



1. Project Data

Project ID P152799	Project Name Health System Strengthening & Support	
Country Turkiye	Practice Area(Lead) Health, Nutrition & Population	
L/C/TF Number(s) IBRD-85310	Closing Date (Original) 31-May-2020	Total Project Cost (USD) 130,674,647.12
Bank Approval Date 21-Sep-2015	Closing Date (Actual) 31-Dec-2023	
	IBRD/IDA (USD)	Grants (USD)
Original Commitment	134,300,000.00	0.00
Revised Commitment	134,300,000.00	0.00
Actual	130,674,647.12	0.00

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2. Project Objectives and Components

a. Objectives

The original objectives of the project were to improve primary and secondary prevention of selected NCDs, increase the efficiency of hospital management, and enhance the evidence-based policy-making capacity of the MOH (Loan Agreement. September 30, 2015, Schedule 1, p. 5).

Explanatory notes on the PDO statement:

- NCDs: Non-communicable diseases.



- MOH: Ministry of Health.
- Primary prevention aims to prevent a disease from occurring.
- Secondary prevention aims to detect and treat a disease at an early stage.

Revisions of project objectives and key associated outcome targets:

1. During implementation, the project scope expanded with the introduction of a new objective introduced in 2020 to respond to COVID-19, further revised in 2023 to respond to the February 2023 earthquake near the border with Syria (ICR, p. 6): (i) in 2020, the statement of objectives was revised as follows: “to improve primary and secondary prevention of selected NCDs, increase the efficiency of hospital management, enhance the capacity of the MOH for evidence-based policy making, and strengthen MOH capacity to control and fight the threat posed by COVID-19 ” (Restructuring Paper, RES41157, May 5, 2020, para. 13); and (ii) in 2023, the statement of objectives was revised as follows: “to improve primary and secondary prevention of selected NCDs, increase the efficiency of hospital management, enhance the evidence-based policy-making capacity of the MOH, and strengthen the government’s capacity to respond to emergencies” (Fourth Amendment to the Loan Agreement, May 24, 2023, p. 1).
2. In terms of associated outcome targets, these were revised upward in line with the extension of the project’s closing date, except for one downward revision of a target related to a sub-indicator on the early detection of breast cancers. The revision was introduced to align with the targets of a new MOH Strategic Plan (2019-2023) and its calculation formulas, and the revision was not related to ambition-related reasons.

Therefore, given the expanded scope of the project and the increase in the majority of associated outcome targets, this ICR Review does not apply a split rating, and will assess the project based on the revised objectives (encompassing both original and additional objectives).

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

21-May-2020

c. Will a split evaluation be undertaken?

No

d. Components

At entry, the project had three components as follows:

I. Primary and Secondary Prevention (Appraisal: US\$44.2 million; Actual: US\$29.8 million)



The main aim of the component was to raise awareness among both the population and health care providers on risk factors related to NCDs and to promote healthy lifestyles and behavior change through the following activities:

Subcomponent 1.1: (i) Developing public outreach materials and methodologies to raise population awareness about NCDs and the importance of healthy living; (ii) promoting physical activity in Healthy Living Centers (HLCs), including rehabilitating community health centers to reconfigure physical activity; and (iii) implementing a nationwide campaign on substance addiction and strengthening the infrastructure of the treatment and research centers for adults and children suffering from alcoholism and substance addiction.

Subcomponent 1.2: (i) Improving the capacity of cancer screening; (ii) introducing and maintaining a national cancer registry software, and provision of training to health workers on the software; and (iii) developing guidelines, standards, and training modules for palliative care.

Subcomponent 1.3: (i) Strengthening the Family Physician Training Program, including through expanding the infrastructure and hardware of the distance learning system to nationwide coverage; and (ii) improving service delivery and the quality of care provided by family physicians through the analysis of current workload practices and procedures.

II. Increasing Efficiency of Public Hospital Management and Operations (Appraisal: US\$46.6 million; Actual: US\$30.5 million). This component aimed at strengthening hospital management and operations through technical assistance and implementation support, and by supporting a health investments program through capacity building of MOH's General Directorate of Health Investments and the Public Hospitals Institution for improving human and physical resources.

Subcomponent 2.1: Provision of technical assistance, consulting services, equipment, and training to increase public hospital efficiency through interventions in four areas: (i) clinical engineering; (ii) drug and medical supply management; (iii) clinical care processes; and (iv) administrative and financial information systems. In each of these areas, MOH planned to provide training to public hospital staff, develop national guidelines and classifications, support public hospital teams to implement guidelines and standards, and strengthen information systems.

Subcomponent 2.2: Developing and implementing architectural and technical standards for health facilities.

Subcomponent 2.3: Strengthening the capacity of the General Directorate of Health Investments in managing public-private partnership (PPP) transactions notably in the administration of contracts with stakeholders, including the Undersecretariat of the Treasury and the Ministry of Development, and service performance management. This would involve the development of in-house capacity in legal, financial, operational, and structural aspects of contract management.

III. Improving the Effectiveness of Overall Health Sector Administration (Appraisal: US\$43.6 million; Actual: US\$43.9 million). This component would facilitate the first two project components and would build on earlier World Bank-assisted Adaptable Program Loans (APLs) that had supported the country's Health Transformation Program (see section 3) to institutionalize a better system of collecting, processing, validating, and using information for policy decisions. As such, the component would support the development of evidence-based policy-making capacity of MOH, while concurrently improving M&E capacity.



Subcomponent 3.1 would be focused on developing an integrated Health Management Information System (HMIS) that supports the enhancement of evidence-based policy and decision-making capacity of MOH. Key activities were to include: (i) institutionalizing health sector performance assessments and harmonizing health sector data in line with international standards; (ii) developing and adopting national e-health standards and legislation to improve the quality of health data and ensure the interoperability of HMIS's nationwide and internationally; (iii) developing and implementing a computerized decision support system for decision makers at various levels, based on the integration of reliable and consolidated data from existing information systems; and (iv) enhancing the technical audit capacity and widening the use of evidence-based medical practice at the primary and secondary levels to improve the quality of health service provision.

Subcomponent 3.2: Developing a model for sharing health sector experiences and disseminating products of the Health Transformation Program.

Subcomponent 3.3: Building capacity in Health Technology Assessment (HTA), including the preparation of an HTA strategy and related legislative documents.

Subcomponent 3.4: Supporting the Project Management and Support Unit (PMSU) in project implementation, including in the areas of financial management, procurement, disbursement, monitoring and evaluation.

Addition of a fourth component during implementation

On May 1, 2020, the project added a fourth component to respond to COVID-19 by using an unallocated category of expenditures resulting from savings generated by the Euro appreciation against the Turkish Lira (see restructurings below). The initial allocation for Component IV was reported at EUR 27 million (Restructuring paper for the Second Restructuring of May 1, 2020). This component would finance procurement activities for:

- i. pharmaceuticals and equipment necessary for COVID-19 treatment;
- ii. specific equipment for the vaccine production center of MoH's Public Health General Directorate;
- iii. recruitment of individual consultants; and
- iv. Bio Safety Level 4 training activities for the vaccine production personnel.

The component's scope was further expanded during the fourth restructuring of May 29, 2023, to include the emergency response to the earthquake. The total actual cost of Component 4 was US\$30.3 million. The Project Task Team clarified on November 5, 2024, that, within the component, the actual cost for COVID-19 expenditures was equivalent to EUR 1.1 million or about 4 percent of Component 4, while the majority of component expenditures pertained to the earthquake response. Further details about component adjustments are discussed with project restructurings in section 2e, below.

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

Cost and financing: At appraisal, the project cost under the World Bank Loan was estimated at US\$134.3 million (EUR 120 million). The Borrower contributions were sizeable but not specified, as they extended over a broad set of themes within the health sector under ongoing health reforms. In fact, a Program for Results (PforR) was initially considered, but the government decided in favor of an Investment Project



Financing modality, as the determination of PforR boundaries was difficult given the breadth and size of the overall reform and the relatively small amount of Bank support (PAD, p. 24). The actual cost of the World Bank Loan was US\$130.7 million. The small difference between the actual cost reported in the World Bank's portal and that of the ICR's Annex 3 (ICR, p. 37) was related to exchange rates, as explained by the Task Team on November 5, 2024.

Dates: The project was approved on May 28, 2015, and became effective on December 1, 2015. A Mid-Term Review was carried out in February 2023. The original closing date was May 31, 2020. Pursuant to closing date extensions aggregating at a total of 3 years and 7 months, the project closed on December 31, 2023.

The project underwent four restructurings (ICR, p. 8 and p. 11) as follows:

First restructuring, April 23, 2019: A new Strategic Plan (2019-2023) was approved in 2019 and triggered the need to align project activities and the results framework with the updated strategic directions of the health sector.

- Under Component 1 (Primary and Secondary Prevention), activities related to palliative care were dropped from the project, and the financing of their implementation was transferred to the national budget.
- Under Component 2 (Increasing Efficiency of Public Hospital Management and Operations), the investments in training centers on clinical engineering and the development of architectural and technical standards for health facilities were dropped in line with MOH changing priorities. New activities consisted of the establishment of simulation-assisted training centers (SEUMs) to increase health workforce specialization, and the establishment of a PPP monitoring and evaluation system.
- Under Component 3 (Improving the Effectiveness of Overall Health Sector Administration), a process mapping of all MOH units was added to help MOH in its organizational restructurings.
- As savings were generated by the Euro appreciation against the Turkish Lira, the government expressed its interest in using project savings to expand the scope of the project mainly to support research and development in the health sector. However, since legal arrangements for such support were not yet in place, an unallocated category of EUR 22.6 million was created in anticipation of a second restructuring, when potential new activities would be concretized.

Second Restructuring, May 1, 2020: The restructuring was triggered by the coronavirus pandemic. It revised the PDOs by adding a new objective (to strengthen the government's capacity to respond to COVID-19) and introduced a fourth component on strengthening capacity to respond to COVID-19 with an allocation of EUR 27 million (mainly from the savings noted above under the first restructuring). Activities included the procurement of pharmaceuticals and equipment necessary for COVID-19 treatment, procurement of equipment for the Vaccine Production Center, and training in Bio Safety Level 4.

Third restructuring, December 1, 2021: The restructuring extended the closing date by 24 months in view of the challenges caused by the COVID-19 pandemic. The results framework was revised, including by increasing target values to reflect the extension of the closing date.

Fourth restructuring, May 29, 2023: In response to the earthquake of February 2023, the restructuring expanded the scope of Component 4 (response to COVID-19) in line with the new PDO statement (to strengthen the government's capacity to respond to emergencies), as noted in section 1a. The PPP Monitoring and Evaluation Automation System was dropped to facilitate reallocations of funds to the



earthquake response, and the financing of equipment for the Ankara Vaccine Production Center was also dropped, as there was an intention to finance related equipment through another project (see section 4, Objective 4).

3. Relevance of Objectives

Rationale

Türkiye is an upper-middle-income country, ranked as the 18th-largest economy in the world. Its development over the past decade is a story of notable turnaround facilitated by structural reforms and sound macroeconomic management (PAD, p. 12). During the past decade preceding appraisal, the country underwent significant improvements in the supply of and demand for health services under a major productive health reform known as the Health Transformation Program that was supported by the World Bank during the period 2003-2015. Improvements were reflected in health outcomes, trends in health financing, and health utilization, including the achievement of universal health coverage. Among the key elements of the reform was the introduction of the family medicine system that provided primary care through community health centers and family medicine centers. The unification of public hospitals transferred managerial responsibility of the Social Insurance Institution hospitals to MOH structures, bringing all public hospitals under one umbrella (PAD, p. 12). The amended Social Security and Universal Health Insurance Law was adopted in 2008, and Universal Health Insurance unified the previously fragmented enrollees (active, self-employees, or retired in both the public and private sectors). Health services were accessible to all, using a single package of benefits. A single purchaser model was created in which the Social Security Institution assumed responsibility for all health financing functions of revenue collection, pooling, and purchasing.

Looking forward, it became increasingly clear that among the evolving challenges was the high burden of the rising non-communicable diseases (NCDs). NCDs were responsible for more than 80 percent of the disease and mortality burden. Ill health due to cardiovascular disease was prevalent, and the reported mortality from coronary heart disease among Turkish women was the highest in Europe (WHO 2014). The prevalence of type-2 diabetes doubled over the past decade and is the fourth most significant cause of ill health in the country. Clinically significant hypertension exists in at least a third of the Turkish population, and the majority are not aware of their condition or taking appropriate care. Several cancers, including lung, breast, and colorectal cancers, were among the top 25 causes of ill health. The Turkish population is also aging, with the number of people over 65 expected to reach 8.6 million by 2023, which would further exacerbate the challenge of NCDs. Tackling NCDs also needs a multi-sectoral approach, and MOH has been working in close cooperation with line ministries (sports, education, transportation), local administrations, local and international institutions, academics, private sector associations, and consumer groups (PAD, p. 15). Substance addiction was another emerging agenda, and the Institute for Health Metrics and Evaluation found that the death rate from drug use disorders increased almost threefold between 1990 and 2010 for both sexes and all ages.

Another challenge was that of hospital efficiency. Although efficiency improved during the implementation of the Health Transformation Program, the latest available hospital efficiency index was 74 percent, indicating that about 26 percent of hospital inputs (e.g., beds, staff, and budgets) were not contributing to the production of any output (PAD, p. 17).



Monitoring the impact of the reforms was a priority for MOH, which had already started focusing on health system evaluation and supporting various studies. These include the World Bank-OECD Health Systems Review, the World Bank-WHO Health System Performance Assessment (HSPA), and MOH's Lancet Turkey Special Edition. MOH intended to sustain such rigorous evaluations to improve its evidence-based policy and decision-making. These necessitated a fully functional and integrated health management information system based on reliable and consolidated data, generating health statistics based on international standards, and employing an efficient audit and monitoring system.

Responding to the above priorities was consistent with MOH 2013-2017 Strategic Plan and the government's vision for a Healthy Living Action Plan, including for fostering healthy lifestyles, providing effective and efficient health services, better responding to the health needs and expectations, and developing the health system as a means of contributing to the economic and social development of the country and to global health. Objectives also responded to a strategic focus of health investments through PPPs (Note: PPP was highlighted because the country was pursuing an ambitious PPP investment program valued at TL 20 billion, PAD, p. 30).

The objectives and the scope of the project were appropriate for the stage of development of the sector in the country (ICR, p. 25) and were in line with the long-standing engagement of the World Bank in the health sector.

The restructurings allowed the project and its objectives to remain aligned with MOH new Strategic Plan (2019-2023) and with Türkiye's 11th Development Plan for 2019-2023, and allowed the project to respond to COVID-19 and the earthquake. The objectives remained in line with Objective 6 of the Country Partnership Framework (CPF) for fiscal year FY18-23 on strengthened performance of the education and health sectors.

At project completion, objectives remained consistent with the World Bank's current CPF FY24-28, specifically with Objective 2 on inclusive services, and with Objective 5 on reducing disparities in health and education access and quality. Objectives also remained aligned with Türkiye's 12th Development Plan for 2024-2028, specifically Goal 3: Qualified human, strong family, and healthy society.

Rating

High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

Improve primary and secondary prevention of selected NCDs

Rationale



The theory of change envisaged that promoting healthy living behavior, improving knowledge about NCDs risk factors, improving cancer screening, raising awareness and capacities to tackle substance addiction, and strengthening and modernizing training for family physicians would result in improved knowledge about risk factors, behavior change, improved coverage, access and utilization of counselling services, and increased detection of cancers. All of the above would collectively and plausibly contribute to improved primary and secondary prevention of NCDs.

Main outputs were related to increasing population and health workers' awareness about NCDs and related risk factors such as tobacco use, unhealthy diet, physical inactivity and substance abuse, Behavior change interventions and promotion of healthy lifestyle in HLCs, improving screening for the early detection of cancer, improving evidence on the prevalence of NCDs and related risk factors among the population, developing the family physician training programs and ensuring nationwide coverage of physicians with distance learning (ICR, p. 12)

The project provided training to health personnel on cancer screening and post-screening diagnosis, and a cancer registry was established based on modern standards, with specialists trained on its use. The project strengthened medical education programs for family medicine and provided distance learning training programs to improve the competence of PHC health staff in primary and secondary prevention of NCDs and their management.

Over 6,390 PHC staff satisfactorily completed standardized face-to-face training modules, surpassing the target of 5,366 staff. The project developed 141 on-line training programs in family medicine and software for nine distance training modules. The development and expansion of distance learning training programs allowed MOH to train 560,124 health personnel, overcoming obstacles created by the COVID-19 pandemic.

The population share covered by screening for cancers substantially increased as follows: for cervical cancer, coverage reached 51.4 percent, surpassing the target of 28.3 percent; for breast cancer, the coverage reached 26.7 percent, surpassing the target of 12.3 percent; and for colorectal cancer, coverage reached 17 percent, surpassing the target of 5.1 percent.

The project increased the provision and utilization of primary and secondary prevention services. The percentage of households that received counselling or education on healthy living from health workers increased from a baseline of 10 percent in 2012 to 47 percent of the overall population in 2023, slightly short of the target of 50 percent, but essentially meeting it. The share of male population increased from 7 percent to 45.3 percent, exceeding the target of 40 percent for males; and the share of females increased from 13 percent to 48.6 percent, short of the target of 60 percent for females.

The project improved the general population's awareness about negative health impact of NCD risk factors and substance use. The share of the population who could state two or more negative health impacts of risk factors and substance use reached 13.6 percent of the general population (including 15.9 percent for males and 11.7 for females), surpassing the target of 4 percent.

The project supported the establishment of HLCs that represented a new model for delivery of preventive services, seeking to trigger sustained behavior change by creating opportunities to learn about healthy living practices. Initially, the project design envisaged the establishment of eight HLCs for piloting this delivery model, however, the intervention was scaled up after the 2019 restructuring for nationwide implementation, and the project supported the establishment of 261 HLCs in all 81 provinces of the country, including through enhancement in multi-disciplinary human resource capacity and infrastructure. The project provided imaging



equipment, including 30 mammographs, and renovated premises for physical exercises. Training was instrumental in establishing multi-disciplinary teams encompassing physicians, dieticians, nurses, midwives, social workers, and psychologists. The project engaged consultants to fill gaps in some clinical specialties. These multi-disciplinary teams provided people-centered services, notably through lifestyle advice, cancer screening and primary prevention of priority NCDs. Service examples included counselling on healthy nutrition, physical activity, NCD management, healthy aging, reproductive and mental health, child and adolescent health, smoking cessation, counselling for drug users, social work and support. A survey of HLC users showed that the share of users satisfied with HLC services was 83.4 percent, surpassing the target of 70 percent.

Also, the project supported skills development and infrastructure improvement in ‘Substance Use Treatment Centers’ in 12 provinces aiming at enhancing effective coverage of patients. A total of 22,614 visitors received services at these centers as compared with 90 persons in 2015, meeting the target of 22,209 visitors.

The share of cervical cancer cases detected at early stages increased from 39.2 percent in 2014 to 70 percent in 2023, surpassing the target of 63.6 percent.

Early detection of breast cancer increased from 48.7 percent in 2014 to 50.4 percent in 2023, short of the target of 52.5 percent, but with a trajectory reflecting progress.

Comparison of NCD risk factors prevalence and public awareness between 2017 and 2023.

Improvements related to the prevention of NCDs in the country were further confirmed by the results of the 2023 second household survey based on WHO STEPS Approach to Surveillance, given its robust methodology, and whose results were compared with the findings of the previous STEPS survey conducted in 2017. The following table shows the positive changes observed in relation to selected risk factors between 2017 and 2023.

Indicators	Year	Both sexes	Men	Women
Respondents who always or often added salt or salty sauce to their food	2017	28.1	29.3	26.8
	2023	20.9	21.8	20.1
Respondents with insufficient physical activity (less than 150 minutes of moderate intensity per week) (%)	2017	43.6	33.1	53.9
	2023	32.1	25.9	38.4
Median time spent in physical activity on average per day (Interquartile range) (minutes)	2017	30.0	51.4	17.1
	2023	47.1	64.3	34.3
Respondents (%) with ≥ 3 risk factors, aged 18-69 years	2017	51.0	51.5	50.5
	2023	43.2	44.8	41.6
Adults (%) who can state ≥ 2 negative health effects of smoking tobacco	2017	76.2	77.0	75.5
	2023	84.0	85.6	82.5
Adults (%) who can state ≥ 2 negative health effects of low consumption of fruits and/or vegetables	2017	33.2	32.8	33.6
	2023	36.7	38.1	35.4
Adults (%) who can state ≥ 2 negative health effects of physical inactivity	2017	58.3	59.6	57.1
	2023	59.3	59.4	59.2



Adults (%) who can state ≥ 2 negative health effects of substance abuse	2017	73.4	75.5	71.4
	2023	82.4	84.4	80.4

The results of the STEPS surveys also confirmed improvements in outcomes by comparing results between 2017 and 2023 for early screening and management of hypertension and diabetes. The ICR (p. 14) noted that, in addition to the project interventions, the government efforts, beyond its project resources, have likely contributed to the observed positive trends shown below:

Early screening and management of hypertension and diabetes in 2017 and 2023:

Indicators	Year	Both sexes	Men	Women
Obese respondents (BMI ≥ 30 kg/m ²) (%)	2017	28.8	21.6	35.9
	2023	25.4	20.0	30.8
Respondents with raised blood pressure (SBP ≥ 140 and/or DBP ≥ 90 mmHg) not on medication (%)	2017	57.1	64.7	50.5
	2023	44.2	51.9	37.2
Proportion of all hypertensive people with controlled blood pressure in the population (%)	2017	23.8	18.5	28.4
	2023	30.8	29.1	32.5
Respondents with impaired fasting glycaemia (plasma venous value ≥ 110 mg/dl and < 126 mg/dl)	2017	7.9	8.1	7.7
	2023	4.6	3.5	5.7

Rating

Substantial

OBJECTIVE 2

Objective

Increase the efficiency of hospital management

Rationale

The theory of change envisaged that training hospital staff in better management of public hospital resources, standardizing architectural and technical standards for the design of hospitals, and strengthening MOH’s institutional capacity for PPP transactions management would increase the capacity for efficient management of hospital resources, and improved institutional capacity for structuring and managing PPP transactions, thus plausibly contributing to uncreased efficiency of public hospital management.



Initially, the planned activities included technical assistance and training in four areas: (i) clinical engineering, (ii) drug and medical supplies management, (iii) clinical care processes, and (iv) administrative and financial information systems (ICR, p. 15). This component also intended to standardize the design of hospitals.

Due to reorganizations at MOH and subsequent changes in priorities, main activities were dropped and substituted by an activity for establishing Simulation-Assisted Training and Implementation Centers (SEUMs). The project established and equipped two SEUMs in Izmir, and the share of health professionals who had simulation-assisted training reached 23.68 percent, exceeding the target of 10 percent. But training activities provided by the Centers were only partly related to improving the efficiency of hospital management, as the training was mainly focused on improving clinical competencies of physicians and enhancing the provision of specialized health care in public hospitals.

The plan for establishing an M&E system for Public-Private Partnership (PPP) hospitals was not implemented due to constant changes in design and failure to organize a tender in compliance with World Bank procurement guidelines (ICR, p. 15).

Rating

Negligible

OBJECTIVE 3

Objective

Enhance the capacity of MOH for evidence-based policy making

Rationale

The theory of change envisaged that monitoring health sector performance, harmonizing health sector data in line with international standards, developing and adopting national e health standards and legislation, ensuring the interoperability of HMIS's nationwide, and widening the use of health technology assessments (HTAs) would lead to improved availability of comprehensive and reliable health data for decision making and to increased use of HMIS by policy and decision makers. These outputs would plausibly result in enhanced evidence-based policy making capacity of MOH.

The project supported the development and implementation of an integrated HMIS by supporting its design, integration strategy, and implementation roadmap, along with the harmonization and standardization of data as discussed below.

Note: Prior to the project, the Health Management Information System (HMIS) involved 20 central and separate systems that collected various sets of clinical, demographic, and administrative data which were not harmonized (PAD, p. 18 and ICR, p. 2).

As a result, administrative and clinical data generated by health providers operating at primary, secondary, and tertiary levels were consolidated and managed under the umbrella of one integrated information system. By the end of the project, all public hospitals and family medicine centers, and 80 percent of private hospitals, shared data through HMIS based on modern and up-to-date information standards. Gender-disaggregated



data were collected at all levels of health care delivery, and a gender-based analysis was mainstreamed in the data management systems. The integration of health information of different actors helped more effective planning and monitoring, and quicker response disposition to emerging needs and threats, while also enabling electronic data exchange between health care providers.

The project supported the development and adaptation of national e-health standards and legislation to improve the quality of health data and ensure the interoperability of HMIS nationwide and internationally. The project contributed to ensuring compliance of the country's health statistics with international standards. A robust model for data definitions, collection, storage, and analysis was established. This resulted in almost all health indicators (95.5 percent) within the database of MOH meeting international standards. A number of health surveys (Obesity, Tobacco, STEPS) conducted based on the methodologies provided by internationally recognized organizations (WHO, OECD, EUROSTAT) also helped to consolidate reliable data used for national decision-making and for international comparisons.

The project supported the improvement and use of the Health Statistic and Causal Analysis system (SINA) which is one of the major decision support system platforms of MOH. Enhancing SINA aimed at facilitating effective management of institutional resources and prompt decision making. SINA is used by both the central administration and provincial, district, and hospital managers and physicians countrywide. As a business intelligence platform, SINA allows live monitoring and reporting of digital records of all healthcare service providers and helps in identifying health management data for better decision making. As an example (also pertinent to Objective 4 on COVID-19), SINA was used during the COVID-19 pandemic along with the national E-Pulse platform to identify the need for intensive care beds and manage free beds effectively. Real-time information about the situation in intensive care wards across hospitals in the country helped improve the referral of emergency cases and informed hospitals to prepare themselves for upcoming patients.

The project strengthened the capacity of the 'Health Information Systems General Directorate' of MOH through the development and utilization of modern ICT management tools aiming to improve in-house management of the Directorate's activities, and these included a road map for software development, testing, maintenance and repair, and tools for managing help desks, among others. The digital transformation also resulted in increased MOH capacity for M&E and for monitoring the implementation of MOH Strategic Plan (2019-2023).

The project developed a specific "Project Management System Software" that was used by the Project Management Support Unit (PMSU) for monitoring project disbursements, activity status, tender and procurement processes, and payments. The software was also used by other MOH units, and whose staff were trained for its use.

The operation supported the development of MOH Strategic Plan (2019-2023) and an HTA strategy. Nine reports on prioritized topics were prepared and published in line with the new HTA strategy that helped in making evidence-based policy decisions regarding the use of new and expensive medical technologies, thus contributing to the institutionalization HTA.

The project helped improve internal administrative processes at MOH by conducting process mapping of all its units. Process flow charts were prepared and used by MOH high-level management to improve organizational structures.



The proportion of policy and decision makers who used HMIS regularly reached 90 percent, achieving the target. The above results and the development change that was realized indicate that the project fully achieved this objective.

Rating
High

OBJECTIVE 4

Objective

Strengthen MOH capacity to control and fight the threat posed by COVID-19

Rationale

The theory of change as illustrated in the ICR (p. 3) envisaged that the procurement of pharmaceuticals and equipment for COVID-19 treatment would improve the capacity of hospitals and other health facilities to provide care to patients with COVID-19.

This ICR Review notes that the provision of medicines and equipment as a contribution to the response does not fully capture the objective, as stated. Also, the project's contribution constituted a complement to the government's larger response to COVID-19 and to the World Bank-assisted Emergency COVID-19 Health Project, P173988 (ICR, p. 17).

The ICR provided cursory information about this objective, while also noting (p. 17) that the provision of medications and medical devices necessary to treat COVID-19 patients helped to organize the effective treatment of patients, shorten the treatment period, and decrease disease complications.

Initially, the project also envisaged to procure equipment for the Vaccine Production Center in Ankara and to provide training in Bio Safety Level 4 training, but these activities were dropped (ICR, p. 6), as they were to be supported by the World Bank-financed Preparedness for Public Health Emergencies Project (P180781). However, the situation and needs analysis for the Vaccine Production Center was prepared with project support and this analysis was expected to benefit the new operation.

In recognition of the project contribution to the COVID emergency response through the reported provision of urgently needed pharmaceuticals and medical equipment, the objective is assessed as substantially achieved.

Rating
Substantial

OBJECTIVE 5

Objective



Strengthen the government's capacity to respond to emergencies

Rationale

The theory of change envisaged that supporting emergency health needs after the earthquake with supplies for water sanitation, materials for infection prevention and control, medical goods to support surgical interventions, hospital equipment, as well as the restoring access to essential and quality health services and providing additional capacities in facilities to which patients are transferred, would collectively result in improved capacity of hospitals and other health facilities to provide emergency care to people injured by the earthquake.

The February 2023 earthquake(s) directly affected 11 provinces in the southeastern region of the country: Kahramanmaraş, Adana, Adıyaman, Diyarbakır, Elazığ, Gaziantep, Hatay, Kilis, Malatya, Osmaniye, and Şanlıurfa. These provinces were home to 14 million people (16.4 percent of the country's population). The earthquake caused massive loss of life, injuries, and very significant damages in and around the southeastern region, resulting in over 50,000 casualties, 107,000 people injured, 3.3 million people displaced, and almost 2 million people living in camps and container settlements. Around 31 percent of all hospitals in the region were severely damaged, at least 448 health workers died and 528 were injured, while many more were unable to resume work due to loss of homes or deaths in their families. Patient care had to be provided in newly established field emergency care hospitals, as well as in hospitals in non-affected cities. Thousands of patients were transferred to hospitals in other cities. The earthquake destroyed or caused major damage to numerous primary and secondary health care facilities and caused significant service disruptions. It also resulted in the destruction of clean water and sewage systems and significantly increased the risk of infectious disease outbreaks.

The project supported the procurement of medical goods, supplies, and equipment for hospitals and primary health care facilities. Specifically, it financed: (i) supplies for water sanitation, such as chlorine and water purification devices; (ii) supplies for infection prevention and control, such as sterilization units, tissue storage cabinets, autoclaves, and insecticides; (iii) medical goods to support surgical interventions for the injured; and (iv) hospital equipment to provide and maintain access to critical health services, such as X-ray machines, neonatal ventilators, hemodialysis devices, incubators, tomography devices, beds and stretchers. The project contributed to improving related capacities in 207 health facilities, exceeding the target of 15 health facilities. The total number of patients cared for by project-supported hospitals under the earthquake emergency was 621, 811 persons, slightly exceeding the target of 611, 383 people.

The ICR (p. 17) noted that the project helped fill emergency health needs in affected areas, and established additional capacity in other cities responding to the increased number of patients transferred to their health facilities. The project supported the restoration of access to essential and quality health services in public hospitals and primary health care facilities. The project provided due attention to supporting the restoration of access to essential health services for women of reproductive age and children, such as antenatal care and child immunization. Concurrently, the project helped improve capacity to prevent and control the dissemination of infectious diseases.

Rating



High

OVERALL EFFICACY

Rationale

The objective to improve primary and secondary prevention of selected NCDs was almost fully achieved and rated Substantial. The objective to increase the efficiency of hospital management was barely achieved and rated Negligible. The objective to enhance evidence-based policy-making capacity was fully achieved and rated High. The objective to strengthen the government's capacity to respond to COVID-19 was almost fully achieved and rated Substantial. The objective to strengthen the government's capacity to respond to emergencies (assessed in the context of the earthquake in this case), was fully achieved and rated High. The project provided due attention to gender aspects, and gender-disaggregated data were collected at all levels of health care delivery. Females constituted 66.3 percent of direct project beneficiaries. The aggregation of achievements is consistent with a Substantial rating for overall efficacy.

Overall Efficacy Rating

Substantial

5. Efficiency

The PAD's economic analysis discussed the rationale for public involvement, development impact in terms of benefits and costs, the World Bank's contribution to the project, and the project's fiscal impact and sustainability. The analysis noted that preventing and delaying the onset of NCDs, and effectively managing them, can lead to savings in health expenditures, including a reduction in the intangible costs for those suffering from NCDs. It concluded that increased spending on health care at this stage of the country's demographic and epidemiological development can help keep future public expenditures at bay by avoiding much more expensive late-stage treatment and co-morbidities.

The ICR carried out a cost-benefit analysis and estimated costs and benefits for the 2015–2035 period. The main direct benefits were derived from the benefits arising from the prevention of NCDs, in addition to benefits from investing in the response to COVID-19 and the earthquake. The analysis used the economic value of averted disability-adjusted life years (DALYs). Baseline DALYs were calculated for various NCDs based on estimates of the Global Burden of Disease 2019 study for Türkiye, adjusted for the population size covered under the project interventions. These included the forward projections of DALYs averted (healthy life years gained) from 2015 to 2035. DALYs saved were valued at three times per capita income, in line with cost-effectiveness references of the second edition of the Disease Control Priorities (DCP-2) and Copenhagen Consensus guidelines. The analysis used the standard 3 percent discount rate (and a 5 percent rate for the sensitivity analysis). The benefits resulting from the project were estimated at US\$1.8 billion, and the overall



Internal Rate of Return was calculated at 309 percent with a Net Present Value of US\$1.2 billion. The benefit-cost ratio was estimated at 11.65, underscoring the overall high value for money of project interventions.

In terms of implementation efficiency, substantial issues were observed. The ICR (p. 21) reported that the project experienced significant delays caused by frequent changes in leadership at the upper and middle management levels of MOH, such as General Directors and Heads of Departments of implementing units, and with four different Ministers of Health and two Project Directors. The turn-over disrupted continuity in decision-making, and the responsible units could obtain neither timely nor sufficient managerial support. Also, the organizational structure of MOH was significantly changed in August 2017, triggering a reshuffle of technical staff and responsibilities for project activities. This also affected procurement and disbursement activities, as responsibility was also transferred several times among MOH Directorates.

Further contributing factors were the complex institutional arrangements involving 11 Directorates, contributing to the dilution of responsibilities and to additional challenges in project monitoring. The preparation of the new MOH Strategic Plan was also delayed due to the above frequent changes, and this also contributed to slowing project implementation, as MOH units were required to realign the targets of individual activities with the new Strategic Plan. The above challenges were understandably compounded by the disruptions caused by the COVID-19 pandemic in 2020 and 2021, including the reassignment of staff to fulfill urgent COVID-19 related activities.

Upon balancing the high cost-effectiveness of interventions with shortcomings observed in implementation and administrative efficiency, this ICR Review concluded that the overall efficiency rating was Substantial, further supported by the completion of implementation plans and all procurement activities by project closing, and facilitated by MOH ownership of the health reform agenda. The extension of the project closing date allowed the completion of activities and the attainment of most intended outcomes. In addition to pursuing its original objectives, the project also responded to two major emergencies beyond its original scope. Project funds were fully disbursed by December 31, 2023. Overall, efficiency was reflective of what would be expected in the operation's sector.

Efficiency Rating

Substantial

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		0	0 <input 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 was rated High, as objectives were fully aligned with national and sectoral development plans and with the Country Partnership Framework at project closing. Objectives were also responsive to the COVID-19 and the earthquake emergencies. Efficacy was rated Substantial, as aggregated objectives were almost fully achieved. Efficiency was rated Substantial and reflected what would be expected in the operation's sector.

Given the negligible achievement of one of the objectives used in the assessment of overall efficacy, the overall outcome is rated Moderately Satisfactory.

a. Outcome Rating

Moderately Satisfactory

7. Risk to Development Outcome

No risks of significance were identified, and several factors suggest that development outcomes are likely to be maintained. First, institutional strengthening at MOH was substantial in terms of overall capacity, stewardship, M&E, and policy formulation and implementation. A new Strategic Plan for the health sector was developed and implemented. The project helped institutionalize a new model for preventive health services through HLCs to sustain behavior change. The project strengthened the capacity for HTA and promoted the integration of information systems. Second, and according to the ICR (p. 26), political risks appear to be low, as government ownership and commitment to sustaining project gains remain high. Third, partnership with the World Bank is also being maintained and promoted, including through the Earthquake Recovery and Reconstruction Project (P180849) and the Preparedness for Public Health Emergencies Project (P180781) that was under preparation at the time of the ICR.

8. Assessment of Bank Performance

a. Quality-at-Entry

The World Bank Team worked closely with national stakeholders in project preparation which was facilitated by the long-standing engagement of the World Bank with the health sector. Preparation benefited from prior analytical work and experience of past operations. Project preparation built on the results of two APLs that supported and advanced the implementation of the country's Health Transformation Program over the period 2003-2015 (see section 3) and on findings related to public hospital reform, health financing, pharmaceuticals policy, and the political economy. It benefited from the 2013 analysis of the burden of NCDs in Türkiye, the Global Adult Tobacco Survey, the Nutrition Survey, the Health Behavior in School-Aged Children Survey, the Salt Consumption Survey, and the 2014 World Bank analytical work on NCD risk factors in the country. The analysis of the first round of Health System



Performance Assessment, conducted between 2009 and 2011 highlighted the need for designing a new and efficient health information infrastructure at the national level. The World Bank experience in tackling NCDs burden in a variety of countries was extensively analyzed, and brought insights from global expertise, best practices, and innovative solutions into project preparation.

The PAD (p. 25) underlined lessons learned that were reflected in the project design, including the merits of further enhancing commitment and ownership in complex reforms, keeping all stakeholders informed and engaged, the critical role of timely and quality information to support informed decision-making, and the centrality of focusing on the primary care level, where NCDs can be most effectively addressed. The PAD (p. 26) reported that, during preparation, there was continued and close coordination with international partners working on the health sector, particularly WHO, in the areas of reforming the health sector and addressing NCDs.

According to the ICR (p. 21), complex institutional arrangements with the involvement of 11 MOH Directorates diluted responsibilities for project implementation, subsequently causing difficulties with monitoring project progress and delays in procurement and disbursement. The PMSU that was established under the Health Transformation Program was maintained, as it continued to support other Bank-assisted operations. The PMSU was responsible for coordinating and facilitating day-to-day activities and fiduciary responsibilities. The PMSU was to ensure the continuity of adequate staffing in the areas of procurement, financial management, and M&E. It would provide technical support and certify compliance with World Bank requirements, auditing and reporting. Its functioning would be overseen by the Deputy Undersecretary for Health, to whom the PMSU Director would report. The Operational Manual was finalized before effectiveness. Financial management arrangements would build upon those developed under the “Project in Support of Restructuring the Health Sector (PSRHS, P102172)” that was ongoing at the time of appraisal.

The ICR (p. 20) reported that the design was developed based on a bottom-up approach. MOH requested all Directorates to submit proposals that could contribute to the implementation of MOH Strategic Plan. About 50 sub-project proposals were submitted. The selected sub-projects were then grouped to establish the three original objectives and components. This approach was noteworthy in promoting participation and overall ownership, but it had a downside as it resulted in fragmentation of project activities (ICR, p. 26).

Shortcomings in M&E design were identified (ICR, p. 22) and included difficulties in measuring the indicators with the available data; (b) absence of a clear methodology for measuring and monitoring three PDO indicators; and (c) absence of a monitoring system to report on two PDO indicators.

Key risks were identified, and the overall risk was rated moderate, with governance and fiduciary risks rated substantial. Risks were adequately mitigated (PAD, p. 28 and pp. 30-31), although the ICR questioned if procurement mitigation measures were sufficient to prevent procurement delays for large and complex packages. While the PMSU had adequate capacities and experience, the delegation of responsibilities for procurement to the Directorates created challenges as these units had different levels of capacity in dealing with high-value Quality and Cost-Based Selection (QCBS) within the framework of international competitive bidding (ICB). Risk mitigation measures for procurement included the following (PAD, p. 31): (a) ensuring regular support/advice by PMSU to the implementing units; (b) starting the preparation of standard bidding document/request for proposal documents for high-value QCBS and ICB contracts in the first year; (c) updating procurement plans on a semi-annual basis and combining similar activities to reduce the number of procurement transactions; (d) extending the existing reporting tool used



by PMSU to produce regular procurement-related reporting and recordkeeping; (e) clarifying the supporting activities of PMSU in the Project Operation Manual, (f) using individual consultant contracts that allow longer-term services; and (g) providing continuous hands-on support from the Bank through supervisory missions and training activities when needed. Also, PMSU prepared a procurement plan covering the first 18 months of implementation.

Initially the project was assigned an Environmental Assessment (EA) Category C that was subsequently raised to Category B at the May 2020 restructuring upon the introduction of Component 4 related to COVID-19. MOH developed new regulations on biosafety level 4 for laboratories in line with WHO laboratory biosafety manual. The project prepared an Environmental and Social Management Framework (ESMF) and a Stakeholder Engagement Plan (SEP) and disclosed them. A standalone SEP under the expanded project scope to finance the earthquake response activities was also prepared in 2023. Citizen engagement aspects, including a Grievance Redress mechanism, are discussed in section 10.

Quality-at-Entry Rating

Moderately Satisfactory

b. Quality of supervision

According to the ICR (p. 25), the project was adequately supervised and monitored with sufficient budget allocations and staff. Supervision and implementation support activities were regular and provided appropriate and well-targeted advice and observations. The aide memoires provided evidence of the professional advice provided by World Bank staff. The Implementation Status & Results Reports and the Mid-Term Review realistically rated the performance of the project both in terms of achievement of development objectives and project implementation.

The Bank was responsive to client needs and demonstrated flexibility in adapting to evolving priorities within the parameters of the PDOs. The Task Team was proactive and conducted four project restructurings in 2019, 2020, 2021 and 2023 to adjust to evolving needs and to support the response to COVID-19 and the earthquake. The ICR (p. 25) reported that the Bank Team was diligent in its communication with the government, providing up-to-date information and analysis on the status and impact of project activities, issues encountered, and suggested measures and options to overcome arising challenges. According to the ICR, the feedback received by the ICR mission during its interviews with stakeholders clearly showed the government's appreciation of the technical skills and advice provided by the World Bank's experts.

The large number of MOH General Directorates involved in project implementation (11 Directorates) and the changes in priorities required close coordination, intensified supervision and monitoring, posing additional challenges to the World Bank Team. MOH and the Bank Team took important steps to consolidate supervision and coordination, including: (i) cancellation of secondary activities and retaining the critical ones and those that were already underway, thus reducing the number of Directorates directly involved in implementation and streamlining coordination with PMSU; and (ii) enhancing supervision, implementation support, and Directorates' accountability by setting clear deliverables, expenditure projections, and timelines for implementation.



The ICR (p. 22) reported that the Bank’s flexibility and responsiveness at various stages of implementation allowed adjustments to respond effectively to evolving needs, including timely response to emergencies, and to closely align the project with the overall reform agenda. Bank support facilitated the full utilization of project funds.

Quality of Supervision Rating

Satisfactory

Overall Bank Performance Rating

Moderately Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

The original objectives were clearly stated, and the results framework included five PDO indicators and 16 intermediate results indicators. Shortcomings in the results framework were discussed in section 8. There were difficulties in measuring and monitoring some of the indicators with the available data, and the project intended to strengthen the monitoring systems during implementation.

M&E functions would be supported by MOH structural units, i.e., the General Directorates and affiliated institutions involved in project implementation. M&E responsibilities for the project mirrored those reflected in MOH Strategic Plan, thus complementing the monitoring of MOH’s strategic objectives to which the project would contribute (PAD, p. 26). Hands-on support and guidance to M&E functions would be provided by experienced M&E staff at PMSU, and would be strengthened through in-service training and capacity-building activities supported by Subcomponent 3.4 on project management. The PMSU would be responsible for data aggregation and reporting. In addition to data available in the information systems and administrative records, information would be supplemented by household and thematic surveys such as the Household Health Survey, Chronic Diseases and Risk Factors Survey, Diabetes Study, Nutrition Survey, Salt Consumption Survey, National Study of Child-Age Obesity, National Study of Health Behavior in School-aged Children, Survey of Healthy Living Centers, and other health research studies.

b. M&E Implementation

Significant progress was achieved by MOH and PMSU in improving the collection of data. Also, in the context of digital transformation, the project enhanced the institutional capacity for M&E at MOH. The development of an integrated HMIS substantially improved monitoring and reporting of digital records of all health care providers. MOH conducted a number of national surveys to collect data related to project indicators, including household health surveys and a patient satisfaction survey. In addition, and beyond core data, the project introduced a special software “Project Management System” that was developed



and used by PMSU for effective monitoring of project disbursements, activity status, tender and procurement processes, and payments by all MOH units (ICR, p. 16).

Beyond corrective revisions of the results framework that compensated for the original flaws at the design stage, the ICR noted an important shortcoming that was associated with measuring efficiency of hospital management. The original PDO indicator and another intermediate results indicator were dropped in 2019 with the approval of a new Strategic Plan, and the newly added indicators measured improvement of health professionals' skills and competences rather than efficiency of hospital management. Although such skills are associated with clinical care processes that influence efficiency, the usefulness of the new indicators was limited.

c. M&E Utilization

Apart from the use of M&E findings for regular project monitoring, there were noteworthy M&E utilization and development aspects that influenced the sector at large and would likely influence future operations:

- The project's M&E and its findings were used to monitor and evaluate the implementation of the MOH Strategic Plan (2019-2023).
- The project management software was used by other units at MOH Directorates, and their staff was trained accordingly.
- The integrated HMIS significantly improved MOH's institutional capacity and helped establish a robust M&E system to monitor performance at all levels of care. Gender-disaggregated data were collected at all levels of health care delivery, and a gender-based analysis was mainstreamed in data management.
- The project supported the development and adaptation of national e-health standards and legislation to improve the quality and harmonization of health data and ensure the interoperability of HMIS nationwide and internationally. It ensured compliance of the country's health statistics and MOH database with international standards. It developed a robust and sustainable model for data definitions, collection, storage, and analysis. The use of Health Statistic and Causal Analysis supported decision making. In addition, a number of health surveys, such as for obesity, tobacco, and STEPS which used internationally endorsed methodologies also helped consolidate reliable data for use both for national and international comparisons.

On balance, taking into account design shortcomings, some of which persisted during implementation, and noteworthy M&E utilization aspects, overall M&E quality is rated Substantial.

M&E Quality Rating

Substantial

10. Other Issues

a. Safeguards

Initially, and as noted in section 8a, the project was classified under Category C for Environmental Assessment. Upon the introduction of COVID-19 related activities, the safeguards EA category was



changed to B. MOH developed an Environmental and Social Management Framework (ESMF), Stakeholder Engagement Plan (SEP), and new biosafety regulations for ABSL 4 laboratories. In 2021, following the MOH decision to change the site selection for the Ankara Vaccine Production Center, the safeguard policy OP 4.12 on Involuntary Resettlement was triggered to mitigate any potential impacts that may occur if additional land for the Center was needed. Also, safeguard policy OP 4.04 on Natural Habitats was triggered as a precaution given the location of the site near the surface water at Ankara Çubuk stream. While the financing of equipment for the Center was dropped in 2023, some related activities were retained to maintain flexibility for the possible use of World Bank resources under the new Preparedness for Public Health Emergencies Project (P180781), and MOH revised the ESMF and SEP. The project financed technical assistance for the preparation of the Environmental and Social Impact Assessment studies (ESIA) for Ankara Vaccine Production Center, and invited a biosafety specialist to support other revisions. The ESIA would be part of the tender documents for the construction of the Center, to be implemented by the government outside the scope of this project.

Although the ICR (p. 23) reported that the environmental and social aspects of the project were in full compliance with the requirements of the World Bank safeguard policies, **the overall safeguards rating was Moderately Satisfactory** throughout the applicable implementation period, including in the last ISR, as recorded in the Operations Portal.

With regard to Citizen Engagement, the ICR (p. 24) reported that a Stakeholder Engagement Plan (SEP) for COVID-19 operations was included under the project's ESMF. Also, PMSU prepared and disclosed a standalone SEP for the changed scope of the project to finance earthquake response activities. Special arrangements for patient/citizen feedback and/or complaints were also established at HLCs, and patient/citizen satisfaction with the services at the centers were regularly monitored through this mechanism. MOH established a robust Grievance Redress Mechanism (GRM) and made it operational for addressing grievances both for this project and the Emergency COVID-19 Health Project (P173988). Through integration with national GRMs, all relevant stakeholders were reached. Project-related complaints were filtered in national systems and conveyed to the project-specific GRM. The integrated national systems consisted of the MOH Communication Center (SABIM) and Health Meeting Point (SBN) for health workers.

b. Fiduciary Compliance

Financial Management: The ICR (p. 24) reported that financial management performance ratings were consistently assessed at levels ranging from moderately satisfactory to fully satisfactory. No major issues in financial management were identified. The financial management arrangements at PMSU, including planning and budgeting, accounting, financial reporting, funds flow, internal control, external audits, and staffing were satisfactory and acceptable to the World Bank. The interim financial reports were prepared and submitted in a timely manner, providing reliable financial information. The financial statements were regularly audited by independent auditors with unqualified opinions. The PMSU had appropriate skills and ability to manage project finances and disbursements in a timely manner.

Procurement: Procurement activities were carried out by MOH through its PMSU and 11 implementing units at MOH. The PMSU supported these units as needed. Procurement performance was rated



Moderately Satisfactory from the beginning of project implementation till May 2021, when performance was downgraded to Moderately Unsatisfactory due to delays in major and complex procurement contracts for activities related to SEUM and the PPP Central Monitoring and Evaluation Automation System (MIDOS). In September 2022, a case of procurement noncompliance pertaining to a US\$6.5 million procurement package for the MIDOS was identified. A corrective timebound action plan was introduced and implemented.

Shortcomings in procurement performance included: technical capacity limitations and frequent staff turnover, unfamiliarity of the other MOH implementing units with World Bank procedures, especially with regards to handling large and complex procurement packages, and insufficient coordination between the implementing units and PMSU. According to the ICR, the World Bank worked closely with MOH to address procurement challenges through focused implementation support and capacity building efforts. The Bank's procurement team organized several procurement trainings for MOH staff to explain procurement rules and procedures to be applied, including training on the Bank's Procurement Framework and Systemic Tracking of Exchanges in Procurement (STEP). Following the fourth restructuring in 2023, the project completed the procurement of all planned activities by the closing date, and procurement performance was upgraded to a satisfactory rating.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

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11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Moderately Satisfactory	Moderately Satisfactory	
Bank Performance	Satisfactory	Moderately Satisfactory	Shortcomings at entry, including M&E design deficiencies, fragmentation of project activities, and complex institutional arrangements with dilution of implementation responsibilities, subsequently causing challenges in project monitoring and implementation delays.
Quality of M&E	Substantial	Substantial	



Quality of ICR	---	High
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12. Lessons

The ICR (p. 26) offered several lessons and recommendations, including the following lessons, restated by IEG Review:

A bottom-up approach to project design enhances ownership, but it may also lead to fragmentation of project activities and responsibilities. Under this project, various MOH Directorates submitted more than 50 sub-project proposals at the design stage, resulting in a degree of fragmentation. The lesson was supplemented by a recommendation noting that a unifying framework with strong justifications for activities can ensure full coherence and complementarity of design under future similar operations.

The ability to mount an effective response to unforeseen emergencies is facilitated by the flexibility of the project and the adaptability of its management. This was demonstrated by the project's ability to quickly reallocate resources, adjust priorities, and launch new interventions in response to the COVID-19 pandemic and the earthquake.

Continuity of health care and resilience to emergencies are facilitated by a strong focus on primary health care. Under the project, a patient-centered primary health care was instrumental for delivering responses to COVID-19 and earthquake emergencies and for restoring access to essential services while concurrently contributing to the resilience of the health system.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR provided a detailed overview of project performance. The narrative supported the theory of change, available evidence, and the ratings. The ICR was in general alignment with the stated objectives. It was results-oriented and candid. The ICR triangulated data to further confirm its findings and conclusions on progress made in NCD prevention. The quality of evidence ranged between adequate and high, and the overall quality of the analysis was high. Some of the evidence gaps were rooted in the project and not in the ICR, which aptly identified them. The ICR's clear analysis of M&E aspects was noteworthy. Its lessons were specific and directly derived from project experience. The ICR was concise, internally consistent, and aligned with the guidelines.



a. Quality of ICR Rating
High