



## 1. Project Data

<b>Project ID</b> P163255	<b>Project Name</b> Peru Integrated Health Networks	
<b>Country</b> Peru	<b>Practice Area(Lead)</b> Health, Nutrition & Population	
<b>L/C/TF Number(s)</b> IBRD-89200	<b>Closing Date (Original)</b> 31-Jan-2024	<b>Total Project Cost (USD)</b> 7,365,224.97
<b>Bank Approval Date</b> 31-Jan-2019	<b>Closing Date (Actual)</b> 31-Jan-2024	
	<b>IBRD/IDA (USD)</b>	<b>Grants (USD)</b>
Original Commitment	125,000,000.00	0.00
Revised Commitment	7,365,224.97	0.00
Actual	7,365,224.97	0.00

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## 2. Project Objectives and Components

### a. Objectives

According to the Loan Agreement dated March 13, 2019, Schedule 1, the objective of the project was to (i) improve the resolute capacity and quality of public First-Level Health Services in Lima Metropolitan Area and Prioritized Regions, and (ii) increase the capacity of the Single Health Information System and the public sector's pharmaceutical products and medical supplies provision system.



In terms of assessing the achievement of PDOs, this ICR Review and the ICR unpacked the compound PDO statement as follows:

1. improve the resolute capacity and quality of public First-Level Health Services in Lima Metropolitan Area and prioritized regions;
2. increase the capacity of the Single Health Information System; and
3. improve the public sector's pharmaceutical products and medical supplies provision system.

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

No

**c. Will a split evaluation be undertaken?**

No

**d. Components**

**Component 1: Improving the Organization and Supply of Health Services Using an Integrated Health Networks Model in Lima Metropolitan Area and prioritized regions** (Appraisal: US\$45,718,898; Used: US\$5,551,874). This component aimed to implement a new service delivery model through Integrated Health Networks (RIS) in targeted areas. It planned to improve the quality, efficiency, appropriateness, and timeliness of public health responses to new and evolving health needs while addressing access and quality disparities. The component included investments in infrastructure such as rehabilitation, expansion, or new construction, mainly for first-level health facilities. It also provided funding for technical assistance, tools, and services to tackle new disease burdens, including clinical practice guidelines and patient care pathways as well as focused on change management and communication plans. Additionally, it would finance both medical (like clinical furniture and instruments) and non-medical equipment (such as IT and electromechanical devices) for these facilities. Eventually, this component would improve resolute capacity, quality, and coordination of care and a reduction in waiting times.

**Component 2: Improving the Capacity of the Single Health Information System at the National Level (*Sistema Único de Información en Salud/ SUIIS*)** (Appraisal: US\$71,664,338; Used: US\$402,840). This component focused on ensuring adequate access to, and management of information for clinical and administrative decision-making in the health system. Access included improving the quantity, quality, and timeliness of information. To achieve this objective, the component focused on: (i) Strengthening governance and standardizing data and ICT processes; (ii) Providing the necessary technological and network infrastructure to support the implementation of the SUIIS; (iii) Enhancing human competencies for effective registration, management, and use of information within the SUIIS; and (iv) Integrating user engagement as a core aspect of the SUIIS development and implementation.

**Component 3: Improving the Management of Pharmaceutical Products and Medical Supplies (including medical devices) in Lima Metropolitan Area and Prioritized Regions** (Appraisal: US\$30,116,764; Used: US\$1,410,511). This component aimed to enhance the quantity, quality, timeliness, and affordability of pharmaceutical products, medical devices, and medical supplies in Ministry of Health/*Ministerio de Salud* (MINSA) and Regional Governments/*Gobiernos Regionales* (GORE) facilities through financing the construction of a new central warehouse in Lima, rehabilitating several warehouses in



prioritized regions, and implementing a traceability and stock management system for these products and supplies.

**Component 4: Project management (Appraisal: US\$10,325,000; 'Used' funds not reported in the ICR) – IBRD: US\$0 and Government of Peru: US\$10,325,000).** This component would fund operating expenses, equipment, furniture, vehicles, and personnel necessary for executing the WB Project in areas such as contract management, procurement, financial management, and monitoring and evaluation, including financial audits. It also planned to finance technical assistance needed to complete the formulation of the Government Program in *invierte.pe* and support selected operational expenses and staff for implementing common activities under the Government's program.

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

The project was financed through the World Bank's Investment Project Financing (IPF) instrument. The estimated cost at appraisal was US\$ 157.83 million, consisting of US\$125 million as IBRD financing, and Recipient contribution of US\$32.83 million (PAD, p.2). The actual amount disbursed was US\$7.4 million through IBRD financing (ICR, p.ii).

**Dates:** The project was approved on January 31, 2019, and became effective on June 4, 2019. The midterm review was held on February 20, 2023. The project underwent one restructuring on August 23, 2021, and closed on January 31, 2024.

**Restructuring:** In August 2021, the Project went through a restructuring aimed at improving implementation speed by changing institutional arrangements and creating a new PIU. Initially, PRONIS, a unit within the Ministry of Health (MINSA) responsible for managing major public infrastructure investments, served as the Project's PIU. However, PRONIS's expertise was focused primarily on infrastructure projects, which did not align with the specific needs of this health-focused Project. In addition, political instability and the COVID-19 pandemic further hindered the authorities' commitment and delayed progress. In response, the World Bank approved the creation of a new PIU within MINSA, dedicated to the Program for Creation of Integrated Health Networks (*Programa de Creación de Redes Integradas de Salud/ PCRIS*), aiming to enhance focus and operational capacity for the Project (ICR, p. 9).

### 3. Relevance of Objectives

#### Rationale

In Peru, the poor face significant barriers to accessing health services, being less likely to seek care when needed and more prone to out-of-pocket expenses for services and medications. Geographic disparities further exacerbate these challenges, especially for members of the Comprehensive Health Insurance System (*Seguro Integral de Salud/SIS*) in underserved areas. (PAD, pp. 8-9).

There were several other constraints identified in Peru which this project planned to address. Health outcomes in Peru lag behind those of comparable countries, particularly in chronic and noncommunicable diseases. Primary healthcare facilities (IPRESS) often prioritize labor and delivery services, and struggle to manage chronic conditions like diabetes and hypertension. This inefficiency leads to unnecessary reliance



on high-cost hospitals for conditions that could be treated more affordably at first-level healthcare centers. Urban areas, in particular, allocate disproportionate resources to labor and delivery rather than chronic care (ICR, p. 2).

To address these health sector issues, the proposed project aimed to strengthen and optimize first-level healthcare facilities, allowing them to provide a broader range of high-quality services. This would involve shifting hospitals' focus from basic care for chronic diseases to more complex treatments. Improvements in the procurement and distribution of medications, along with modernizing clinical and administrative management through information technology were important for ensuring better chronic care. (ICR, p.2).

The project's broader goal was to reduce the burden of disease for those without social security or private health insurance, improve health sector efficiency, and alleviate the saturation of second- and third-level facilities. This would allow hospitals to focus on more complex cases while enhancing the quality and access to primary care services. Hence making this project relevant to the changes needed in the health sector.

**Alignment with Strategy:** The project aligned with both WBG Country Partnership Frameworks (CPFs) implemented during the project timeframe (CPF FY17-FY21 and CPF FY23-FY27) with the goal of improving health service accessibility and quality. The CPF FY17-FY21 emphasized improving health service delivery for the poor, including the design of a new service delivery model for healthcare. This model aimed to adapt health services to the country's evolving epidemiological challenges, incorporating shifts in infrastructure, technology, and the referral system. The CPF FY23-FY27 focused on enhancing the delivery of public services, particularly through Objective 3 of High-Level Objective (HLO) 2 which targeted improved access to quality services across multiple sectors, including health, education, energy, and housing. It emphasized integrating infrastructure investments with other social sector improvements, such as health, and continues WBG's engagement in the health sector, including through this Integrated Health Networks Project.

However, effective execution and realization of the project required preconditions and major reforms (ICR, p. 15). There were gaps in the theory of change and a disconnect between the planned activities and the borrower's institutional capacities and institutional readiness. Therefore, the project, as designed, had limitations to effectively address the development problems it intended to tackle. Consequently, the relevance of objectives is rated as Substantial, but only marginally so.

## Rating

Substantial

## 4. Achievement of Objectives (Efficacy)

### OBJECTIVE 1 Objective



Improve the resolute capacity and quality of public first-level health services in Lima Metropolitan Area and prioritized regions

### **Rationale**

Overall, the project's theory of change faced challenges due to unmet preconditions, including the absence of a shared institutional vision for healthcare delivery, which required cultural shifts, technological consensus, and strong governance of the health information system. There was also a lack of stakeholder consensus, and early user consultations, which led to delays and bottlenecks. The project's ambitious goals, compounded by limited sector experience, political changes, and the pandemic, also hindered progress (ICR, p.15). Additionally, the project's Results Framework had design flaws, with problematic and unclear indicators. For instance, one indicator (IRI 6) measured multi-step achievements for the Single Health Information System, extending the timeline for confirming results (ICR, p.19).

The first objective included activities like redesign of the model of care with an emphasis on the new disease burden pattern, development of standardized clinical practice guidelines and clinical pathways, establishing new construction standards to make patient flow more efficient at health centers as well as renovation, expansion, or reconstruction of health facility infrastructure depending on the current situation of the facility (p.7, ICR). Overall, these activities fed into the project's aim of improving the organization and supply of health services using an Integrated Health Network (RIS) model by improving and expanding physical infrastructure and equipment, while enhancing the care at first-level healthcare facilities through the use of clinical practice guidelines, clinical pathways, and supportive care services. (p.4, ICR).

### **Outputs and intermediate results**

Delivery of equipment to 88 healthcare centers was completed, consisting of 4,884 goods which included biomedical, complementary, instrumental and administrative equipment.

There was progress reported on the development of three cancer practice guidelines on colon, prostate, and breast cancer, but these guidelines were not approved and published through an online or mobile application (ICR, p.31).

Targets were not achieved with the project reporting no change in baseline vs targets for the number of works and equipment of first-level IPRESS concluded (IRI1) in accordance with current infrastructure and equipment regulation (baseline was zero and actual achievement at project closing was also zero, even though target was six); no clinical guidelines were established or published for relevant chronic and noncommunicable diseases (IRI2) through an online or mobile application (both baseline and actual achievement at project closing was reported at zero, even though and target was set at 8 clinical practice guidelines); no changes observed between percentage of adults above 35 years of age in control of hypertension in the Lima Metropolitan Area for men and women (IRI 4 and IRI 5); and MINSA was not able to establish a system for measuring user satisfaction results or a protocol for measuring satisfaction (IRI 3). The ICR does not explain the reasons for why these IRIs were not achieved.

### **Outcomes**

The three outcome indicators associated with this objective were not achieved. This included indicators on percentage of RIS that offered expanded range of health services in the Lima Metropolitan Area and prioritized regions for which the baseline and actual achievement at project closing remained at zero, despite



an end target of 100 percent; the percentage of adults ages 35 and above who are able to control hypertension in the Lima Metropolitan Area remained at the baseline of 19.5 percent which was below the target of 26 percent; and the percentage of targeted populations with a health issue that seek care in the first-level of health services remained at the baseline of 55 percent, below the target of 65 percent. For all three outcome indicators, the baseline and the actual achievement data at project closing remained the same or lower than end target values, indicating zero change/ no change during the project timeframe.

**Rating**  
Negligible

## **OBJECTIVE 2**

### **Objective**

To enhance the capacity of the Single Health Information System

### **Rationale**

The theory of change underlying the second objective held that the design and implementation of the Single Health Information System (SUIS) and the construction of (three) data centers would lead to better management of patient appointments, admissions, and records by health center facilities through the use of the SUIS.

### **Outputs and intermediate results**

Activities completed included implementation of technical files for civil works and equipment of the Lima, Trujillo and Huancavelica Data Center. However, more detail on the specifics of the equipment and the extent to which these technical files contributed to the actual start-up and working of the data centers is not reported in the ICR.

At project completion no MINSA data center locations were operational (IRI 7), with both baseline and actual achievement at project closing reported at zero data centers. There were no new modules and components of the Single Health Information System that were developed, integrated, and operationalized during the project time frame with 4 modules reported at baseline and project closing, compared with the end target of 51 modules and components.

### **Outcomes**

The project did not make any progress on the indicator that measured the outcome associated with this objective through “percentage of RIS in Lima metropolitan area and prioritized regions that reach optimal implementation of the five essential SUIS modules.” These modules are the medical programming module, the unique patient portal, the referral/counter-referral module, one consultation module (which included prenatal care, growth monitoring, and vaccination sub-modules) and the pharmacy module. Both baseline and actual achievement and project closing remained zero while the end target was set at 60 percent.



**Rating**  
Negligible

### **OBJECTIVE 3**

#### **Objective**

To improve the public sector's pharmaceutical products and medical supplies provision system

#### **Rationale**

The theory of change underlying the third objective emphasized activities like construction of a new national warehouse for pharmaceuticals and medical supplies, provision of equipment to regional warehouses, and developing a new management model for the procurement and logistics chain eventually providing greater availability of medicines through cost efficiency for each health center, as well as reducing waste and illicit use of pharmaceutical products and medical devices. This would enhance and improve the capacity of the public sector's pharmaceutical products and medical supplies provision system.

#### **Outputs and intermediate results**

The project delivered eight refrigerators to CENARES (National Center for Strategic Health Resourcing) to enhance the distribution of medical goods. Additionally, supply trucks were provided to facilitate the transportation of medicines and supplies to pharmacies and first-level healthcare facilities in Lima Metropolitan Area.

The project also completed implementation of the technical specification documents for the central warehouse of metropolitan Lima and three regional warehouses.

The project struggled to achieve key targets related to pharmaceutical procurement and medical supply management. It did not make progress in using registered demand data from the Lima metropolitan area and prioritized regions to guide the purchase of pharmaceutical products and medical supplies, it was not able to ensure that that state-owned pharmaceutical product and medical supply warehouses conformed to BPA (Good Distribution Practice) guidelines for which the baseline and actual achievement at project closing remained at zero, despite an end target of 5 percent, and also could not ensure the optimal availability of essential medicines in health facilities (IPRESS) in the Lima metropolitan area with a baseline of 5 percent and actual achievement at 14 percent, which was well below the 60 percent end target.

#### **Outcomes**

The outcome indicator associated with this outcome was not met since MINSA was not able to trace pharmaceutical products in real time as was initially planned for Lima metropolitan area and prioritized regions.

**Rating**  
Modest



## OVERALL EFFICACY

### Rationale

While the project aimed to establish an integrated health care network by strengthening capacity of first-level health centers in Lima and other specified regions through a multitude of approaches including redesign of the model of care with an emphasis on the new disease burden pattern, developing clinical guidelines, improving and expanding physical infrastructure and equipment, building health information systems, and aiming to provide better access to pharmaceutical products and medical supplies through the public sector, the project did not achieve any outcomes, and struggled throughout implementation. Challenges included political instability, a lack of ownership by the government, weak capacity, and the Covid-19 pandemic. Since majority of the outcomes have a negligible rating, the overall efficacy is rated 'negligible'

**Overall Efficacy Rating**  
Negligible

**Primary Reason**  
Low achievement

## 5. Efficiency

The PAD provided an Economic and Financial Analysis and an Internal Rate of Return but the ICR did not assess cost-effectiveness of the project due to 'slow implementation progress and lack of any achieved targets for indicators in the Results Framework' (ICR, p.14).

The PAD as part of its 'Economic and Financial Analysis' explains costs and benefits of the project by focusing on selected direct and indirect impacts (PAD, p.31-35). Indirect benefits generated by the project include a reduction in the burden of noncommunicable diseases (NCD) following the expansion of the resolutive capacity of first-level health services to include cardiovascular diseases and diabetes, cost savings for MINSA through the control of hypertension, reduction in waiting times at first-level health facilities, and direct monetary benefits through centralized procurement of pharmaceutical products and medical equipment to help reduce costs throughout the health system.

The PAD also identified 'benefits that are not immediately quantifiable'. For example, the use of clinical guidelines and the establishment of a referral and counter-referral system is expected to improve quality of care and increase efficiency at all levels of care. The benefits associated with a robust information system were recognized in context of opportunity costs related to staff efforts, patient access, and streamlining other resources, but were not calculated.

The PAD further calculates benefits of the project for 'impact indicators' with changes from the baseline measured under three scenarios of low, medium, and high effectiveness. The PAD also provides information on 'Current Economic Value' of the project under the medium-effectiveness scenario (PAD, Table 3, p.34), and summarizes the Net Present Value (NPV) of the project based on present value of benefits and present value of costs under the current scenarios. The NPV under the high Time Value of Money (TVM) scenario is US\$23.8 million. These correspond to an Internal Rate of Return (IRR) of 25.9 percent. IRRs provided for other scenarios are:

- High-effectiveness scenario: The IRR is 42.5%, indicating a high return on investment.
- Medium-effectiveness scenario: The IRR is 25.9%, suggesting a positive and strong return.





- Low-effectiveness scenario: The IRR is 11.7%, still positive, but lower than the other two scenarios.

These economic calculations suggest that the project is expected to generate substantial benefits, with a particularly high return in scenarios where its effectiveness is optimized. The NPV and IRR values demonstrate the potential long-term financial viability and value of the project under different assumptions of effectiveness.

Returns to investment: Overall, the economic analysis of the Project shows that there are high returns to the investments. Even under a low-effectiveness scenario that does not account for all economic benefits of the Project, the IRR is 11.7 percent.

However, the ICR did not include, assess, or compare economic analysis provided in the PAD due to significant implementation deficiencies'. Implementation inefficiencies were also identified in the ICR in terms of the challenges faced by the PIU due to which a restructuring created a new PIU midway through the project (in 2021).

Given that significant shortcomings in implementation reduced project efficiency, and that efficiency was below expectations in the operation's sector, overall efficiency is rated modest.

## 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	✓	25.90	0 <input checked="" type="checkbox"/> Not Applicable
ICR Estimate		0	0 <input type="checkbox"/> Not Applicable

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

## 6. Outcome

Relevance of objectives is rated Substantial in view of alignment with Bank and government strategies, but with disconnect between the planned activities and the Borrower's capacities and addressing preconditions. Overall efficacy is rated Negligible, as the project barely achieved its objectives. Efficiency is rated Modest, as it was below expectations in the operation's sector. The findings are consistent with an Unsatisfactory outcome rating.

### a. Outcome Rating

Unsatisfactory



## 7. Risk to Development Outcome

Risks and challenges identified at appraisal included frequent changes in leadership especially at MINSA causing volatility in staffing as well as policy shifts, limited capacity at MINSA further compounded by decentralization potentially hindering coordination, an ambitious technical design including developing an in-house information system and designing a new model of care as well as limited implementation capacity given the projects scale and geographic outreach (PAD, p.31). Several risk mitigation factors were also identified at appraisal. These mitigation factors were considered to be the project being anchored in the government program creating a strong government commitment to the program, sufficient funding to mitigate the risk related to ambitious technical design so that the required expertise can be secured, and to overcome the risk related to limited implementation capacity the project included a dated covenant to guarantee hiring of additional fiduciary staff (PAD, p.31).

According to the ICR (p. 24), it did not address the risk to development outcome, as the project failed to achieve any final outcomes. However, the ICR reported that the main risk was related to the sustainability of the distribution of 4,884 pieces of equipment (biomedical, complementary, instrumental, and administrative) to 88 health facilities. While the equipment intended to improve healthcare delivery, the sustainability of its impact was questionable since the health facilities may not have technical and financial resources for equipment maintenance and use, and hence undermine long-term project effects (ICR, p.24).

## 8. Assessment of Bank Performance

### a. Quality-at-Entry

The project was designed during the first year of a new government and was focused on strengthening the health sector, particularly through Integrated Health Networks. Leveraging the World Bank's experience in Peru, the project team identified a key opportunity to support improvements in the governance, efficiency, and equity of the country's health system (ICR. p.15).

Even though project design demonstrated relevance to health sector priorities and needs, there were several risks and weaknesses in project preparation and implementation that were not taken into consideration at project entry. These included: (i) a lack of shared vision, and implementation readiness for major reforms within the PCRIS (the ICR says a broader institutional vision for the PCRIS program beyond the small team involved in project implementation was not achieved); (ii) development of the in-house Unified Health Information System lacked strong governance and consensus on technical solutions among various stakeholders; (iii) overall project design did not consider adjustments to payment mechanisms and financial incentives to support integrated healthcare networks; (iv) lack of early consultations with health centers about equipment and human resource gaps caused delays and bottlenecks; (v) not having a clear theory of change linking project objectives to concrete and clear outputs and activities was not prepared and could have helped in the preparatory stage of the project (as suggested in the ICR). The results chain of the government program in the PAD mixes up activities and outputs/ outcomes with no clear linkages between activities and expected outputs.



Some of these shortcomings are also mentioned in the PAD which identified 'substantial' risks for project implementation (after consideration of mitigation measures), especially those related to political, technical, and implementation risks associated with frequent changes in political authorities including at MINSA coupled with MINSA's limited capacity, an ambitious goal of developing in-house software for the Single Health Information System and the design of a new model of care as well as limited implementation capacity of the PIU team.

In view of the lack of implementation readiness, unclear links between activities and expected outcomes, lack of consensus around implementation aspects, lack of adjustments to payment mechanisms and incentives, absence of diagnosis of gaps in human resources and equipment, and inadequate clarity on supported information systems (ICR, p. 23), the Quality at Entry is rated Unsatisfactory.

### **Quality-at-Entry Rating** Unsatisfactory

#### **b. Quality of supervision**

The World Bank project team/ task team maintained strong local presence through regular missions, and collaboration with local counterparts on an ongoing basis. But several challenges persisted despite task team efforts. While the WB task team provided technical assistance and advice on optimizing health service delivery and implementing interoperable health information systems, procurement activities faced challenges despite the introduction of hands-on extended implementation support (HEIS). The team maintained close communication with health authorities and the Project Implementation Unit (PIU) after the decision not to extend the operation, ensuring a proper closure. When the COVID-19 pandemic began, the team made efforts to restructure the project to support the country's emergency response. However, the plan failed to proceed due to limited buy-in and coordination issues between the PIU, MINSA, and the Ministry of Economy and Finance (MEF).

The project faced delays and coordination issues due to low quality Terms of Reference (ToRs) submitted by the PIU for WB review, which required multiple revisions and extended approval times. These documents often lacked key details, leading to inefficiencies in the review process. The mid-term review (MTR) was delayed until February 2023 due to COVID-19, staff turnover, and political instability, and led by the PIU without closer involvement of the WB. The proposed measures from the MTR (e.g., improving implementation arrangements and training PIU staff) were not implemented, as the project was nearing its original closing date, and the government did not formally request an extension or restructuring. As a result, the MTR recommendations remained general and could not address the urgent need for faster project implementation.

Other issues that the project team indicated they could have done differently when approached by IEG, included (i) establishing consistent and better coordination with the IADB and develop a comprehensive annual implementation plan that could have minimized overlapping activities, and helped speed up implementation; (ii) facilitate coordination workshops with user areas involved in the project to help align activities and clarify priorities; and (iii) the Bank being more assertive in advocating for transparency and efficiency within the PIU structure, to prevent redundant roles and create a more streamlined project team.



Throughout project implementation, Peru experienced significant political instability, with three unexpected changes in administration and frequent turnover of key officials. Over the course of the Project, there were 18 different ministers of health, six vice ministers of Health Benefits and Insurance, and 13 vice ministers of Public Health. This high turnover in leadership was outside the control of the Bank, and resulted in shifting policy directions and inconsistent implementation strategies, which undermined the project's ability to maintain momentum and achieve its intended outcomes.

The Bank team was proactive and made substantial efforts to navigate an unstable political environment and COVID-19 disruptions, maintain contact with local counterparts, and provide technical assistance to the PIU (even though implementation shortcomings remained).

### **Quality of Supervision Rating**

Moderately Satisfactory

### **Overall Bank Performance Rating**

Moderately Unsatisfactory

## **9. M&E Design, Implementation, & Utilization**

### **a. M&E Design**

Overall, there were deficiencies in project M&E design with significant gaps seen in what was planned at appraisal (in the PAD) and reported by the ICR. The M&E system at project design planned for project results to be monitored using surveys and administrative data including data on chronic disease indicators like blood pressure through Peru's National Institute of Statistics and Informatics' (INEI) annual health surveys, and to monitor the delivery of first-level healthcare services/ public sector service delivery in the Lima Metropolitan Area through the already existing Health Information System (HIS). The SUIIS would track project implementation indicators, including usage of the health information system itself, with MINSA and the Vice Ministry of Health Services to compile and produce service delivery and investment progress indicators.

In the design phase, the impact of the project service delivery was to be monitored through trend analysis with several proposed evaluations like a pre- and post-evaluation of healthcare utilization patterns; surveys of health personnel to assess the implementation of the RIS model in context of health personnel training; use of standardized/ simulated patients to measure care quality and clinical practices in first-level care, as well as patient satisfaction surveys through the SUIIS. MINSA was to use feedback to adjust the RIS model as needed (PAD, p.29-30).

The ICR does not refer to follow-up on M&E design described at appraisal (in the PAD and mentioned above) but only offers a critique of the project results framework including selection of indicators both at the IRI level and the PDO level.



Hence even though an M&E system was established early in the project implementation cycle, it was not followed through in implementation and not reported on in the ICR indicating significant gaps between M&E design at the beginning and end of the project timeframe.

### **b. M&E Implementation**

The M&E function of the project was not effectively implemented or used. The PIUs (i.e., first PRONIS and subsequently the dedicated PCRIS PIU) were responsible for monitoring progress, tracking indicators, and preparing reports, but many PDOs and IRIs relied on new data that the PIU needed to collect and this posed challenges.

Progress was mainly tracked through PIU reports and the procurement plans, with weekly meetings for coordination and support. However, due to the limited progress in implementing components, the M&E system was not fully utilized. Specific challenges in data collection are not mentioned by the ICR.

The project's results framework was not updated, indicators were not refined or added, and neither were targets adjusted through restructuring. M&E data were not collected or analyzed in a consistent and robust manner through an M&E system that was established early in the project implementation cycle. ISRs did not collect data as the project progressed.

### **c. M&E Utilization**

Overall, available data on project results and performance were inadequate to measure achievement of the PDO. The ICR rightfully reported that the Results Framework/ RF was of little utility given the lack of implementation across the three project components. The RF provided no data and only explained how data were to be collected. The latest ISR of July 2023 does provide data, but for several indicators, the baseline and actual achievement at project closing are the same with the value zero indicating there was no change during project implementation. Insights from M&E data and analysis also reflected that after the MTR, no changes were made by the implementing entities.

The project did not produce sufficient M&E data to inform decision making, and to make changes in implementation. There was no utilization of M&E findings as suggested by the ICR, and hence the project did not inform subsequent policies and interventions.

### **M&E Quality Rating**

Negligible

## **10. Other Issues**

### **a. Safeguards**

The project triggered four safeguard policies of the World Bank: Environmental Assessment (OP/BP 4.01), Physical Cultural Resources (OP/BP 4.11), the Indigenous Peoples (OP/BP 4.10), and Involuntary



Resettlement (OP/BP 4.12) policies. The project was classified as a category B based on the temporary nature of its anticipated adverse impacts, and had a Social Risk Rating of Moderate (PAD, p.41-43).

Various safeguard instruments were prepared to identify and then mitigate related risks. For example, MINSA developed three key frameworks related to the RIS (Component 1) and regional warehouses (Component 3) with *undefined project locations*. These were: (i) an Environmental and Social Management Framework (ESMF) which included an environmental screening checklist as a tool for evaluating existing conditions to identify potential environmental risk and social impact for mitigation measures once the investments are defined; (ii) Indigenous Peoples Policy Framework (IPPF), to guide the preparation of Indigenous Peoples Plans (IPP) through consultation, risk mitigation, and protection of indigenous communities if affected; (iii) Resettlement Policy Framework (RPF), for creating Resettlement Action Plans (RAPs) if displacement occurs. For the three *known project locations* (Lima, Trujillo, and Huancavelica), MINSA developed site-specific Environmental and Social Assessments (ESA) and their respective Environmental and Social Management Plans (ESMP), in compliance with World Bank and national standards. These locations which included data centers and a Lima warehouse were considered urban and were not supposed to provide direct services to the public.(PAD, p.42). These frameworks for the known and unknown locations were published in November 2018 on both MINSAs/PRONIS and World Bank websites.

Due to the lack of civil works execution, the Environmental and Social Management Framework (ESMF) and related policies (RPF and IPPF) were not fully implemented. Although the Environmental and Social Management Plans (ESMPs) were developed and complied with World Bank and national standards, many planned civil works (e.g., healthcare facility upgrades and construction of data centers and warehouses) were not carried out, resulting in no environmental impacts (ICR, p.21). The limited implementation of these plans was due to poor coordination within the Project Implementation Unit (PIU) and slow progress in the project overall.

## **b. Fiduciary Compliance**

**Financial Management:** The Financial Management Assessment (FMA) for the project highlighted the need for a dedicated Project Implementation Unit/ PIU (PRONIS), to manage project funds and report to PRONIS' General Coordinator. Key requirements for the project's financial management included the adoption of an Operational Manual by PRONIS (a condition for loan effectiveness) and the hiring of procurement and financial management specialists within 90 days of loan effectiveness. The challenges identified in the PAD included building the PIU staff's experience in implementing World Bank-financed projects, recruiting skilled fiduciary staff familiar with WB guidelines, and ensuring timely submission of financial reports. Additionally, the PIU would need to collaborate with subnational governments, which could introduce delays. As a result of these challenges, the fiduciary risk for the project was rated Substantial (PAD, p.35-36).

There were several financial administration challenges through the project timeframe. Only 6.5 percent of the loan proceeds were disbursed during the project, and the annual budget implementation averaged only 3 percent. Political instability and changes in decision-making further hindered disbursements and implementation. A request from the Government during negotiations to exclude taxes (e.g., VAT) from loan financing also impacted the budget. However, despite challenges, the PIU submitted financial reports and audits on time, with auditors providing an unqualified opinion. The financial management specialist



remained consistent throughout the project. But the ICR assesses the financial management rating as Negligible due to the overall lack of coordination within the PIU, and minimal progress in project implementation. (ICR, p.21).

**Procurement:** On procurement, the risk was assessed as Substantial due to gaps in the PIU capacity to implement procurement activities. A capacity assessment (WB assessment, November 2018) findings showed that staff working in procurement had limited qualifications and experience to local laws and procedures, procurement planning systems, and PRONIS or the PIU had low capacity to meet WB’s procurement requirements (PAD, p.39).

The ICR rates the procurement performance as Negligible due to several factors, including lack of defined procurement activities, inexperienced PIU staff in procurement processes, and delays in the selection processes for contracts. Although the PIU participated in World Bank training and specialized sessions, the lack of clarity on procurement activities led to many planned actions not being executed on time or at all, with the procurement plan frequently needing modifications. Delays were exacerbated by low bidder participation and the PIU’s failure to resolve issues promptly, requiring repeated extensions for deadlines. Political instability further discouraged participation due to concerns about contract compliance. Additionally, documentation issues (e.g., improper uploads to the STEP system) caused discrepancies between the Bank’s and Government’s records, complicating contract management and milestone validation (ICR, p.22).

**c. Unintended impacts (Positive or Negative)**

None reported.

**d. Other**

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**11. Ratings**

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Unsatisfactory	Unsatisfactory	
Bank Performance	Unsatisfactory	Moderately Unsatisfactory	There is no disagreement as both ICR (p. 24) and ICRR rated Bank Performance as Moderately Unsatisfactory. It appears that the ICR’s rating was incorrectly uploaded into the Operations Portal.
Quality of M&E	Negligible	Negligible	



Quality of ICR

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Substantial

## 12. Lessons

The ICR (pp. 24-26) offered several useful lessons, including the following lessons restated by IEG:

- **Early and sustained consensus-building among key stakeholders, clear roadmaps, and adequate preparation for institutional and technical capacity, can pave the way for successful implementation of complex public health system reforms, like the establishment of Integrated Healthcare Network.** . This includes thorough consultations with end users (e.g., healthcare providers, patients, managers) to ensure the reforms align with healthcare needs on the ground. Additionally, addressing governance, financial incentives, and infrastructure, along with adequate political and institutional stability, is crucial. In the absence of these elements, ambitious health reforms may struggle to succeed, even with technical assistance and external financing.
- **A detailed and robust theory of change is essential for identifying gaps, ensuring implementation readiness, and achieving desired outcomes,** which in this case could have revealed major shortcomings in the Government Program as well as the lack of project implementation readiness. Also, clear linkages between activities, outputs, and outcomes can show necessary reforms and foundational steps, such as in adjustments to provider payment mechanisms and public financial management. Ultimately, a well-constructed theory of change would ensure alignment between project design and implementation, improving efficiency and effectiveness.
- **A well-supported, stable Project Implementation Unit (PIU) with dedicated full-time staff is crucial for implementing large-scale, complex reforms.** While the original design of relying on existing Ministry of Health (MINSA) staff for implementation aimed at sustainability, it ultimately failed due to insufficient capacity and high turnover among ministry staff. Furthermore, the lack of external oversight and accountability - in this case, not vetting PIU appointments through the World Bank (as they were financed through the National Budget) led to an opaque structure and ineffective management. Therefore, a more flexible and pragmatic approach that incorporates external support for the PIU and ensures consistent staff stability and accountability is essential for the success of large, multi-faceted projects.

## 13. Assessment Recommended?

No

## 14. Comments on Quality of ICR





The ICR was clear, reasonably concise, and its narrative was generally aligned with the PDO. The ICR focused on results and was candid in identifying project shortcomings and the lack of evidence in several places. It offered lessons derived from project experience, and is rated 'Substantial' in quality.

**a. Quality of ICR Rating**  
Substantial