



1. Project Data

Project ID P114859	Project Name LS-Health Sector Performance Enhancement	
Country Lesotho	Practice Area(Lead) Health, Nutrition & Population	
L/C/TF Number(s) IDA-52290,TF-14147	Closing Date (Original) 30-Jun-2017	Total Project Cost (USD) 14,728,016.58
Bank Approval Date 11-Apr-2013	Closing Date (Actual) 30-Jun-2019	
	IBRD/IDA (USD)	Grants (USD)
Original Commitment	12,000,000.00	4,000,000.00
Revised Commitment	16,000,000.00	3,906,234.01
Actual	14,728,016.58	3,906,234.01

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2. Project Objectives and Components

a. Objectives

According to the Grant Agreement (p. 5) and the Project Appraisal Document (PAD, p. 5), the objectives of the original project, titled "Maternal and Newborn Health Performance-Based Financing (PBF) Project," were "to improve the utilization and quality of maternal and newborn health services in selected districts in Lesotho." Nine of the country's ten districts (excluding only the more well developed capital district, Maseru) were to be covered.



A 2016 restructuring revised the objectives to: "(i) increase utilization and improve the quality of primary health services in selected districts in Lesotho with a particular focus on maternal and child health, tuberculosis (TB), and HIV; (ii) improve contract management of select public-private partnerships (PPPs); and (iii) in the event of an Eligible Crisis or Emergency, provide immediate and effective response to said Eligible Crisis or Emergency" (Restructuring Paper, p. 2). The project's title was changed to "Health Sector Performance Enhancement Project," and its scope was reduced from nine to six districts due to low implementation capacity. New PDO-level indicators were added to measure achievement of the added objectives.

A 2018 restructuring scaled up the project's coverage from six to all ten districts (Restructuring Paper, p. 7), as implementation capacity had improved and the government requested institutionalization of the PBF approach throughout the entire country. PDO-level indicators were revised to harmonize with the Health Management Information System (HMIS) and routine utilization data from the project, replacing indicators that were sourced from infrequently conducted household surveys that could provide only estimated data for project intervention areas.

Due to the revisions of project objectives and scope, a split rating will be performed. At the time of the 2016 restructuring, 20% of Bank financing had been disbursed.

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

Yes

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

Yes

Date of Board Approval

15-Nov-2016

c. Will a split evaluation be undertaken?

Yes

d. Components

The original project had two components, to be implemented in three phases: a one-year pilot in two districts; then gradual scale-up in the subsequent two phases to the other seven participating districts. The pilot districts, Leribe and Quthing, were chosen in order to provide a range of geographic balance, and were also based on district maternal health indicators relative to other districts (one was worse and one better than the national average) and the existing capacity of District Health Management Teams (DHMTs) (PAD, p. 34). The timing of scale-up was to be determined by each individual district's readiness to do so (PAD, p. 7). All districts of the country were eventually to be covered, with the exception of the capital district, Maseru, where health outcomes were better than the others.

Component 1: Improving Maternal and Newborn Health (MNH) Service Delivery at Community, Primary, and Secondary Levels through PBF (appraisal, US\$ 13.7 million; 2016 restructuring, US\$ 11.45 million; 2018 restructuring, US\$ 11.64 million; actual US\$ 11.64 million) was to complement support provided by the Millennium Challenge Account (MCA) to renovate, refurbish, and equip health centers. The



project was to build on these infrastructure improvements with supply-side activities designed to strengthen the quality and utilization of health services.

The first subcomponent, delivery of MNH services through PBF, was to support the provision of quality MNH services as well as selected services in the Essential Services Package by providing PBF to village health workers (VHWs), health centers, and hospitals. The choice of specific services was "carefully selected with inputs from various departments of the Ministry of Health (MOH)" (PAD, p. 22). PBF was also to be made to DHMTs based on their supervision of health facilities, using a quality checklist. Overall, the PBF was intended to stimulate health worker motivation and productivity, and to provide additional cash to overcome obstacles affecting the quality or continuum of patient care.

The second subcomponent, PBF implementation and supervision support, was to provide technical assistance and build in-country capacity for PBF through a performance purchasing technical assistance (PPTA) firm; this firm's role was to diminish as implementing entities and facilities gained greater experience with PBF implementation. Capacity building was to be provided to the MOH and Christian Health Association of Lesotho (CHAL, the other main provider of health services in the country) at central and district levels, and for district and community councils.

At the 2016 restructuring, this component was renamed "Improving Health Service Delivery through PBF." It was revised to suspend implementation of the VHW PBF program, due to challenges associated with its organization; adjust the PBF program at the district hospital level to focus more on quality of services, and to provide individual bonuses to hospital staff; and to revise the quantitative incentive indicators at the health center level to include additional HIV and TB indicators. Planned scale-up was reduced from nine to six districts.

At the 2018 restructuring, PBF was to be scaled up to all ten districts.

Component 2: Training of Health Professionals and VHWs and Improving Monitoring and Evaluation (M&E) Capacity (appraisal, US\$ 2.3 million; 2016 restructuring, US\$ 3.73 million; 2018 restructuring, no change; actual US\$ 3.73 million). This component was to support an ongoing MOH program for training doctors, nurse anesthetists, and midwives to achieve an acceptable standard of competency in the delivery of MNH services, including emergency obstetric and neonatal care. Health center nurses were also to be trained on drug supply management, and pharmacists on supply chain management and quantification of health commodities. M&E capacity was to be developed through strengthening of the HMIS in all districts and building capacity of M&E personnel at the central and district levels. The project was to support health facility quality of care assessments and a baseline household survey. An impact evaluation of the project was to be carried out with a separate Bank-executed Health Results Innovation Trust Fund (HRITF).

At the 2016 restructuring, this component was renamed "Capacity Building Support to the Ministry of Health." Its scope of activities was expanded to provide additional support to strengthen MOH procurement capacity; better align the MOH's Annual Joint Review with health sector strategic objectives; and improve the integration into the health system of the Queen 'Mamohato Memorial Hospital (QMMH) network, a PPP that had replaced the old national referral hospital and established filter clinics in Maseru in 2010-2011, supported through the International Finance Corporation. The hospital accounts for approximately 30% of the MOH budget.

Also at the 2016 restructuring, two components were added:



Component 3: Enhance PPP Management Capacity within the Government of Lesotho (2016 restructuring: US\$ 0.82 million; 2018 restructuring, US\$ 0.63 million; actual, US\$ 0.63 million), to support the QMMH network PPP, including PPP management capacity building. Activities were to include the provision of technical assistance to strengthen oversight over PPPs. The Ministry of Finance (MOF) was added as an implementing agency to be responsible for this component.

Component 4: Contingent Emergency Response Component, was a no-cost component designed to support activities related to mitigating the impact of shocks.

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

The project was originally to be financed by a US\$ 12 million Specific Investment Loan from the International Development Association and a US\$ 4 million grant from the HRITF from Norway and the United Kingdom. The government was to make a parallel US\$ 4 million contribution to cover operating costs for the MOH PBF unit, and the costs of scale-up for three districts during the project's third and fourth years. Actual total costs were US\$ 17.28 million of the planned US\$ 20 million, reflecting an actual government contribution of US\$ 2.55 million and Bank financing of US\$ 14.73 million. The project team confirmed that the difference between planned and actual Bank financing was due to exchange rate fluctuations.

The project was restructured twice:

- On November 15, 2016, the project's title, objectives, components, and results framework were revised. The closing date was extended by two years, from June 30, 2017 to June 30, 2019. Implementation arrangements were revised, and funds were reallocated.
- On May 5, 2018, the project's scope was increased and the results framework adjusted accordingly, and funds were again reallocated.

An Additional Financing (AF) and project extension were discussed but ultimately cancelled. The Country Management Unit decided instead to consolidate the portfolio and incorporate activities into a new Nutrition and Health System Strengthening Project (2021-2025), under preparation. The project closed on June 30, 2019.

3. Relevance of Objectives

Rationale

At appraisal, Lesotho was off track for meeting Millennium Development Goals to reduce child mortality and improve maternal health. In 2009, the maternal mortality ratio was high, at 1,155/100,000 live births, and the under-five mortality rate had improved only slightly in the preceding 20 years, from 89/1,000 live births in 1990 to 86/1,000 in 2011. Weak health service performance had contributed to poor health outcomes,



exacerbated by the HIV/AIDS epidemic. In 2012, Lesotho had the third highest adult HIV prevalence rate in the world (23%). Partly as a result, life expectancy at birth had declined from 60 years in 1992 to 49 years in 2012. The project's objectives were highly relevant to this country context.

The government's 2012/13 - 2016/17 National Strategic Development Plan (NSDP) identified "improve the quality of health; reduce maternal and child mortality; combat and prevent the spread of new infections of HIV and AIDS; and reduce social vulnerability, especially for children and old people" as one of its six key pillars. The project's original objectives were highly relevant to this strategy. Its revised objectives remained relevant to NSDP II (2018-2023), which has a strategic key pillar for strengthening human capital, including health, education, and skills development.

The project was aligned with the Bank's Country Assistance Strategy at appraisal (2010-2014) and its second area of engagement, human development and service delivery, which explicitly called for reversal of negative trends in health and improved access to services. The revised objectives were aligned with the Country Partnership Framework (CPF) at closing (2016-2020), specifically its strategic objective on "Improving Health Outcomes," through: (i) "introduction of a performance-based approach in primary health centers and district hospitals to improve health outcomes, including the HIV/AIDS response"; a specific CPF indicator for "improved QMMH contract management" (CPF, p. 33); and an explicit "urgent" goal to integrate the QMMH network with the rest of the hospital system (p. 38). The CPF (p. 14) also notes that, given Lesotho's variable climate and vulnerability to natural disaster, Crisis Emergency Response Components were being restructured into all existing projects.

Rating

High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

Improve the utilization of maternal and newborn health services in selected districts in Lesotho / Increase utilization of primary health services in selected districts in Lesotho with a particular focus on maternal and child health

Rationale

The project's implicit theory of change held that the incentive structures of the PBF program would, facilitated by complementary infrastructure investments through the MCA, increase the availability of health services and their utilization in participating districts.

Outputs



The project supported capacity development at the PBF Unit of the MOH for management of day-to-day implementation, M&E, and management of PBF activities. It also supported the National Sexual and Reproductive Health Steering Committee to provide national-level policy guidance and oversight of project activities. A PPTA organization with PBF implementation experience was contracted and worked on building local capacity on strategic purchasing within the MOH. (The ICR [p. 30] indicated that the capacity building work was completed and the firm was phased out, as planned; later comments from the Borrower stated that implementation of the PPTA capacity building plan had advanced but was not completed when the project closed.) At the district level, the project supported capacity building for district steering committees that included DHMTs, district councils, CHAL representatives, and civil society organizations. These committees supported oversight and supervision of PBF services at the district level.

171 health facilities were operating under PBF contracts at project closure, exceeding the original target of 107 and the revised target of 75. The PBF scheme was rolled out in the following sequence:

- 2014: Quthing, Leribe
- July through October 2016: Mafeteng, Mohale's Hoek, Mokhotlong, Thaba-Tseka
- 2018: Maseru, Berea, Butha Buthe, Qacha's Nek

Outcomes

The number of children under one year of age who were fully immunized at PBF-enrolled health facilities increased from 22,834 in 2014 to 35,607 in 2019, exceeding the target of 31,440. This indicator was changed from percentage to numerical terms at the 2018 restructuring. The ICR (p. 21) noted that this achievement occurred despite shortages of vaccines. It also noted that, according to data from the Demographic and Health Survey (DHS 2014) and Multiple Indicator Cluster Survey (MICS 2018), the two districts that enrolled in PBF in 2014 saw significant increases in vaccine coverage, from 60.1% in 2014 to 81.5% in 2018, while coverage nation-wide remained stagnant, suggesting that the project had an impact.

The number of women and children using basic nutrition services increased from 1,319 in 2016 to 1,808 in 2018, not reaching the target of 2,050. This indicator was added at the 2018 restructuring. The ICR (p. 22) explained the underperformance as due to reductions in funding for VHWs by a key (unidentified) development partner. DHS and MICS data, however, indicate progress in one of the two districts that enrolled in PBF in 2014, Leribe, with the prevalence of underweight, stunting, and wasting decreasing from 8% to 5%, 31.3% to 29.8%, and 3.3% to 1.7%, respectively, against little to no progress at the national level. No information was provided, however, on Quthing, the other 2014 pilot district.

The number of women using modern contraceptive methods in PBF-enrolled health facilities in target districts increased from 70,956 in 2014 to 91,658 in 2019, not achieving the target of 117,900. This indicator was adopted at the 2018 restructuring, to replace an initial indicator that covered only married women and to change measurement from percentage to numerical terms (to match HMIS reporting). The ICR (p. 21) stated that the underachievement was due to shortages of family planning commodities due to supply chain management and budget reduction issues that were not within the control of the supported health facilities. The ICR offered additional information from the DHS 2014 and MICS 2018 indicating that the prevalence of married women aged 15-49 using modern contraception increased nationally from 59.8% in 2014 to 64.6% in



2018; the two districts that enrolled in the PBF program in 2014 showed more modest improvement (Quthing, increase from 63.6% in 2014 to 67% in 2018; Leribe, no change, 63.4% in 2014 and 63.6% in 2018).

The original project had an outcome indicator for percentage of pregnant women delivering in PBF-enrolled health facilities. The ICR (p. 17) stated that this indicator was dropped because "the percentage of institutional deliveries improved during project implementation and was relatively high," and therefore a decision was made to include a more challenging indicator on family planning. However, the ICR presented additional DHS/MICS data indicating that, nation-wide, coverage of institutional deliveries increased from 76.5% in 2014 to 89.4% in 2018, and deliveries attended by a skilled attendant from 77.9% in 2014 to 86.6% in 2018. The ICR also provided information specifically on Quthing, one of the two pilot districts that began PBF in 2014: institutional deliveries increased from 71.9% in 2014 to 87.8% in 2018, and deliveries with a skilled attendant increased from 72.8% in 2014 to 89.1% in 2018, in both cases a larger improvement than nation-wide. Similar information for the other pilot district, Leribe, was not provided. Original indicators on pregnant women in the lowest income quintile delivering at health facilities, women with at least four antenatal care visits during pregnancy, births attended by skilled health personnel, mothers who received postnatal care within two days of childbirth, pregnant women receiving antenatal care from a health provider, and children under five years of age whose height and weight are monitored regularly were dropped because of lack of data. The ICR provided additional data that the percentage of women nation-wide with a live birth and at least one antenatal care visit increased from 94.7% in 2014 to 96.4% in 2018; with at least four antenatal care visits increased from 74.4% in 2014 to 76.6% in 2018; and with their first antenatal care visit in the first trimester of pregnancy increased from 41.2% in 2014 to 57.1% in 2018. Separate data were not provided for the two pilot districts that enrolled in PBF in 2014, and therefore the project's specific impact on these improvements is not clear.

For some indicators, the ICR provided district-level DHS/MICS data for some of the "Phase II" districts that began PBF in mid- to late 2016. It is not clear how much of the change between 2014 and 2018 on these indicators took place before versus after the project took effect in these districts, and therefore what specific impact the project may have had.

Overall, while progress on use of modern contraceptive methods was modest, the data plausibly indicate that the project had significant impact on immunization coverage, on nutrition services in Leribe, and on maternal health services in Quthing. Achievement of this objective is therefore rated Substantial.

Rating

Substantial

OBJECTIVE 2

Objective

Improve the quality of maternal and newborn health services in selected districts in Lesotho / Increase quality of primary health services in selected districts in Lesotho with a particular focus on maternal and child health

Rationale



The theory of change for this objective held that on-the-job clinical training and coaching, as well as the financial autonomy granted to facilities under the PBF program to expeditiously procure necessary inputs, would contribute to improved quality of services.

Outputs

Four quality checklists were revised and streamlined, meeting the target. The University of Pretoria worked with MOH in June 2018 to revise the checklists to put additional emphasis on health workers' clinical skills.

826 health personnel received training focused on clinical services, nearly doubling the target of 465. This training included a mentoring program at all public hospitals in the country. The focus of training was on maternal, newborn, and child health issues, as well as handling of complex HIV/AIDS and TB cases. Coaching and mentoring included case simulations/vignettes, provided by the project to complement regular trainings.

2266 health personnel received non-clinical health systems-related training, not reaching the target of 6500. The ICR (p. 24) stated that the shortfall was "due to the delayed adoption of a new VHW policy which involved significant revisions to their training curriculum, thereby preventing them from benefiting from planned training activities under the project." Later comments from the Borrower stated that "the shortfall was due to a lack of a standardized VHW policy that could be adopted across government and partner implementation activities. The VHW policy was eventually approved in November 2019."

There were 42 District Steering Committee meetings to provide feedback and grievance redress mechanisms based on assessment to facilities and involving community representatives, exceeding the target of 18 meetings. Government comments on the ICR (p. 73) noted that community participation helped health centers to address local issues that would otherwise have gone unaddressed, including advocacy for repair of roads and access to water and electricity.

Outcomes

The average health facility quality of care score in target districts increased from 59.6% in 2015 to 81% in 2019, exceeding the original target of 50% and the revised target of 78%. This score is a composite indicator covering staff attendance, record-keeping and timeliness of reports, adherence to protocols for child survival, environmental health, general consultations, reproductive health, essential drugs management, tracer drugs, maternal health, sexually transmitted infections, HIV, TB, and community-based services. Government comments on the ICR (p. 73) reported that PBF incentives produced a reduction in health facility staff absenteeism and facilitate development of business planning at the health facility level to prioritize immediate needs (for example, hiring of nurses to conduct deliveries and provide other services).

63% of maternal deaths at QMMH from referrals in PBF-enrolled district hospitals were caused directly by a maternity-related condition, compared with 88% such deaths from referrals in non-PBF-enrolled district hospitals, indicating better quality handling of these cases in PBF-enrolled hospitals. (The ICR did not provide the time frame for this data.)



The community-based satisfaction score for PBF-enrolled facilities in the target districts increased from 75% in 2014 to 78% in 2018, not meeting the target of 89%. The ICR (p. 24) explained that this shortfall likely arose from shortages in health commodities due to budget and stock management issues at the central level, and reduction in VHW case management support following reduced funding from a key development partner.

An original indicator on health facilities reporting stock-outs of tracer medicines and medical supplies was dropped "because it was not considered relevant to the PDO" (ICR, p. 55). Stock-outs are part of the health facility quality of care score.

Overall, despite the shortfall in achievement of the target for community-based satisfaction with health facilities, the exceeding of the target for health facility quality of care scores merits a Substantial rating for this objective.

Rating

Substantial

OBJECTIVE 3

Objective

There was no original objective in this area.

Rationale

There was no original objective in this area.

Rating

Not Rated/Not Applicable

OBJECTIVE 3 REVISION 1

Revised Objective

Increase utilization of primary health services in selected districts in Lesotho with a particular focus on TB and HIV (new objective)

Revised Rationale

The theory of change and outputs for the first objective apply here, with PBF incentives to health facilities having been added for TB and HIV services.

Outcomes

The number of patients started on TB treatment in the target districts declined from 3725 in 2014 to 3428 in 2019, not reaching the target of 4220. The underperformance was consistent across districts, explained in the ICR (p. 21) as due to decreasing TB incidence in the country and therefore a positive outcome. This indicator



was added at the 2018 restructuring, implying that the trend of decreasing TB incidence should have been apparent at that point and a more appropriate indicator chosen that would reflect level of utilization of services for those people who have been diagnosed with TB.

The number of people currently on HIV treatment in the target districts increased from 128,037 in 2016 to 213,233 in 2018, surpassing the target of 178,300. This indicator replaced an earlier indicator on prevention of mother-to-child transmission of HIV at the 2018 restructuring, in order to measure all HIV patients.

Due to lack of data on TB services, but overachievement of targets for HIV services, achievement of this objective is rated Substantial.

Revised Rating

Substantial

OBJECTIVE 4

Objective

There was no original objective in this area.

Rationale

There was no original objective in this area.

Rating

Not Rated/Not Applicable

OBJECTIVE 4 REVISION 1

Revised Objective

Improve the quality of primary health services in selected districts in Lesotho with a particular focus on TB and HIV (new objective)

Revised Rationale

The project's original indicator for tuberculosis treatment success rate was dropped due to lack of reliable routine data. The ICR (p. 54) stated that a similar indicator was to be included as part of the results framework for a Southern Africa TB project.

Due to lack of data, achievement of this objective is rated Negligible.

Revised Rating

Negligible



OBJECTIVE 5

Objective

There was no original objective in this area.

Rationale

There was no original objective in this area.

Rating

Not Rated/Not Applicable

OBJECTIVE 5 REVISION 1

Revised Objective

Improve contract management of select public-private partnerships (PPPs) (new objective)

Revised Rationale

The project's implicit theory of change held that training of staff across relevant agencies would improve contract management skills, leading to better contract management in practice.

Outputs

The project supported PPP training and certification of an unspecified number of officials from MOH, MOF, and the Ministries of Development Planning and Public Works. It also assisted with development of PPP legal and regulatory frameworks in the country. Four Terms of Reference for key PPP positions in the government were drafted and approved, meeting the target of four.

Outcomes

Only one of the four planned MOF Central PPP Unit and MOH PPP Contract Management Office positions was established and fully staffed, not meeting the target of four. The ICR (p. 25) explained that the shortfall was due to MOH and MOF delays in approving the positions as well as protracted procurement procedures (failure to attract viable candidates and political delays in decision processes). Consultants for two of the remaining three positions were identified in the second quarter of 2019, but they were not hired due to project closure. Subsequently, these two positions were filled through the Public Sector Modernization Project based at the MOF.

Due to the shortfall in achieving planned staffing goals for PPP contract management, achievement of this objective is rated Modest.

Revised Rating



Modest

OBJECTIVE 6

Objective

There was no original objective in this area.

Rationale

There was no original objective in this area.

Rating

Not Rated/Not Applicable

OBJECTIVE 6 REVISION 1

Revised Objective

In the event of an Eligible Crisis or Emergency, provide immediate and effective response to said Eligible Crisis or Emergency (new objective)

Revised Rationale

No such emergency occurred during the project period. However, it should be noted that the ICR does not provide information on project activities that would have prepared for the eventuality of an emergency.

Revised Rating

Not Rated/Not Applicable

OVERALL EFFICACY

Rationale

The Bank was one of many donors supporting Lesotho in the area of MNH, TB, and HIV/AIDS, but the information presented in the ICR was not sufficient to assess relative attribution of achieved outcomes specifically to the Bank's interventions, or to understand how the Bank's interventions contributed to achieved outcomes in a crowded donor environment.

Overall efficacy under the original objectives is rated Substantial, based on substantial achievement of the objectives to improve utilization and quality of MNH services.



Overall Efficacy Rating

Substantial

OVERALL EFFICACY REVISION 1

Overall Efficacy Revision 1 Rationale

Overall efficacy under the revised objectives is also rated Substantial, but with moderate shortcomings related to lack of information on quality of TB and HIV services, and modest achievement of the objective to improve PPP contract management. In addition, there was no information provided in the ICR on project activities that would have prepared the country for an Eligible Crisis or Emergency, should one have occurred.

Overall Efficacy Revision 1 Rating

Substantial

5. Efficiency

The economic analysis at appraisal found a net present value (NPV) of US\$ 89.8 million and an economic rate of return (ERR) of 70%, robust to sensitivity analysis undertaken to address uncertainties across several variables (life expectancy and gross domestic product). The analysis excluded indirect costs and benefits because of measurement difficulties. Its assumptions, including a 12% discount rate and a ten-year time horizon, were transparent and reasonable (PAD, p. 94). A fiscal impact analysis showed that the PBF instrument would bring substantial resources into the sector in the foreseeable future, especially for MNH services, contributing to sustainability of development outcomes after project closure.

The ICR's analysis (pp. 62-66) found an NPV of US\$ 48.4 million and rate of return of 14%. These findings varied from the PAD's estimates because different assumptions were used (5% and 10% discount rates, and elimination of double counting of beneficiaries who may have received services across multiple years of the project), and because some original outcome targets were not met, the original investment was not completely disbursed, and the project's two restructurings resulted in different scope, targets, and resource allocations. Sensitivity analysis showed that the results were sensitive to changes in assumptions, but all results showed that the investment was justified on economic grounds (ICR, p. 28).

The ICR (pp. 28-29) noted some significant operational inefficiencies. The initial pace of implementation was affected by incomplete financial management (FM) and M&E arrangements, though FM and funds flow capacity constraints were eventually resolved as the MOH Project Accounting Unit (PAU) took over responsibility for the project and health facilities opened bank accounts. Commitment to the project in the early phases of implementation was not universal among government officials, as PBF was a relatively unknown instrument, particularly at the district and facility levels. Recruitment of the PPTA organization and staffing of the MOH PBF Unit took a long time, contributing to the slow start of implementation. Other delays resulted from procurement issues, including inadequate specifications for medical equipment and issues with bid evaluation teams. At the national level, transitions in MOH leadership contributed to delays in "key decisions that affected the smooth



running of the project" (ICR, p. 32). Low capacity and high turnover of senior government officials contributed to delays in Quthing.

Efficiency Rating

Modest

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

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal	✓	70.00	100.00 <input type="checkbox"/> Not Applicable
ICR Estimate	✓	14.00	100.00 <input type="checkbox"/> Not Applicable

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

6. Outcome

The project's original and revised objectives were highly relevant to country context, government strategy, and Bank strategy at appraisal and closing. Overall efficacy is rated Substantial under both the original and revised objectives, reflecting the PBF scheme's contributions to utilization and quality of MNH services and to utilization of HIV and TB services, but no information on the quality of HIV and TB services, and only modest achievement of improvements in PPP contract management. Efficiency is rated Modest due to implementation inefficiencies. On balance, these ratings reflect moderate shortcomings in the project's preparation, implementation, and achievement, producing an Outcome rating of Moderately Satisfactory.

a. Outcome Rating

Moderately Satisfactory

7. Risk to Development Outcome

According to the ICR (p. 36), PBF is now a "popular and well accepted approach ... whose benefits are appreciated by stakeholders." After project closure, the MOH continued to implement the PBF scheme by paying for performance from counterpart funding that had been mobilized for the anticipated AF of the project (which did not take place). The follow-on Nutrition and Health Systems Strengthening Project (2021-2025, under preparation) is designed to finance the provision of quality grants and bonus grants to eligible health facilities, based on lessons learned under this project. The Ministry of Development Planning has expressed interest in implementing similar approaches in other sectors (ICR, p. 32). Other donors, including UNICEF and UNFPA, were also mobilized to contribute to PBF efforts. However, there is risk that current levels of commitment may not be sustained because PBF is not institutionalized in government accounting systems,



and budget items for PBF-like interventions are not clearly defined in government budgets. Government comments on the ICR (p. 77) note that, with the failure to implement the project's requested AF, the last four districts had less than one year to roll out PBF. There is also risk that human resources trained under the project may leave the health sector or the country.

8. Assessment of Bank Performance

a. Quality-at-Entry

Project design learned lessons from experience with PBF approaches in other countries, particularly Rwanda, Zimbabwe, Cambodia, and Afghanistan (PAD, pp. 11-12; ICR, p. 31): the need to ensure transparency and independent verification; the identification of individual health facilities as the appropriate recipients of PBF proceeds; the need for clear approval channels for invoices; the importance of high-quality training for health workers and supervisors involved in PBF, as well as resources to facilitate effective health facility supervision; and the need to measure results through a rigorous impact evaluation. At appraisal, Lesotho had some limited prior experience with output-based financing models for improved service delivery: the PPP hospital and filter clinics in the capital, with subsidies from the Global Partnership for Output-Based Aid; the introduction of performance indicators in service contracts with CHAL and LRCS; and small PBF projects supported by the NGO Partners in Health to test their feasibility in rural communities. The Bank had supported health sector reform through a two-phase Adaptable Program Loan (2000-2005 and 2005-2009), and through an HIV and AIDS Technical Assistance Project (2009-2015) to build capacity of government and civil society to respond to the epidemic. Important lessons were drawn from this experience as well (PAD, p. 12): the need to avoid excessive ambition and to focus on practical institutional arrangements, taking capacity limitations explicitly into consideration. Existing systems were used, and plans made for their strengthening, rather than creating separate fiduciary and other systems. Project design was also guided by two 2010 feasibility studies conducted with resources from the HRITF. These studies recommended a focus on reducing health sector spending inefficiency by financing services based on performance, and addressing human resources shortages by maximizing the productivity and performance of existing health care workers through incentive-based compensation schemes.

Implementation arrangements were well specified at entry (PAD, pp. 13-15), including the continuation of a Technical Working Group to provide operational and administrative support for the PBF scheme, a detailed Project Implementation Manual, and the establishment of a PBF Unit in the MOH Health Planning and Statistics Department to manage day-to-day implementation. Overall implementation risk was assessed as High at appraisal (PAD, pp. 19-20), related to the introduction of a new instrument, PBF, in a relatively low-capacity setting. Several key aspects of project design -- gradual scale-up, and technical assistance and training -- were specifically intended to mitigate this risk. However, some key risks, including the project's institutional complexity and lack of initial buy-in for the PBF scheme, were not adequately mitigated.



M&E design included a clear set of objectives and plausible results chain connecting project activities to intended outcomes. However, the results framework depended on household surveys that were conducted only every several years.

Quality-at-Entry Rating

Moderately Satisfactory

b. Quality of supervision

Supervision missions were conducted regularly, and a health specialist was based in Lesotho to provide regular implementation support. Fiduciary and other subject matter technical specialists were part of supervision missions. The Bank proactively and flexibly restructured the project, including its results framework, to adjust to evolving implementation capacity and circumstances. Task team leadership (TTL) turnover was minimal, with only two TTLs over the project's lifetime.

Quality of Supervision Rating

Satisfactory

Overall Bank Performance Rating

Moderately Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

The Health Planning and Statistics Department (HPSD) of the MOH was responsible for project monitoring. Indicators, baselines, and targets were clearly defined and were adequate measures of implementation progress and achievement of objectives. Data were to be drawn from the MOH's routine HMIS, annual health facility quality of care assessments, household surveys, PBF Unit administrative records, and monthly supervisory visits. Dependence on household surveys conducted every few years would prove to be a shortcoming, resolved through revisions of the results framework at restructuring. Several mechanisms were put in place for ex-ante and ex-post verification of data reported by health facilities. Identified M&E capacity challenges at appraisal included staff shortages; inadequate data quality assessment and verification; lack of an MOH M&E plan/framework; separation of TB, HIV/AIDS, immunization, and nutrition data from the HPSD M&E Unit's HMIS; and low use of HMIS data to inform decision-making at the facility level. The MCA was providing support for strengthening the HMIS, and the United States President's Emergency Plan for AIDS Relief was building M&E capacity at the central and district levels. The project's M&E capacity building efforts under its second component were designed to complement the activities of these other donors.



b. M&E Implementation

At the two restructurings, and as a web-based HMIS was developed that could provide information on regularly collected indicators, the results framework was amended to rely less on national surveys that took place only at extended intervals. Data for monitoring the indicators in the results framework were routinely collected. The project also contributed financially to the collection of MICS data to supplement information from the HMIS. The MOH PBF Unit included a staff member with responsibility for M&E, and Bank supervision missions included an M&E specialist. According to the ICR (p. 34), the Senior Health Specialist based at the Bank country office "took a hands-on approach to capacity building for M&E of the PBF Unit on a routine basis." According to the Operations Portal, the planned impact evaluation was conducted in 2017, but the ICR did not mention it.

It was an important shortcoming that, at the 2016 restructuring, outcome indicators were not added to measure full achievement of the added objectives. In particular, there was no outcome indicator to measure improved quality of TB and HIV services. This lack of data precludes full assessment of project efficacy.

c. M&E Utilization

According to the ICR (p. 34), data from the M&E system were used consistently to inform project management and decision making, "particularly due to the data-intensive nature of PBF." Routine data collected by the M&E system determined payments of PBF funds to the implementing entities. "Policy making and advocacy at all levels of the project were informed by these results" (ICR, p. 34).

M&E Quality Rating

Modest

10. Other Issues

a. Safeguards

The project was rated Environmental Assessment category "B" and triggered OP/BP 4.01, Environmental Assessment, due to risks associated with handling and disposal of medical waste. The MOH was to implement the Consolidated Lesotho National Health Care Waste Management Plan that had been prepared and adopted in 2010, and then updated in August 2012 specifically for the project. No major works were to be financed by the project, but health centers and hospitals could use the PBF under the first component for minor repairs of existing health structures. Quarterly quality assessments were carried out for health centers and hospitals to monitor compliance with national regulations and guidelines. Based on these assessments, "performance on environment health in health centers located in the initial six districts of the project improved between 2014 and 2018" (ICR, p. 34). The ICR did not make a clear statement about compliance with Bank safeguard policies, but the project team later confirmed compliance.



b. Fiduciary Compliance

At appraisal, the Bank conducted an FM Assessment of the MOH and CHAL, concluding that FM arrangements met the Bank’s minimum requirements. During implementation, independent external audits were carried out regularly. There was one reported qualified external audit due to lack of reconciliation of accounts; the other audits were unqualified. According to the ICR (p. 32), human resources challenges led to weak FM capacity at the country level, contributing to initial slow project implementation. These issues were resolved through capacity building during the project period.

Key identified procurement issues at appraisal included staffing, limited capacity of existing staff, and the potential risk of using government or CHAL procurement procedures for Bank-financed activities. Training, strengthening of procurement systems, prior review of selected contracts, and preparation of a Procurement Manual were implemented to solve these problems. Nevertheless, procurement processes experienced delays, particularly during bid evaluation processes.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Moderately Satisfactory	Moderately Satisfactory	
Bank Performance	Moderately Satisfactory	Moderately Satisfactory	
Quality of M&E	Modest	Modest	
Quality of ICR	---	Substantial	

12. Lessons

The ICR (pp. 37-38) contained several insightful lessons, four of which are summarized here by IEG:

- **Piloting and phased implementation of PBF projects is good practice.** In this case, the experience of the two pilot districts allowed for smoother implementation and scale-up in subsequent districts.



- **The absence of PBF budget items in MOH and other sector budgets is a risk for sustainability of the benefits of PBF-like interventions.** In this case, PBF is not yet institutionalized in government budget and accounting systems, posing a risk to the project's development outcomes.
- **Early staffing of key positions is essential for quick start-up.** In this case, there were delays in getting the project up to speed due to low or no staffing in key areas: the PPTA, the MOH PBF Unit, and key FM staff.
- **PBF is facilitated by concurrent health system strengthening in human resources and drug supply management,** as was undertaken by the project.

13. Assessment Recommended?

Yes

Please Explain

To understand what worked and what did not with the rollout of PBF across districts, and with the strengthening of the PPP and its relationship to the overall health sector.

14. Comments on Quality of ICR

The ICR was comprehensive and results-oriented. It carefully tracked the evolution of the project's theory of change and results frameworks through its two complex restructurings. It integrated DHS and MICS data to supplement information from the project's M&E system in its assessment of outcomes. The assumptions and methodology governing the efficiency analysis were clearly explained. However, there were moderate shortcomings. The presentation of project cost figures was inconsistent. Despite the presence of numerous other donors in the health sector during the project's lifetime, there was no discussion of attribution issues. The document was lengthy and somewhat repetitive.

a. Quality of ICR Rating

Substantial

