restructuring) to December 31, 2011. This aggregate 12-month extension was to enable completion of rehabilitation work on maternity facilities and of technical assistance activities related to the development of the primary health care strategy. The results framework was again revised at this restructuring, with some indicators revised and others dropped.

In December 2011, the project's closing date was again extended from December 31, 2011 to December 15, 2012, to introduce new technical assistance activities to support ongoing sector reforms, introduce a minor reallocation of loan proceeds, and further fine-tune the results framework. As part of this restructuring, although the objectives were not revised, a key associated outcome target (24-hour death rate for patients treated in emergency rooms) was changed.

In November 2012, the project's closing date was again extended from December 15, 2012 to March 15, 2013.

In March 2013, the project's closing date was again extended from March 15, 2013 to December 31, 2013, to complete activities, primarily the preparation of a financial impact assessment of health sector reforms .

3. Relevance of Objectives & Design:

a. Relevance of Objectives:

Relevance of Objectives is rated Substantial under the original objectives and under the revised objectives at the 2008 restructuring and 2011 restructuring . At appraisal, progress had been made in improving the efficiency, equity, and transparency of health sector financing, but several important agenda items remained : increasing resources allocated toward primary and outpatient care, rolling out new payment mechanisms for hospitals, better defining the basic benefits package under the national health insurance mechanism, increasing the efficiency of resource distribution to hospitals, and improving infrastructure in maternal /neonatal care and intensive care units (ICR, p. 2). The Romanian national health strategy for 2014-2020, "Health for Prosperity," focuses on the development of community health services and the restructuring of specialized services, covering issues of both access to and quality of care . The Bank's current Country Partnership Strategy (2014-2018) has as a pillar shared prosperity with a focus on access to health care . The original objectives were therefore substantially relevant to country conditions at the time of appraisal, and they remain relevant to current Bank and government strategy.

In 2008, the objective to provide quality, accessible services to those requiring rural primary health care was replaced with an objective to provide support for the preparation of a primary health care strategy . Despite the changes in legislation and the fiscal environment that precluded the financing of rural multi -purpose health centers and micro-credit lines for family physicians, coverage and quality of rural and overall primary health care still remained directly within the mandate of the Ministry of Health . The PAD (p. 38) indicates that a primary health care strategy had been prepared under the first phase of this APL in the early 2000s. Although the Project Paper for the 2008 restructuring and the ICR do not provide an explanation of the decision to update the strategy at this time, it is reasonable to assume that the preparation of a new strategy was necessary and appropriate. It is a shortcoming that the added objective, "to provide support for the preparation of the primary health care strategy," is not an outcome-oriented objective, but rather an activity or input.

The original project-specific objectives were relevant to the overall APL objectives to reduce preventable deaths among those seeking emergency medical services, improve access and quality in primary health care in poor and remote areas, help the Romanian health system focus on priority problems (assuming that maternal/neonatal, emergency, and rural primary health care were accurately specified as priority problems), lower overall morbidity and premature deaths, and provide equitable access to health services (assuming that improving rural primary care would improve equity of access to care). However, the original project-specific objectives did not address the overall APL objectives to improve efficiency and equity in the planning and regulation of the health services delivery system, or to improve the efficiency of the health sector; however, although there was not a specific objective related to this component, the project's fourth component on establishing National Health Accounts was directly in support of these overall program objectives . Without information on the direction of the new primary health care strategy, it is not possible to assess whether that

added objective contributed to the APL objectives related to efficiency and equity in planning and regulation of service delivery and sectoral efficiency.

b. Relevance of Design:

Relevance of Design is rated Substantial under the original objectives, and under the revised objectives at the 2008 restructuring and 2011 restructuring. The project's original components contained some activities that were plausibly and logically linked to achievement of its three objectives: improved outcomes for maternal/newborn care, emergency care, and rural health care. The fourth component, establishing National Health Accounts, seems not to have been directly in support of a project objective, but it would have been directly and substantially relevant to the overall program objectives of improving planning, regulation, efficiency, and equity. There were some minor shortcomings in the original design. Investments in emergency services were intended to be integrated with other services, training, and equipment, in order to lessen the degree to which the poor used emergency services as a substitute for primary care (PAD, p. 14), but the project's planned activities do not appear to have included measures that would have decongested emergency services in this manner. Also, the inclusion in the revised design of activities to identify underserved populations calls into question the original design, as it implies that these populations had not been well identified previously. The original design anticipated the collection of data to show stratified results (by geographic location and income), but the project logic does not seem to capture this intended focus on poor and underserved locations.

The replacement at the 2008 restructuring of the objective related to rural health care with development of a primary care strategy was supported by the removal of activities in the third component relevant to the former, and addition of technical assistance and dialogue relevant to the latter.

Although there was not an objective to match the fourth component's activities on National Health Accounts, this component did support the overall APL objectives to improve efficiency and equity in the planning and regulation of the health service delivery system and to improve efficiency of the health sector. Overall, therefore, the planned activities as specified in this project's components did complement the first project in the APL, to make the overall APL log frame complete.

4. Achievement of Objectives (Efficacy):

ORIGINAL OBJECTIVES:

Provide more accessible services of increased quality and with improved health outcomes for those requiring maternity/newborn care is rated High.

Outputs:

A new institutional approach for maternal and neonatal care was introduced, with integrated regional networks serving defined geographic areas. These networks include one centralized hub/regional center, and several subordinated level two and three units. The project invested in facilities at all levels.

Small rehabilitations and provision of medical equipment were planned for 45 obstetric/neonatal facilities. However, once the work began, it became clear that much more extensive building repairs were necessary, resulting in a rapid price escalation for civil works per unit and a reduction in the number of facilities impacted to 22. 204 facilities were provided with various types of equipment, and new procedures for maternal and neonatal referrals, quality assurance, and other areas were developed and implemented. 737 physicians and nurses were trained (the specific type of training is not provided), with 94 through a training-of-trainers model.

Patient satisfaction scores for maternity/neonatal services increased as follows (with maximum questionnaire scores of 140): for Level 1 facilities, from 109/140 in 2008 to 127/140 in 2013; for Level 2 facilities, from 110/140 in 2008 to 121/140 in 2013; and for Level 3 facilities, from 109/140 in 2008 to 119/140 in 2013. These results overachieved the targets of 10% improvement for Levels 1-2 and 3.5% improvement for Level 3.

Outcomes:

The number of maternal deaths decreased from 52 in 2004 to 29 in 2013, far surpassing the target of 41. The maternal mortality rate decreased from 0.24/1,000 in 2004 to 0.14/1,000 in 2013, surpassing the target of 0.19/1,000.

The maternal mortality rate by level of maternal and child health facility changed as follows: for Level 1, from

0.09% in 2008 to 0.15% in 2011; for Level 2, from 0.07% in 2008 to 0.08% in 2011; for Level 3, from 0.17% in 2008 to 0.16% in 2011. Level 1 and 2 data actually show an increase from 2008 to 2011, but Level 3 achieves the target of a 3.5% decrease. However, the ICR data sheet explains that, because of the improvement in health care conditions, more women began to give birth in the hospital rather than at home, and consequently more died in hospital. Preliminary data for 2012 (not yet verified) indicates a significant improvement, with Level 1 mortality at 0.06% (a 33% decrease from 2008 baseline), Level 2 mortality at 0.05% (a 29% decrease), and Level 3 mortality at 0.05% (a 70% decrease). If verified, all of these data would overachieve the targets (10% decrease for Levels 1-2 and 3.5% decrease for Level 3).

The number of neonatal deaths decreased from 2,068 in 2004 to 673 in 2013, far surpassing the target of 1,551. The neonatal death rate decreased from 9.6/1,000 in 2004 to 4.5/1,000 in 2013, far surpassing the target of 7.2/1,000.

The neonatal mortality rate by level of maternal and child health facility decreased as follows: for Level 1, from 4.06% in 2008 to 2.09% in 2013; for Level 2, from 8.40% in 2008 to 5.31% in 2013; for Level 3, from 10.6% in 2008 to 8.22% in 2013. All three levels of facility significantly overachieved the target of a 10% decrease.

The number of post-neonatal deaths decreased from 1,573 in 2004 to 634 in 2013, far surpassing the target of 1,180. The post-neonatal death rate decreased from 7.3/1,000 in 2004 to 4.2/1,000 in 2013, surpassing the target of 5.5/1,000.

Provide more accessible services of increased quality and with improved health outcomes for those requiring emergency medical care is rated Substantial .

Outputs:

The ambulance dispatch system was upgraded through the establishment of central emergency call centers and voice/data communications links between dispatchers and ambulance sub-stations. As a result, a nation-wide communication system now exists linking ambulance, police, defense, and fire services. According to the ICR (p. 21), "this system is considered a best practice and many countries are turning to Romania to learn from its example (Croatia, Bulgaria, Moldova)." In addition, over 1450 ambulances were provided with communications equipment to facilitate participation in this network.

The project supported major rehabilitation of 17 county hospital emergency departments and provided substantial medical equipment to the emergency and intensive care units of 63 additional hospitals. An additional 190 small municipal and town hospital emergency rooms were provided with basic equipment. Based on information provided in the ICR Data Sheet, it appears that only six hospitals were provided with a full package of equipment that included ventilators for Intensive Care Units (ICUs). A telemedicine system for imaging data transmission for the central and south regions of the country was extended to further cover the north-east region.

Response times for urban emergency services declined from 18 minutes, 25 seconds in 2007 to 17 minutes, 23 seconds in 2013.

Outcomes:

The 24-hour death rate among patients treated in an emergency room and then admitted to the intensive care unit in that same hospital decreased from 5.78% in 2007 to 4.16% in 2013, surpassing the original target of 4.91% (a 15% decrease) and 4.62% (a 20% decrease). These data cover only the six hospitals that received full equipment under the project. The ICR (Data Sheet) notes that this sample size is too small to extrapolate to the entire emergency system, and in any event, an extrapolation of these results to facilities that did not receive the full equipment package would be inappropriate. Also, no information is provided on the patient case mix and severity of illness, making comparisons over time and between hospitals difficult.

The 24-hour death rate for patients admitted to and treated in hospital intensive care units decreased from 2.84% in 2007 to 2.76% in 2013 (a 2.8% decrease), not achieving the target of a 5% decrease. These data also cover only the six hospitals that received full equipment under the project.

The death rate in emergency departments decreased from 0.079% in 2007 to 0.066% in 2013, not quite achieving the target of 0.064%. According to the ICR data sheet, pre-hospital project interventions resulted in some patients who previously would have been declared dead on arrival now being brought to emergency departments showing vital signs, and a higher percentage of those cases dying in the emergency departments at a later point in time. The death rate of patients treated in small emergency rooms increased from 0.04% in

2008 to 0.042% in 2013, not achieving the target of a 5% decrease; this increase is also explained by those pre-hospital interventions resulting in more seriously injured patients now presented in the emergency rooms as initially alive.

Provide more accessible services of increased quality and with improved health outcomes for those requiring primary rural health care is rated Negligible .

Outputs:

According to the ICR (pp. 17-18), no investments were made specifically in rural communities. The planned establishment of multipurpose rural health centers was cancelled as part of the 2008 restructuring. This was partially because of a change in the national legislation governing health financing, no longer allowing the MOH to finance investments in primary health care infrastructure, and also because developments in capital markets allowed existing group practices better access to commercial loans.

Outcomes:

No outcomes are reported for this objective.

REVISED OBJECTIVES. The following objective was added:

Provide support for the preparation of the primary health care strategy is rated Modest .

Outputs:

Extensive dialogue and technical assistance/training on policy development occurred under the project. Information, education, and communication campaigns were conducted to educate the public on a new package of basic health services. A National Health Accounts system was put in place, but the legal framework supporting it has not been established.

Outcomes:

A primary rural health strategy, "Strategy 2012-2020," and related Action Plan were formally approved by the MOH on February 27, 2012. It is expected to be approved within the framework of the overall Health Sector Reform Strategy for the country for the next programming period of the European Union financing exercise (2014-2020). The ICR provides no information on the content or quality of this strategy, nor on the consultative process that contributed to it and the level of buy-in it has achieved.

Overall, the project made marked contributions to the overall objectives of the APL series to reduce preventable deaths among emergency medical cases and to help the country's health sector to better focus on priority health problems, thereby reducing preventable illness and deaths. However, its contributions to the objectives to improve efficiency and equity in the planning and regulation of the health service delivery system are less clear, and it made no immediate contribution to the objective of improving access and quality in primary health care in poor and remote areas.

5. Efficiency:

Efficiency is rated Modest .

The PAD (pp. 30, 57-62) estimated an internal rate of return of 30% and a net present value of US$ 109 million, assuming a time horizon of ten years and a discount rate of 10%. Taking health benefits gained over a period of ten years, the ICR (pp. 33-35) finds a benefit/cost ratio of 1.65 at a 10% discount rate, with an internal economic rate of return of 28.4% and a net present value of benefits of US$ 89.35 million. A sensitivity analysis shows that the project remains viable under a 20% reduction in benefits from the maternity and emergency services components (ERR = 26.4%), as well as under a 20% reduction in benefits from one component and a 40% reduction in benefits from the other (15.2% and 15.5%).

There was a 1.5-year delay caused by revision of architectural designs requested by the EIB for rehabilitation of maternity facilities. Though these delays may have improved the quality of design and therefore ultimately proved cost effective, there were also inefficient delays in related procurement processes due to "constant changes" in the appointment of members of specialty technical commissions, "causing frequent revisions of technical specifications and bid evaluation reports" (ICR, pp. 9-10, 13). In some cases, design revisions

resulted in 15% increases in the cost of civil works contracts, resulting in rebidding processes that incurred additional delays (ICR, p. 13). On the other hand, other competitive bidding procedures, in particular for emergency medical services packages, produced cost savings estimated at EUR 5 million (ICR, p. 14). Overall, the project's lifespan was almost doubled (from five years to nine), yet not quite all of the initial financing was used.

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

	Rate Available?	Point Value	Coverage/Scope*
Appraisal	Yes	30%	100%
ICR estimate	Yes	28.4%	100%

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

6. Outcome:

Under the original objectives, the project's objectives were substantially relevant, and relevance of design was substantial. Achievement of the maternity/newborn services/outcomes objective was high, of the emergency services/outcomes objective was substantial, and of the rural health services /outcomes objective was negligible. Efficiency was modest. Outcome is therefore rated Moderately Unsatisfactory under the original objectives, under which 46% of Bank funds had been disbursed.

Under the objectives/targets as revised in 2008 and 2011, the project's objectives and design were substantially relevant. Achievement of the maternity/newborn services/outcomes objectives was high, of the emergency services/outcomes objective was substantial, and of the support for the primary health strategy was modest. Efficiency was modest. Outcome is therefore rated Moderately Satisfactory under the 2008/2011 objectives/targets, under which 54% of Bank funds had been disbursed.

According to the harmonized OPCS/IEG guidelines for restructured projects, the final outcome rating is determined according to the percentage of the loan disbursed before and after project restructuring. In this case, the calculation is as follows:

Original objective: Outcome Moderately Unsatisfactory = 3 (0.46) = 1.38
Revised objective/targets: Outcome Moderately Satisfactory = 4 (0.54) = 2.16

Overall Outcome = 1.38 + 2.16 = 3.54, which rounds to 4 = Moderately Satisfactory

a. Outcome Rating : Moderately Satisfactory

7. Rationale for Risk to Development Outcome Rating:

A follow-on project, the Improving Health System Quality and Efficiency Project, was approved by the Board on May 28, 2014. It is intended to further reforms in the areas of hospital rationalization, strengthening of ambulatory care, and health sector governance and stewardship. Maintenance costs, especially for the emergency health program, now fall under a dedicated line item in the MOH budget; this should ensure autonomy and financial sustainability, if that line item is adequately funded and if there is transparency and efficiency in the use of those funds. According to the ICR (pp. 20-21), institutional development at both the local and national levels was substantial, with significant increases in the capacity of the MOH to plan and manage the health system and of local governments to make decisions related to infrastructure and human resource development.

a. Risk to Development Outcome Rating : Negligible to Low

8. Assessment of Bank Performance:

a. Quality at entry:

The APL was an effective instrument to provide a necessary long-term framework to support the sector and

complement reforms achieved through a prior Programmatic Adjustment Loan (PAL). Key lessons were learned from Phase 1 of the APL, including the need for advance development of a solid implementation plan, the availability of committed counterparts not only in the Project Management Unit but also in each of the subject matter areas, the importance of lining up funding in advance for necessary training, and the need for clear planning for monitoring and evaluation (including methods of ensuring data accuracy and consistency) (PAD, p. 9). Risk analysis in the PAD included only one risk rated Substantial or higher, that of lowered commitment to hospital restructuring/rationalization; appropriate mitigation measures were put in place, including leverage through the sequence of PAL conditionality mechanisms and triggers (PAD, p. 12; ICR, p. 8).

However, according to the ICR (p. 22), the project's design was overly ambitious and did not appropriately take into account some limitations imposed by the country's legal environment, including state budgetary limits and ceilings. Because of the ambitious scope, several project extensions became necessary. The original project objectives are somewhat awkwardly worded, as they conceptually de-link rural primary health care from neonatal and maternity services, which are implicitly included in primary care. Also, some of the original indicators were not readily measurable, and there were no indicators to measure achievement of the objective related to rural primary health care. The inclusion of an activity to identify underserved areas in the restructured project implies that these areas were not well identified under the original project design.

Quality-at-Entry Rating: Moderately Satisfactory

b. Quality of supervision:

The Task Team Leader (TTL) and key health consultants were based in Romania. Key Project Management Unit staff were retained from the first phase of the APL, ensuring the presence of necessary experience and capacity. The Bank team was responsive to government needs throughout implementation in a timely manner. Coordination with international partners, especially the European Investment Bank, was smooth, and all donors worked well with the government to reach consensus throughout on optimal use of loan funds (ICR, p. 22). The ICR (p. 7) states that the Bank restructured the project appropriately, in line with the evolution of government policy and sector developments; however, it is not clear how the project's existing maternal/neonatal health interventions were linked to the primary health strategy development.

Quality of Supervision Rating: Moderately Satisfactory

Overall Bank Performance Rating: Moderately Satisfactory

9. Assessment of Borrower Performance:

a. Government Performance:

The government coordinated the project effectively with a wide array of other donors in the sector, making sure that different donors' activities complemented one another (ICR, p. 7). According to the ICR (p. 8), strong leadership and vision from the MOH drove progress under the project, especially in the areas of emergency services and telemedicine, making Romania a model for other countries in the region on integrated emergency medical services. Broad government reforms in the area of public financial management created conditions for improved agency performance, including the units responsible for project implementation. However, there were shortcomings. A change in government soon after project approval led to revisiting of priorities and resultant delays, and there was high turnover of ministers throughout, slowing implementation (ICR, pp. 9, 23). The ICR does not indicate how the change in government may have impacted the project's restructuring.

Government Performance Rating Moderately Satisfactory

b. Implementing Agency Performance:

The Project Management Unit (PMU) had implemented a prior Bank-financed health project and several

projects financed by the Global Fund. It was well staffed with effective component coordinators and a skilled fiduciary team. Staff turnover was high due to staff salary decreases in 2010, but these issues were effectively resolved (ICR, pp. 23-24). According to the ICR (p. 24), PMU implementation capacity increased significantly over the project's lifetime. Challenges with procurement stemmed with issues at the MOH rather than the PMU (see Section 11b).

Implementing Agency Performance Rating : Satisfactory

Overall Borrower Performance Rating : Moderately Satisfactory

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

a. M&E Design:

The PAD's results framework (pp. 30-34) contained a large set of outcome and intermediate outcome indicators, with baselines and targets well established and good specification of institutions responsible for data collection and analysis. The M&E framework was developed in close collaboration with the PMU and other major stake holders. However, there were no health outcome indicators for the objective related to rural primary health care, and there was no stratification of data by geographic location (rural/urban) and income level, as discussed in the PAD. Also, according to the ICR (p. 10), definitions of some indicators were not well understood by all reporting entities across the country.

b. M&E Implementation:

As implementation progressed, M&E functions became integral to the work of eight regional coordinators, with one dedicated M&E expert in the central project office, and definitions of indicators became commonly understood. The PMU submitted well-prepared timely biannual progress reports that included information on the status of implementation and key outputs and outcome indicators. The results framework was adjusted appropriately as the project was restructured in 2008 and 2011. However, none of these revisions added appropriate outcome indicators for the rural primary health care objective. In addition, a planned follow-on to the initial baseline social survey to monitor access to health services (especially for poor and rural populations) appears not to have been implemented.

c. M&E Utilization:

According to the ICR (p. 11), the government did not make sufficient use of the project's M&E data and analysis. However, project data and analysis were clearly reflected in the decisions to restructure the project in 2008 and 2011.

M&E Quality Rating : Modest

11. Other Issues

a. Safeguards:

The project was Category B and triggered Environmental Assessment (OP/BP/GP 4.01), as it envisaged limited minor construction, such as remodeling, renovation and refitting of existing buildings and the provision of equipment to health facilities. An Environmental Management Plan was prepared and published, and public consultation with stakeholders was held in September 2004 (PAD, p. 15). According to the last Implementation Status and Results Report (ISR) of December 2013, safeguards compliance was satisfactory.

b. Fiduciary Compliance:

The PMU had significant prior experience with Bank-financed projects, and the country's pubic financial management systems satisfied Bank requirements. Three financial experts within the PMU supervised the project's financial management. Internal controls were adequate, and annual audits were on time and unqualified (ICR, p. 12).

There were challenges with procurement processes, largely due to the "cumbersome and long-term" process required by the MOH for approving technical specifications for medical equipment and civil works (ICR, p. 12). Overall, procurement complied with Bank guidelines. However, many issues emerged, including delays due to the organization and role of the "expert groups" working on technical specifications and evaluation of bids, and differing opinions on the technical quality of equipment available from prominent as opposed to less well-known manufacturers.

c. Unintended Impacts (positive or negative):

None reported.

d. Other:

12. Ratings:	ICR	IEG Review	Reason for Disagreement /Comments
Outcome:	Moderately Satisfactory	Moderately Satisfactory	
Risk to Development Outcome:	Negligible to Low	Negligible to Low	
Bank Performance :	Moderately Satisfactory	Moderately Satisfactory	
Borrower Performance :	Satisfactory	Moderately Satisfactory	A change in government soon after project approval led to revisiting of priorities and resultant delays, and there was high turnover of ministers throughout, slowing implementation.
Quality of ICR :		Satisfactory	

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

13. Lessons:

The following lessons are adapted from the ICR (pp. 24-25, 49):

Strong government ownership and close coordination with development partners are essential to achievement of development objectives. In this case, the government's strong level of commitment, together with strong donor harmonization, kept key project activities on track despite challenges and delays .

Proactive and continuous Bank supervision is also a key element of success . The on-site support provided by the local Bank team, backstopped by strong and timely policy dialogue provided by headquarters-based health specialists, was central to the project's success. The location of the TTL in-country was particularly important, enabling collaboration with frequently-changing senior decision makers in the MOH.

Careful periodic review of technical designs for civil works can avoid costly delays . In this case, the EIB requested revision of technical designs after bidding procedures were initiated . Although these requests were reasonable, they might have been avoided with adequate prior review .

14. Assessment Recommended? ○ Yes ● No

15. Comments on Quality of ICR:

The ICR is clear, candid, and concise, and it follows guidelines appropriately . It brings a wide array of evidence to bear on its assessments of project achievements, and it is careful to assess issues related to attribution of observed results to project-sponsored interventions. It provides a clear assessment of the Bank's contributions compared with those of other donors, especially the EIB. However, the ICR does not provide sufficient information on the rationale for development of a new primary health care strategy, making it difficult to evaluate the relevance of the project's revised objectives and design.

a.Quality of ICR Rating : Satisfactory