2. Project Objectives and Components

a. Objectives

As stated in the Financing Agreement of May 6, 2014 (Schedule 1, p. 5), the project’s objective was “to increase utilization of selected maternal and child health and nutrition services for pregnant women and children.” This statement is consistent with the one provided in the Project Appraisal Document (PAD, p. 7).

The PDO statement remained unchanged throughout the life of the project. Under a Level 2 restructuring, approved on June 1, 2018, the end-targets of PDO indicators were revised in light of a mix of updated baselines, project performance, changes to indicators, and a one-year extension of the closing date. A split
rating will not be undertaken as the outcome indicators were all revised upward, in which case the guidelines call for project assessment against the revised targets.

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
01-Jun-2018

c. Will a split evaluation be undertaken?
No

d. Components

Original Components:

Component 1. Improved utilization of malaria and nutrition services (estimated cost: $10.0 million; actual cost: $8.0 million).

Subcomponent 1.1: Malaria Control: Country-wide support for (i) malaria control during pregnancy through provision of long-lasting insecticide treated bed nets (LLINs) and intermittent preventive treatment for malaria during pregnancy (IPTp) with Sulfadoxinepyrimethamine (SP) as part of the basic package of antenatal care (ANC) services to reduce the risk of acute malarial illness in pregnant women and contribute to reduced anemia, better pregnancy outcomes, and improved birth weight; (ii) community-based diagnosis and treatment of malaria through the procurement of malaria rapid diagnostic tests (RDTs) for the use of community health workers (CHWs) to confirm suspected cases prior to treatment with Artemesinin-based combination treatment drugs (ACTs) and ensure that persons living more than five km from a health facility and seeking care for malaria would be treated with antimalarials only if RDT is positive; and (iii) improvements in management, supervision, and behavior changes to ensure effective utilization. It is significant to note that the PAD (footnote 30, p. 32) stated that a US$2 million gap nationwide of ACT at the community level would only be able to be addressed by the project if the project budget were to be increased. No such increase was recorded in the ICR, indicating that ACTs were likely not financed by the project.

Subcomponent 1.2: Community-based nutrition services for pregnant women and children under five years of age: Support for provision of basic nutrition and selected C-IMCI (community-based integrated management of childhood illnesses) services for pregnant women and children under five in Centrale and Plateaux regions, made up of the most cost-effective interventions. Community-based delivery of services included: iron folic acid supplements for pregnant women, child growth monitoring and promotion, behavior change interventions, provision of micronutrients and oral rehydration salts, and referral of sick, malnourished children to health centers.
Component 2. Strengthened health monitoring and evaluation systems and project management (estimated cost: $4.0 million; actual cost: $4.1 million).

Subcomponent 2.1: Strengthening the health monitoring and evaluation (M&E) system, particularly the health management and information system (HMIS), including the government's capacity to monitor its maternal and child health programs: Technical and financial assistance for HMIS development (skills and knowledge development, selection of core indicators, harmonization of data collection tools and transmission channels, introduction of District Health Information Software [DHIS2] for data storage, analysis and feedback report production and dissemination); and development and regular updating of a Master Health Facility list and periodic health facility surveys to assess system and project performance.

Subcomponent 2.2: Project coordination and implementation support: Support to Ministry of Health (MoH) coordination and planning; financial management and audit; procurement and support to supply chain management; and training and supervision, including development and implementation of a medical waste management plan. Capacity strengthening included: (i) financing of external experts for the project implementation unit (PIU) in procurement, financial management, and M&E, and office equipment and operating costs; and (ii) support to technical programs involved in implementation: malaria, nutrition, communal affairs, community health, information, studies and research, and family health.

Revisions to components

A Level 2 restructuring approved on June 1, 2018 reallocated funds from Component 1 to Component 2 to support preparatory and pilot activities for a new Performance-Based Financing project, and to cover incremental costs of coordination and implementation during the one-year extension period. Funds were available because the project did not procure the total number of LLINs originally planned. Restructuring also introduced a Contingent Emergency Response Component to facilitate a rapid response in the event of an epidemic or another public health emergency.

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

Cost. The total actual cost of the project was $12.14 million, or 87 percent of the original estimate of $14.0 million.

Financing and Borrower Contribution. The project was fully financed by an IDA grant. Of the original grant amount of 9.1 million SDRs, 8.72 million SDRs (96 percent) were disbursed. No contribution from the Borrower was planned or delivered.

Key Dates. The project became effective on February 23, 2015, a year after its approval on February 19, 2014. The mid-term review took place on March 15, 2017. The project was restructured on June 1, 2018 a few months before the original closing date of October 31, 2018, at which time an amount of $10.2 million had been disbursed, or 84 percent of total actual disbursements ($12.14 million). Restructuring involved: (i) a change in the results framework, including a redefinition of some indicators, an updating of some baselines, and changes in some target values; (ii) a reallocation of funds; and (iii) a one-year extension in
3. Relevance of Objectives

Rationale

The PDO is highly relevant to current country conditions, which have not evolved significantly from the baseline conditions documented at preparation. After a long period of political isolation and economic stagnation and a drastic reduction in public development assistance, there were some improvements in political stability and modest acceleration of GDP growth during 2009-2011. But poverty was still high at the time of project preparation, and maternal and child health indicators had been stagnant over the previous two decades, with infant and child mortality at around 80/1,000 and 123/1,000, respectively, and maternal mortality at 350 per 100,000 live births. Malaria was endemic and the primary cause of child morbidity and mortality. Almost half (40 percent) of the 900,000 confirmed cases in 2013 afflicted children under the age of five. The government’s objective of universal coverage of LLINs (defined as one net for every 1.8 persons) was far from being achieved (with household ownership of at least one LLIN at 56 percent). The nutrition status of children under five also posed a serious threat to child morbidity and mortality and prospects for their full development. The 2014 Togo Demographic and Health Survey (DHS) documented an increase chronic malnutrition beginning in 1998, affecting nearly 30 percent of children under five, with great variation across regions. Basic health services, including those addressing malaria and malnutrition, were in short supply, inequitably distributed, and of poor quality. Utilization of these services was low. Moreover, sector coordination and stewardship were constrained by a fragmented health information system, limiting capacities for monitoring interventions and outcomes. Severe underfinancing of the sector limited the quality and availability of services (ICR, pp. 6-7). Some marginal improvements notwithstanding, current country conditions reflect the persistence of these issues: poor health and nutrition status of mothers and children under five, inadequate service quality and access, information systems and evidence-based decision-making in need of further strengthening, and severe underfinancing of the sector.

The PDO is highly relevant to the current development priorities of the country. Pillar 3 of Togo’s National Development Plan for 2018-22 aims to consolidate social development and strengthen inclusion. Objective 3.2 under this Pillar is to provide the population with access to universal health care and nutrition. The first strategic axis of Togo’s National Health Development Plan (PNDS) 2017-22 focuses on rapid reduction of maternal, neonatal, and infant-child mortality and strengthening family planning and adolescent health. This strategic axis also includes the fight against malnutrition. The second strategic axis of the PNDS aims to strengthen the fight against communicable diseases, with a specific target to reduce malaria incidence from 153 percent to 40 percent by 2022. In support of the 2021-22 PNDS, the government has stated its commitment to strengthening the HMIS to ensure timely and quality information for evidence-based decision making at all levels of the system.

The PDO is also relevant to the Bank’s current Country Partnership Framework (CPF) for Togo for 2017-2020 (extended to 2022). The project supported the CPF’s objective 2.1 (to strengthen health services), which falls under Focus Area 2: Inclusive Public Service Delivery. Health services strengthening indicators (CPF, p. 47) are fully aligned with the project’s objectives and interventions to (a)
enhance utilization of ANC services, which deliver malaria prevention information and services to pregnant women, and of community-based nutrition services, and (b) improve breastfeeding of young children.

Rating
High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective
Increase utilization of selected maternal and child health services for pregnant women and children

Rationale
As outlined in the project's theory of change (ICR, p. 7/Figure. 1), the original project design envisaged a number of activities to strengthen the supply of key services targeted to pregnant women and children under five. Malaria prevention and treatment services were to be strengthened countrywide through the acquisition and distribution of critical inputs (LLINs, SP, iron folic acid [IFA] supplements, and rapid diagnostic tests for malaria) delivered through community and primary health services. The project was also designed to support and nurture the activities of CHWs in two regions (Centrale and Plateaux) with high rates of chronic under-nutrition and not covered by other partners. CHW activities were to include: monthly growth monitoring and counseling sessions, monthly visits to households, provision of micronutrients and oral rehydration salts, and promotion of healthy behaviors and practices and the effective use of health services. A particular focus of CHWs was to incite pregnant women to make the recommended four ANC visits, at which they would receive goods and services to protect their health and wellbeing during pregnancy (LLINs, malaria prophylaxis/3 doses of SP [IPTp], 90 IFA tablets) and to deliver in a health facility. CHWs were also to inform mothers about the proper nutrition of their young children and to refer sick, malnourished children to a health facility. Investments in both the supply and the promotion of these services were expected to stimulate an increase in the uptake of these services by pregnant women and children. In turn, greater utilization of these services was expected to contribute to improved maternal and child health.

While the design focused on improving the supply of essential health and nutrition services and also provided support to encourage greater utilization of these services and behavior change, it did not systematically address financial and other impediments to services uptake and changes in behaviors. This is considered a design shortcoming that affected efficacy, especially given statements in the CPF and the ICR noting that financial barriers to health services (with users paying more than half of health costs) constitute a formidable constraint to services access, especially for the poor. A performance-based pilot, introduced under the 2018 restructuring and implemented during the project's final (extended) year, provided incentives to CHWs to enhance their work and outreach.
Investments in strengthening the health management information system aimed to support PDO achievement through: the strengthening of systems and practices to monitor, and act upon, the conditions of health facilities; and improvements to the tracking and use of data on service quality and coverage to facilitate improved management, supervision, decision-making for improvements, and accountability.

**Note on reported data:** The following data is drawn from the ICR’s results reporting (Section II B. on Efficacy, and Annex 1). Evaluation of project efficacy was challenging because evidence presented in the ICR was lacking in several ways: (1) the ICR did not cite data sources; (2) it was not clear for some indicators whether data and trends reported in the ICR were only for the Centrale and Plateaux regions, which received targeted community-based health and nutrition support, or countrywide in scope, as was the malaria control subcomponent; and (3) the ICR did not draw on the results of two national surveys conducted in 2017, which documented relevant data and trends overlapping with the project implementation period (2017 Malaria Indicator Survey/MIS and 2017 Multiple Cluster Indicator Survey/MICS). The ICR Main Contributor, in a 9-13-21 meeting with IEG, provided clarification on some, but not all, indicators. The Region’s written response (10-28-21) to IEG’s ICRR draft, which included data from the 2017 MIS and 2017 MICS, pointed to higher levels of achievements on key outcome indicators than those cited by IEG from these same sources, but the data cited by the Region were reporting on different (lower bar) indicators, and not an exact match with the indicators (their numerators and denominators), as defined in the project’s M&E framework and plan.

**Outputs and intermediate results:**

- The following building blocks of a strengthened HMIS supported the PDO, with good performance against original targets:
  - The development and updating of a basic health facility master list was **fully achieved**. This was an important first step for improving the monitoring of health centers countrywide and for improving the HMIS, which was weak at the project’s outset.
  - Eighty-seven percent of health facilities submitted standardized HMIS monthly reports within one month of the reporting period, **surpassing the original and revised targets of 70 and 80 percent, respectively. (Annex 1 shows the “original” target, set in Oct 2018, as 50 percent).** This achievement was made possible by the project’s support of training at central and district levels and equipment for primary health care centers, and enabled more effective tracking of project beneficiaries. The ICR noted shortcomings, specifically that women living beyond five km of a health facility could not be properly tracked.
  - One hundred percent of health districts succeeded in verifying at least 25 percent of HMIS reports they received, **surpassing the original and revised targets of 50 and 80 percent, respectively.**

- The government’s contribution to the ICR (Annex 5) reported that the project acquired:
  - 1,278,176 RDTs, which CHWs used to identify 1,032,886 positive malaria cases at the community level.
  - 2,995,170 SP tablets for intermittent preventive treatment of malaria during pregnancy.

- The project purchased 345,700 LLINs, **not achieving the original target of 521,165 LLINS** (66 percent of original target), but **fully achieving the revised target of 345,700.** Capacity issues with the Purchasing Center for Essential and Generic Medicines (CAMEG) and the government’s long procurement review and approval process caused significant procurement delays. Despite the corrective actions taken by the PIU, the anticipated number of LLINs could not be purchased.
A total of 156,696 LLINs were distributed to pregnant women during ANC visits (routine distribution), falling far short of the original target of 521,165 (30 percent achievement of original target), and also not achieving the revised target of 213,440 (or 73 percent achievement of the revised target). Over and above the shortfall in procurement, some pregnant women did not follow up on their planned ANC visits to obtain the LLINs during those visits.

The government’s contribution to the ICR (Annex 5) reported that, in support of community-based health and nutrition activities, the project acquired:
- 26,605,694 IFA tablets for pregnant women
- 80,700 sachets of fortified flour for children 0-2 years who are malnourished
- Anthropometric equipment for child growth monitoring activities

**Outcomes:**

- In the Plateaux and Centrale regions (the focus of community-based health and nutrition support and promotion under Component 1, subcomponent 2), the share of pregnant women who attended at least four ANC visits during the last pregnancy actually declined throughout the project from 57 percent to 44 percent (for the two regions combined), not achieving Plateaux’s original target of 63 percent (from its 50.6 percent baseline) or Central’s original target of 65 percent (from its 51.4 percent baseline), and not achieving the revised target of 69 percent. The ICR noted that this poor outcome was affected by: difficulties tracking pregnant women, especially in communities beyond the five km radius of health centers; the inability of some households to pay for health services; and lack of incentives for some CHWs. There are a number of issues raising questions about the reliability of this data (itemized in Section 14 on ICR Quality).

- A total of 173,867 pregnant women received antenatal care during a visit to a health care provider, achieving neither the original target of 312,653, nor the revised target of 213,440.

- The indicator tracking the number of doses of SP for malaria prophylaxis provided to pregnant women changed at the restructuring (from at least 2 doses to at least 3 doses). Between 2013-14 and 2017, women who reported that they received at least two doses of SP during their last pregnancy, as a share of all women who delivered a live birth in the previous two years, rose from 57 percent (Togo DHS 2013-14) to 68 percent (Togo Malaria Indicator Survey 2017). This increase of 11 percentage points, achieved two years before project closing, exceeds the increase of five percentage points embedded in the original target. There are no national survey data beyond 2017 to indicate continued trends. This relevant national survey data, found by IEG, was not reported in the ICR. In 2017, an estimated 42 percent of pregnant women reported receiving at least 3 doses of SP as part of ANC visits (MIS 2017). The ICR reported that, by the project’s end, one half (51 percent) of women giving birth in the previous two years had received at least three doses of SP (IPTp) as part of ANC visits during their last pregnancy, not achieving the revised target of 74 percent, and the source of this end-of-project data point is not specified in the ICR.

- Ninety-eight percent of suspected malaria cases presented to a CHW were tested by the CHW using a RDT, surpassing the original and revised target of 60 and 83 percent. In comments on the previous draft of this ICR Review, the Region stated that the latest data (HMIS 2020) shows a continued high rate (92 percent) post-project. The ICR stated that this outcome indicates strong involvement of CHWs and their activities’ effectiveness with the advanced strategy implemented within the communities. The ICR provided little results chain analysis of this aspect of project support: no
data or information on trends/likelihood of community members to consult CHWs with malaria symptoms (i.e., how significant the denominator is as a share of expected malaria cases in a given population), the coverage or nature of outreach or promotion of this activity, whether the project purchased ACT for CHWs and in what quantities, or what portion of positive malaria cases identified were treated with ACT at the community level. The ICR Main Contributor, in a 9-13-21 meeting with IEG, noted that CHWs undertook frequent household visits (twice weekly to close-by households) and were incentivized to test for malaria. The PAD, p. 32, indicated that $2 million worth of needed ACT would not be financed by the project, unless its budget were increased. There is no record in the ICR of this budget increase happening. In the absence of adequate supplies of ACT (and there were issues in availability of drugs supplies, as indicated in IEG's 9-13-21 interview with the ICR Main Contributor), the RDTs do not constitute an adequate malaria intervention in and of themselves.

- **The ICR does not report data to assess the extent to which the original target -- of 75 percent of pregnant women reporting that they slept under an LLIN the previous night -- was achieved.** This outcome indicator was dropped in December 2017 because it was reported that there were no survey data available to measure it, and the indicator was replaced with an output indicator (share of women receiving LLINS during ANC visits). IEG, nevertheless, did find viable national survey data that reveal a positive trend in LLINs utilization by pregnant women. However, this outcome data fell short of the 75 percent target. Between 2013-14 and 2017, the share of pregnant women aged 15-49 years reporting that they slept under a LLIN the previous night rose from 40 percent (Togo DHS 2013-2014) to 69 percent (according to the Togo Malaria Indicators Survey 2017) or 57 percent (according to the Togo Multiple Cluster Indicator Survey 2017). It is not clear how much of this achievement can be attributed to the project, given (1) delays and shortfalls in the procurement of LLINs, and (2) the fact reported in the 2017 MICS that distribution of LLINs through ANC services (as supported under this project) made up only four percent of all LLINs distributed (with mass distribution campaigns accounting for 82 percent of all LLINs distributed). There are no data beyond 2017 to indicate whether trends continued during the two remaining years of implementation, during which there was not enough time to complete planned LLIN purchases prior to closure.

In Centrale and Plateaux regions, where the project invested in community-based health and nutrition services:

- Ninety-seven percent of children under two years of age attended growth monitoring and promotion sessions at least once (the time frame for this attendance was not provided) in Centrale and Plateaux, **surpassing the original target of 88 percent** (+45 percent over the baseline of 52 percent) **and the revised target of 90 percent**.
- Eighty-six percent of households with children under the age of two were visited by the CHW (the time frame and frequency of these visits were not provided) to support infant and young child nutrition practices, surpassing the original and revised targets of 60 and 75 percent, respectively. The ICR noted that the community performance-based financing pilot ensured that CHWs provided information and support to households to encourage sound infant and child nutrition practices, but it did not provide detail on the pilot’s design, effect, or lessons.
- Sixty-six percent of infants 0-5 months (less than 180 days) of age were exclusively breastfed in the Plateaux and Central regions combined, **falling slightly short of the revised target of 70 percent.**

The absence of disaggregated data makes it difficult to assess the achievement of original targets set for each of the two regions (63 percent for Plateaux, from a baseline of 50.5 percent; and 77 percent for Centrale, from a baseline of 63 percent). The 66 percent rate reported as the
project's achievement appears to be drawn from 2017 Malaria Indicators Survey, in which case data is countrywide.

- Ninety-six percent of pregnant women attending ANC received 90 IFA tablets during their last pregnancy in Plateaux and Centrale regions, **surpassing the original target of 78 percent and the revised target of 83 percent**. A caveat to these achievements is the fact that the denominator (pregnant women attending ANC) is shrinking (with the ICR reporting a significant decline in the share of pregnant women undertaking at least four ANC visits).

- A total of 647,967 people received essential health, nutrition and population services as of May 31, 2019. **This is more than double the target of 293,000 set only six months prior to project closing (ICR, Annex 1), perhaps more indicative of an under-estimated target, rather than a surpassing of a target set on the basis of actual performance data**. IEG assumes that this data is for two regions (Central and Plateaux), rather than national data, but this is not specified in the ICR. Of these 647,967:
  - 499,901 women and children received basic nutrition services, **surpassing the target established just one year before closing (end-2018) of 161,000**; and
  - 148,066 deliveries were attended by skilled health personnel, **surpassing the target established just one year before closing (end-2018) of 132,000**.

- A total of 5,146,449 people are estimated to have directly benefited from the project, **fully achieving the PAD’s target of 5,109,968**. It is not clear why Annex 1 shows original and formerly revised targets of 1,221,645 and 1,408,355, respectively, significantly scaling back the target documented in the PAD. IEG's meeting with the ICR Main Contributor 9-13-21 ascertained that, given Togo's total population of 8.02 million in 2019, there surely must be double- (and triple- or more) counting of the same women or children under five years receiving multiple services, as this target group would represent a much smaller share of the total population.

**OVERALL EFFICACY**

**Rationale**

**Attribution:** While the ICR does not assess attribution, the ICR Main Contributor provided some clarification during a 9-13-21 meeting with IEG. The project supported malaria prevention activities and the provision/use of RDTs of potential malaria cases at the community level, so that only those testing positive would receive treatment with ACT. The only other malaria intervention in the country at the time of the project was UNICEF’s distribution of LLINs in certain regions. The Bank did not duplicate this effort, but supported complementary malaria activities in those regions. AFD (French Development Agency) supported pilot nutrition activities in Kara Region. Again, the Bank was careful not to duplicate this effort, intervening in two different regions. The World Bank was the largest contributor to malaria and nutrition, in terms of both geographic coverage and financing, in the country. The Bank’s support of malaria treatment was limited to the
provision/use of RDT of potential malaria cases. It did not cover the malaria treatment drug (ACT), even though the PAD established that there was a $2 million financing gap.

Counterfactual. The ICR did not assess the counterfactual, but this was subsequently discussed with the ICR Main Contributor during a 9-13-21 meeting. The World Bank was the largest contributor to the malaria and nutrition programs in a context of significant fiscal constraints in the health sector. As such, it provided substantial resources to help address the two main causes of morbidity and mortality among young children and important causes of poor maternal health. It is plausible to assume, therefore, that in the absence of this project the quality and availability of malaria prevention and diagnostic services and of community-based nutrition and C-IMCI services would be lower than what was achieved with the project. Malaria and nutrition were logical, well-chosen entry points into the health sector, after a long period of no operations in the country.

According to the ICR, the World Health Organization’s World Malaria Report 2020 states that Togo is among 17 African countries that achieved reductions in malaria case incidence between 2015 and 2020. These reductions in incidence may well have been smaller, if achieved at all, in the absence of the project, especially its malaria prevention activities (prophylaxis for pregnant women and LLINs delivered through ANC services). On the other hand, reductions in malaria case incidence may have been greater, had LLINs acquisition and distribution not fallen short of initial plans and rates of ANC attendance increased, rather than decreased, during implementation.

Overall Efficacy Rating                  Primary Reason
Modest                                  Low achievement

5. Efficiency
Project appraisal in 2014 included an assessment of the economic benefits of the project, considering only the supply-side of malaria and nutrition interventions. It predicted significant economic returns from improving utilization of selected maternal and child health and nutrition services. The appraisal estimated that project support would result in the saving of 14,841 lives over the project’s five-year implementation, of which 11,062 would be attributable to malaria prevention and case management and 3,779 attributable to nutrition activities. Project benefits were estimated at $14.4 million (PAD, Annex 4, p. 16). Given the total estimated project cost of $14.0 million, this translated into a benefit-to-cost ratio of 1.03, a benefit of just over one dollar for every dollar invested.

The ICR’s assessment of allocative efficiency pointed to the project’s investments in maternal and child health and nutrition interventions that are highly cost-effective, many of which emphasize prevention. It cited various research studies that document the unequivocal cost effectiveness of (a) a standard maternal and child health service package (between $24 and $585 per disability-adjusted life year [DALY] averted) and of a standard package of prenatal and delivery care (between $92 and $148 per DALY averted); and (b) nutrition interventions (e.g., community management of severe and acute malnutrition, costing between $26 and $39 per DALY averted). It also noted high rates of return on investments in nutrition: between $4 and $35 for every dollar invested. However, the project’s neglect of the affordability of services to the poor – an issue raised in the PAD and the CPF – undermined its effectiveness in achieving greater utilization of services by the target group: poor, vulnerable women and children. The government’s comments on the ICR noted its decision to provide IFA and LLINs for pregnant women and fortified flour for malnourished children free of charge, but there are still charges
for ANC and delivery services post-project. The ICR Main Contributor, in a 9-13-21 meeting with IEG, was almost certain that ANC and delivery services were provided free of charge under the project, but could not confirm whether they remain free post-project. He also could not confirm whether free maternal and child health services, mentioned in Togo’s national health plan, were stated as a goal or an already adopted and implemented policy. He promised to get back to IEG on this, but has not yet provided additional information as of 9-27-21.

Several shortcomings undermined implementation efficiency. First, it took slightly over a year after project approval to reach effectiveness and then an additional three months for the first disbursement to be effected. These delays slowed the launch and pace of project implementation. Second, project management and fiduciary issues also impacted project activities, including slow procurement, which significantly curtailed the quantity of LLINs ultimately purchased compared to original and revised targets, even with project restructuring and extension. Third, restructuring was undertaken very late, about one year before the initial closing date, when about 80 percent of committed funds had already been disbursed. Restructuring was challenging due to the weak results framework, including unavailability of some performance and outcome data. Fourth, high turnover of task team leaders (four TTLs during the course of the project) and the fact that all four were based in Washington undermined the speed and proactivity with which implementation bottlenecks were addressed, especially with regard to procurement issues. This conclusion was emphasized in the government’s contribution to the ICR (Annex 5). Of the project’s approved grant of 9.1 million SDRs, 8.72 SDRs (or 96 percent) was disbursed.

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:

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

6. Outcome

The relevance of the PDO is rated high, as it was highly responsive to: (i) current country conditions (high child and maternal morbidity and mortality caused by malaria and malnutrition; a poorly functioning, under-financed health system with limited quality, reach, and capacity; and low stewardship and M&E capacity); (ii) current development priorities of the country to accelerate improvements to maternal and child health care, including reductions in malaria incidence and child malnutrition; and (iii) the Bank’s current CPF for Togo for 2017-2020 (extended to 2022), which supports increased utilization of maternal and child health and nutrition services, at
the primary health and community levels. The project’s modest efficacy is attributable to a mix of some outcome targets not achieved and others achieved. Despite project efforts to promote increases in use of ANC (which delivers malaria prevention goods and services), shortfalls in LLINs acquisition and a decline in utilization rates of ANC undermined full achievement. Targets for children under two attending growth monitoring sessions and for household visits by CHWs were exceeded, and most women attending ANC received IFA to prevent anemia. Efficiency is rated modest. The cost-benefit analysis reveals the project's benefit-to-cost ratio of 1.03, or a benefit of just over one dollar for every dollar invested. The project was strategic and efficient: (i) in its focus on the most vulnerable populations; and (ii) in its design, which focused on mutually reinforcing, high impact, supply- and demand-side interventions. However, the project did not support provision of ACTs for treatment of malaria cases identified at the community level, despite the PAD highlighting a $2 million gap in ACT financing, undermining design efficiency. Nor was this issue addressed in the ICR. Implementation delays and general management and fiduciary issues, especially slow procurement, culminated in an important shortfall in the acquisition of LLINS, a key component of malaria prevention. Project restructuring was undertaken late, and the results framework suffered from the unavailability of some performance and outcome data. High turnover of TTLs (four during the course of the project) and their slow response to implementation bottlenecks undermined implementation efficiency.

Taken together, these ratings are indicative of significant shortcomings in the project's preparation and implementation, resulting in an Outcome rating of Moderately Unsatisfactory.

a. Outcome Rating
Moderately Unsatisfactory

7. Risk to Development Outcome

The ICR’s assessment of risk to development outcome (pp. 18-19) focused on the important role of CHWs in delivering information and services at the community level and in promoting an increased, more effective utilization of ANC and delivery services. The ICR went on to note the uncertain financing, post-project, of all CHWs, which puts the project’s development outcomes at risk in the medium term. Currently there is no harmonization of CHW financing and incentive practices. While most of the CHWs funded under the project have been remapped for Global Fund support, there were still 800 CHWs financed under the project, whose continued financing had not been identified at the writing of the ICR. The ICR recommended that the new Bank health operation address this issue, especially given that the PNDS (2017-2022) sees CHWs as critical for bringing health care closer to communities.

IEG gleaned other risks to development outcome from other other sections of the ICR. In its Key Factors During Implementation section (p. 18) the ICR noted that, “despite having worked closely with national counterparts during preparation, the project did not enjoy a strong sense of ownership by the national stakeholders, mainly during the first years.” The government's contribution to the ICR (Annex 5, p. 44) was more vehement on the low level of ownership of this project, which it attributes to the lack of a sufficient participatory approach and a marginal role for the government during project design and restructuring. The government also noted (p. 45) that low ownership of externally financed projects risks continuing unless and until a strategic operational framework, supportive of national plans and priorities, is put in place to allow the government to take the lead in mobilizing and coordinating donor support around national visions and programs. “The absence of such a strategic operational framework undermines endogenous development;
the ownership of projects by beneficiaries; the participatory approach and hence the quality of the projects as well as the results. Without (such a) framework, it is difficult for a Government to escape ‘in vitro’ projects that in most cases have a mixed probability of success."

COVID was not mentioned in the ICR, finalized in April 2021. The ICR Main Contributor stated that the pandemic has had a negative effect on the quality and availability of malaria and child health and nutrition services. On the supply side, the low-capacity health sector – from central to frontline levels – is highly focused on containing the spread of the virus. In this context of constrained human and financial resources for health, the delivery of quality maternal and child health services is neglected. Demand for these services has been curtailed by fears of contracting COVID at points of service delivery.

8. Assessment of Bank Performance

a. Quality-at-Entry

The Bank’s first health project in Togo after an extended period of no involvement focused on the right entry points to the sector: malaria and malnutrition (the primary causes of high child mortality and morbidity); and the strengthening of the HMIS at all levels of the system to enhance the sector’s results focus and evidence-based decision-making. The design had several significant shortcomings. First, it did not squarely take on the issue raised in the CPF and PAD of the unaffordability of basic services to the poorest and most vulnerable, either at the policy or at the pilot level. Second, the lack of adequate participation of the client in project preparation resulted in low government ownership from the project’s outset. Another design shortcoming is the absence of project financing for ACT to treat malaria cases, especially given that the PAD identified a $2 million financing gap for ACTs. Neither the original nor the restructured project designs mention how, where or whether malaria cases confirmed at the community level would be treated, whether in communities or at health facilities through referrals.

Implementation arrangements were designed to use and strengthen national institutions and at the same time supplement MoH’s weak capacity and inexperience with Bank operations. Arrangements included the recruitment of external specialists (procurement, financial management, M&E) and the training and designation of local experts located within MoH.

A procurement assessment carried out at appraisal culminated in agreed measures to strengthen capacity: (i) recruitment of an external procurement specialist; (ii) nomination of a project procurement officer within MoH; (iii) use of external specialists to help with complex/specialized procurement; (iv) training for MoH staff; and (v) preparation of a project procurement manual to be approved by the Bank. The PIU was given the option of delegating procurement to CAMEG or to an appropriate United Nations agency as needed. While not experienced with Bank procedures, CAMEG was assessed to be experienced in drugs and medical supplies procurement and adequately staffed, and its standard bidding documents were allowed to be used for the project subject to a few modifications.

M&E arrangements were laid out in the PAD, including relevant and clearly defined indicators, baselines and targets, data sources, and responsibilities for data collection (see also Section 9a of this Review). M&E arrangements were ambitious, given reliance, for some indicators, on the conduct of national surveys at project completion.
b. Quality of supervision

There were shortcomings during project supervision in the focus on development impact. This was reflected in the late restructuring of the project’s results framework, and also in the absence of data to assess critical outcome indicators by the project’s end. There was opportunity for the Bank to have taken on a more proactive role in ensuring that needed national surveys to document end-of-project outcomes be undertaken and financed, especially those involving targeted behaviors. Short of ensuring these national surveys, there was opportunity to support the design and implementation of simple but systematic beneficiary surveys that could have culled the perspectives of women who did not use services, as well as those who did. This could have provided important reasons underlying declines in ANC rates and shed light on financial and other impediments to service utilization.

Supervision inputs and processes fell short of needs. A significant turnover of TTLs (four TTLs in five years), all based in Washington with inadequate handover processes, undermined the quality, quantity, and timeliness of the Bank’s dialogue and support. High turnover of TTLs hindered project implementation, with the transition periods needed to ensure each TTL achieved a firm grasp of PDOs as well as design and implementation issues. The government highlighted this issue as a point of concern during implementation. Both the Bank's and the government’s sections of the ICR pointed to slow response times on procurement, in terms of Bank decisions (on which institution would undertake procurement) and its non-objections. Both the Bank’s and the government’s sections of the ICR also revealed the absence of a good dialogue, including the consultative identification and resolution of issues and approaches during preparation and supervision. Adequacy of transition arrangements was not addressed in the ICR.

In comments on the previous draft of this ICR Review, the Region noted that the Bank took the following steps to provide hands-on implementation support to the client: (i) recruitment, before restructuring, of a health specialist based in Togo to work closely with the DC-based TTL, now serving as co-TTL of health projects in Togo; (ii) proactive work by the CMU to address procurement issues that were beyond the sole control of the project team; and (iii) support of studies, including a pilot of community performance-based financing to inform the preparation of a new project.

These steps are well noted, but the shortcomings listed above (inadequacy of focus on development impact; late restructuring; absence of evidence on some key outcomes; inadequate supervision and processes; and slow response time of the Bank on non-objections) remain and are considered significant, consistent with a rating of Moderately Unsatisfactory.
Moderately Unsatisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

The design of project M&E was challenging, given Togo’s weak M&E capacity at the project’s outset. MoH’s 2013 assessment of its HMIS, corroborated by the Bank, found it to be fragmented, with different tools and approaches and oversight across the various vertical (health and disease) programs, supported by different donors. Moreover, M&E was under-resourced, in terms of both financial and human resources, and data quality control, analysis, dissemination, and utilization of information for evidence-based policy were all lacking. This provided a strong rationale for the project’s Component 2, which aimed to strengthen routine HMIS, with a focus on malaria and nutrition indicators for the purposes of project M&E, and the implementation of a periodic health facility survey.

For the most part, indicators in the project’s results framework provided adequate measures of the PDO, with several measures each of utilization of malaria and nutrition services. It would have been useful to complement the tracking of RDTs for malaria at the community level with the tracking of community-based actions for those testing positive (availability/dispensing of ACT at the community level, and referral to health centers of those testing negative but with symptoms). For each indicator, the results framework provided baselines (some to be refined as the HMIS would be strengthened), annual targets, data source/methodology, responsibilities for data collection, frequency of reporting, and definitions (numerator and denominator) (PAD, p. 27). Data sources were mostly identified as HMIS/(malaria and nutrition) program reports, with anticipated surveys (Multiple Indicator Cluster Surveys, MICS) serving as sources for behavior changes (breastfeeding practices and women sleeping under LLINS). Technical assistance (an international M&E expert) to develop and plan the M&E/HMIS strengthening and the training of responsible people at all levels in data collection, compilation, reporting, and retro-feedback was expected to take time.

Data was to be collected at community levels and at health facility levels on a monthly basis and ultimately reach the PIU through the district health bureau, regional health bureau, program focal point, and HMIS central unit. The PIU was responsible for data compilation, analysis, and dissemination. The PAD showed system participants with their respective responsibilities and data flow.

b. M&E Implementation

For most of the implementation period, measurement of the behavior in the results framework was difficult because the anticipated surveys (DHS, MICS) were not carried out at the project’s end. As a part of the June 1, 2018 restructuring, the original behavior indicator (women sleeping under LLINs) was dropped and replaced with a proxy indicator (women receiving LLINs during ANC visits). The proxy indicator, however, was not an outcome indicator. Rather than dropping the original indicator, some progress against this indicator could have been reported, as documented in the 2017 MIS and MICS surveys, at least to capture some trends during implementation. Likewise, the 2017 MICS provided a value for breastfeeding, but it did not provide a full measure of achievement, as it was based on data collected two years before the completion of project activities in 2019. The restructuring also reflected revisions of baselines and adjustments to targets, based on baselines and interim achievements. These changes to the results framework were formalized late during the course of project implementation – four
months before the original closing date, or when 84 percent of actual funding was disbursed. The Bank could have been more proactive in supporting national surveys to track service utilization and other behavior change, or at least some kind of beneficiary assessment that would capture the perspectives of women who utilized services, as well as those who did not. The Bank missed an opportunity to strengthen the country system and capacity on this front.

Project support strengthened M&E capacity and systems, which, in turn, had a positive effect on project M&E implementation. Support included: HMIS data cleaning and review; the development of an HMIS metadata dictionary; the production of HMIS guidelines; selection of HMIS baseline indicators; updating of the HMIS master plan; development of HMIS validation tools; and rules for DHIS2. Project provision of training and information technology equipment was also acknowledged by MoH to have had a positive impact on capacity. The ICR (p. 20) noted that training and equipment strengthened the country’s HMIS, and the countrywide scale-up of the DHIS2 improved the availability and quality of health data. While the project M&E specialist left his post in January 2019 to work on another Bank-financed project, an agreement was reached allowing this specialist to provide needed support during the remaining nine months of the project's (extended) life.

c. M&E Utilization

The ICR did not assess the extent to which information generated by M&E activities was used for improving project performance or supporting evidence-based decision-making. A meeting with the ICR Main Contributor (9-13-21) explored this question. There was some use of data for decision-making. The HMIS informed decisions about the allocation of medicines from central, regional, district and primary health care levels, countrywide. Bottom-up reporting on the use/consumption of allocations received, populations in the catchment areas, and transportation/logistical difficulties (“last-mile” concerns) all were factored into allocations and revisions to allocations, and used to address delivery issues.

Project support culminated in the production of Annual Health Yearbooks, managed by the HMIS director. The ICR Main Contributor in the 9-13-21 meeting with IEG expressed that he was not sure whether the production of these yearbooks continued post-project. ICR technical discussions with the Secretary General of MoH revealed that allocation of health resources from one program to another, and within and across health facilities, districts, and regions, draws on the HMIS.

M&E Quality Rating

Modest

10. Other Issues

a. Safeguards

The ICR indicated satisfactory compliance with the Bank’s safeguard policies (ICR p. 20). The project was classified as category B and triggered two safeguard policies: Environmental (OP 4.01) and Pest Management (OP 4.09). An environmental assessment carried out during project appraisal assessed that the government’s 2010-2014 Medical Waste Management Plan was of good quality. The plan was updated to cover the project implementation period and was executed in a satisfactory manner. However, some
incinerators acquired and installed under the project faced some maintenance issues, which took time to address due to repair warranty issues. In addition, the contractor who installed the incinerator for the private sector platform for health has not documented the end-of-work report on environmental and social management.

b. Fiduciary Compliance

Financial Management

The project’s financial management (FM) system was sound overall, and project FM was assessed to be compliant with the Bank’s operational policies and procedures (OP/BP 10.02) (ICR, p. 20). The project’s FM team submitted Interim Fiscal Management Reports (IFR) consistently and without delays. At the time of ICR preparation, the recruitment of the external auditor for FY 2019 was ongoing, and completion of the external audit was expected to be completed in 2020. In a 9-13-21 meeting, the ICR Main Contributor confirmed that the final external audit was submitted to the Bank in July 2020. But it remains unclear whether any of the external audits were qualified and, if so, whether issues raised were properly addressed. The disbursement rate at project closing (87 percent) was assessed by the ICR to be acceptable, and the fund flow mechanism was assessed to have worked well throughout the project implementation period.

Procurement

The ICR reported that the project complied with the Bank’s procurement policies and procedures (OP/BP 11.00) (ICR, p. 20). At the project’s outset, the project team prepared an 18-month procurement plan that was reported to have been systematically updated to incorporate new activities that emerged during implementation. During implementation, the Bank’s internal reporting (implementation status reports/ISRs) assessed procurement to be moderately satisfactory for the most part, due largely to long delays in contracts approval (157-336 days) by Ministry of Finance, even though the PIU had the funds available to make payments. Drugs procurement also suffered long delays, both with the central drug purchasing agency (CAMEG-Togo) and UNICEF (long internal processes and procedures), with the Bank and PIU ultimately intervening to resolve. Moreover, procurements of anthropometric equipment and LLINs also suffered from a protracted contracting process, further complicated by multiple revisions to quantities to be ordered. This resulted in the project purchasing and distributing only two-thirds (66 percent) of the total number of LLINs planned for purchase.

The ICR Main Contributor conceded that there had been a procurement capacity assessment during design (IEG found this to be documented in the PAD, contrary to what was stated in the ICR), and that the issues of government procurement were not only about limited capacity of CAMEG. The real issue was about the extremely long and slow approval process within the government, requiring the review and approval of bids submitted by CAMEG, of various levels and authorities, including: Ministry/Minister of Health, Director of Public Finance, and Ministry/Minister of Economy and Finance. Moreover, once documentation was submitted to the Bank, there were also delays in non-objections, due to the frequent turnover of TTLs and slow response of the Bank.
c. Unintended impacts (Positive or Negative)

An amount of US$117,221 equivalent of project funds was allocated to supporting the country’s response to curbing Togo’s first major meningitis outbreak, affecting nine health districts in particular. This support helped improve the country's response.

d. Other

Gender. Over and above the deliberate targeting of women of reproductive age and pregnant women – and the expected impacts on women’s health and wellbeing – the project offered employment opportunities for women, who took on the role of CHWs at the village and district levels.

Institutional Strengthening. Focus group discussions with primary health care personnel, CHWs, and some pregnant women attending ANC, held during the ICR preparation, revealed the project’s contributions to management of health facilities in addition to improvements in HMIS and M&E. In particular, the pilot community-based performance-based financing in the Centrale and Plateaux regions was assessed to have promoted client-centered quality care to children and pregnant women and improved community participation in malaria and nutrition services. The ICR qualified that evidence revealed through these discussions was anecdotal.

Private Sector Mobilization. The project provided a small ad hoc allocation (US$37,100 equivalent) to: (i) strengthen public-private sector collaboration towards achieving the PDO; (ii) allow the private sector to inform the national HMIS and complement public sector data; and (iii) make available quality, reliable data for a more realistic overview of the population’s health profile. The project also acquired and installed two incinerators under its medical waste management plan arrangements for the private health sector’s use.

Poverty Reduction. The project likely contributed to poverty reduction in that it supported activities to prevent and treat malaria and malnutrition among the most vulnerable population groups (women and children). These activities likely averted the financial burden households were facing when visiting health facilities to treat serious illnesses. However, although ANC and delivery services financed with project support were free of charge, the ICR Main Contributor noted that on occasion, when essential drugs for ANC were not available because of issues/delays in the replenishment of drug stocks, women were asked to pay. In many of these cases, women went without, as they were unable to afford the cost of these drugs.

11. Ratings

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<th>Ratings</th>
<th>ICR</th>
<th>IEG</th>
<th>Reason for Disagreements/Comment</th>
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| Outcome       | Moderately Satisfactory | Moderately Unsatisfactory | IEG rated efficacy as modest, due to a mix of outcome targets achieved and not achieved, resulting in a lower overall efficacy rating than the ICR. Strengthening of HMIS was not assessed as an outcome (as it
was in the ICR), because it was not specified in the PDO.

The ICR and ICRR's ratings of quality of supervision are the same. The ICRR's rating of quality at entry is lower than that of the ICR, based on the identification of two significant shortcomings.

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<th>Bank Performance</th>
<th>Moderately Satisfactory</th>
<th>Moderately Unsatisfactory</th>
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<tr>
<td>Quality of M&amp;E</td>
<td>Modest</td>
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<td>Quality of ICR</td>
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12. Lessons

The following lessons were derived from: the ICR (and reworded by IEG), IEG's own review of the PAD and ICR, and its discussion with the ICR Main Contributor:

**Failure to nurture and support the full involvement of the government in the design and implementation of a Bank-funded project is likely to undermine the potential for strong country ownership**, which, in turn, risks jeopardizing the sustainability of a project’s development outcomes.

**Fragile countries with limited human and financial resources need a strong, in-country presence of Bank staff** to ensure a sound and ongoing dialogue, a well-designed project with strong national and local ownership, and an iterative, respectful process of trouble-shooting, learning, and adaptation. The quality and potential of the Bank’s contribution to this project was undermined by the rapid succession of four TTLs, all based in Washington, whose response time and dialogue fell short of needs. Moreover, in this context, analytic work both prior to and during project design and implementation may have enhanced the evidence base of the government’s malaria and nutrition programs and the Bank’s contribution thereto.

**In a low capacity country, with weak evidence and M&E capacity, investments in strengthening HMIS are critical to establish the importance of an evidence-based culture.** In this project, the Bank’s investments in building HMIS capacity at every level of the system, which enabled the collection and reporting of information at every level of the health system, did indeed stimulate an improved capacity – and appreciation – for the production and use of information for decision-making. This component contributed to the government’s interest and leadership in undertaking the first DHS in the country’s history.

**The importance of meeting the informational demands of a well-defined project results framework cannot be overemphasized**, for the purposes of: learning, dialogue, evidence-based decision-making, adaptation, and sector M&E capacity building. In the case of this project, the Bank could have been more rigorous, proactive, and supportive on a number of M&E fronts, including:

- Provision of technical and financial support for the undertaking of national surveys to ensure the availability of viable end-of-project data on key indicators;
• The undertaking of an assessment of beneficiary perspectives (including both women who accessed services and those who did not) that would assess financial and other impediments to utilization;
• An earlier restructuring of the results framework;
• Consistent clarity (building on the PAD’s M&E plan), especially during restructuring and final evaluation, in the definition of indicators, data sources, and geographic scope of measures (whether data are national or for two project regions or countrywide).

More than the tally of data on indicators, evaluation requires the triangulation and analysis of qualitative and quantitative data and the assessment of results chains to understand a project’s cause and effect, attribution, contribution, and counterfactual. Evaluation is important not only to assess a project’s performance, but also (and more importantly) to factor learning from evaluations into ongoing and new investments.

13. Assessment Recommended?

Yes

Please Explain

There seem to be many lessons to learn from this project, some reflected in the Bank’s ICR, and many others not: top-down design, lack of consultation, lack of attention to financial and other impediments to utilization of services, Bank technical and financial support of national surveys, shortcoming in HMIS (including the inability to to assess behavior change), and lack of assessment of beneficiary perspectives, among other issues raised in this Review.

14. Comments on Quality of ICR

There were a number of shortcomings in the ICR, as noted below. This being said, IEG commends the ICR Main Contributor for the quality and depth of their discussions, which took place on 9-13-21, and for his willingness to seek answers to IEG’s queries.

Quality of Evidence and Results Orientation

Preparation of the ICR was indeed challenged, given important data gaps on key outcome indicators, but there were additional issues with the presentation of data that were available.

• Data sources were not cited.
• It was not consistently clear whether some data presented applied to the two regions of focus (of subcomponent 1.2) or were nationwide in scope (reflecting the coverage of subcomponent 1.1).
• Some targets labeled as “original” in the ICR were different than those set in the PAD’s Annex 1.
• The ICR did not draw on relevant data and trends to assess performance, specifically trends IEG was able to establish (on malaria prophylaxis provision through ANC and use of LLINs by pregnant women) from comparable data from two national surveys: 2013-25 DHS; and 2017 Malaria Indicators Survey.

Quality of Analysis

The ICR undertook interesting and candid analysis of certain elements, notably: low level of government ownership; late restructuring; persistent data gaps in the results framework; procurement and other issues delaying implementation; and late restructuring. But there also gaps in the analysis.

• The ICR’s efficacy section presented a tally of available data on project indicators, but it did not analyze the results chain drawing on quantitative and qualitative data available. For example, the ICR stated that 97 percent of suspected malaria cases were tested by CHWs using an RDT, exceeding the target of 83 percent. In order to fully appreciate this outcome, it would be necessary to know: (i) how many suspected malaria cases were brought to the attention of CHWs (compared to all suspected malaria cases); and (ii) how many positive cases were treated with ACT, especially given that ACTs were not financed under the project; and the ICR noted issues with drugs logistics and availability at the frontline services level.

• The ICR did not explain the realism/logic of end-project target setting, especially the setting of some revised targets that had no coherence with revised baselines.

• The ICR’s discussion of efficacy did not include an assessment of attribution/contribution or the counterfactual.

• The ICR did not assess impediments to service utilization consistently raised in the CPF, the PAD, and the ICR: high poverty rates, unaffordability of services for the majority of the population, and underserved populations (especially those living beyond five km of services). The ICR did not indicate whether services were provided free of charge either during the project. The ICR Main Contributor subsequently stated on 9-13-21 that they were, but there was a lack of certainty whether maternal and child health services remained free of charge post-project. This information may help explain why trends in the undertaking of four ANC visits declined during implementation.

Quality of Lessons

Lessons presented in the ICR flowed from its analysis and were noteworthy and relevant for working in low capacity, fragile states.

Internal Consistency

The ICR contained a few inconsistencies: between the original baselines and targets presented in the PAD and those presented in the ICR; among data presented in the efficacy section of the ICR (II.B) and Annex 1 (Results Framework); and between the PAD and ICR on whether an assessment of procurement capacity was undertaken during appraisal.

a. Quality of ICR Rating
Modest