Document of

The World Bank

FOR OFFICIAL USE ONLY

Report No: ICR00006015

IMPLEMENTATION COMPLETION AND RESULTS REPORT

TF-18986

ON A GRANT

IN THE AMOUNT OF US$8.5 MILLION

TO

THE PALESTINE LIBERATION ORGANIZATION

(FOR THE BENEFIT OF THE PALESTINIAN AUTHORITY)

FOR THE

Health System Resiliency Strengthening Project

February 28, 2023

Health, Nutrition & Population Global Practice
Middle East And North Africa Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective {Feb 09, 2023})

Currency Unit =	Israeli New Sheqalim (ILS)
ILS 3.49 =	US$1
US$0.29 =	ILS 1

FISCAL YEAR
July 1 - June 30

Regional Vice President:	Ferid Belhaj
Country Director:	Stefan W. Emblad
Regional Director:	Keiko Miwa
Practice Manager:	Rekha Menon
Task Team Leader(s):	Samira Ahmed Hillis, Denizhan Duran
ICR Main Contributor:	Sherin Varkey[1]

=

[1] This ICR report was prepared by Sherin Varkey (Senior Health Specialist), with support from Mariam Mohamed Samir Amin Hamza (Consultant) and Elizabeth Mziray (Senior Operations Officer). The authors would like to express gratitude to Mohammad Ali Jaber (Financial Management Specialist), Zeyad Abu-Hassanein (Senior Environmental Specialist), Najm-Ul-Sahr Ata-Ullah (Senior Social Development Specialist), Ala' Turshan (Procurement Specialist), Samira Ahmed Hillis (Program Leader), Mariam William Guirguis (Operations Analyst), Fernando Xavier Montenegro Torres (Senior Economist) and the West Bank and Gaza Country Management Unit for their valuable inputs for this ICR report. Minh Thi Hoang Trinh (Program Assistant) and A. Juliana Williams (Team Member) provided administrative and editorial support. The authors would also like to thank Rekha Menon (Practice Manager), Avril Dawn Kaplan (Senior Health Specialist), Naoko Ohno (Senior Operations Officer), Rajagopal S. Iyer, Suzana Abbott, and Virginia Jackson (Consultants) for their guidance.

ABBREVIATIONS AND ACRONYMS

AS	Assistance Strategy for the West Bank and Gaza
CPD	Continuous Professional Development
DALY	Disability-adjusted Life Year
DFID	Department for International Development
DRGs	Diagnostic Related Groups
EU	European Union
FCDO	Foreign, Commonwealth and Development Office
FCV	Fragile, Conflict and Violent
FM	Financial Management
GDHI	General Directorate of Health Insurance
GDP	Gross Domestic Product
GHI	Government Health Insurance
GHI MIS	Government Health Insurance Management System
GPC	General Personnel Council
GRM	Grievance Redress Mechanism
HH	Hebron Hospital
HQ	Headquarters
HRH	Human Resources for Health
HSRSP	Health System Resiliency and Strengthening Project
ICD-10	International Classification of Diseases
ICR	Implementation Completion and Results
ICU	Intensive Care Unit
IMF	International Monetary Fund
IR	Intermediate Results
IRI	Intermediate Results Indicator
IT	Information Technology
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MENA	Middle East and North Africa
MIS	Management Information System
MMR	Maternal Mortality Ratio
MOF	Ministry of Finance
MOH	Ministry of Health
MOL	Ministry of Labor
MTF	Mid-term Review
NCDs	Non-Communicable Diseases
NDP	National Development Plan
NGO	Non-governmental organization
NICUs	Neonatal Intensive Care Units
NPR	National Price Reference
OMR	Outside Medical Referrals
OOP	Out-of-Pocket
OP	Operational Policy

OPD	Outpatient Department
PA	Palestinian Authority
PAD	Project Appraisal Document
PDO	Project Development Objective
PER	Public Expenditure Review
PHC	Primary Health Care
PHCC	Primary Health Care Center
PHCP	Palestinian Health Capacity Project
PMC	Palestine Medical Complex
PMU	Project Management Unit
PNIPH	Palestinian National Institute of Public Health
RDNA	Rapid Damage and Needs Assessment
RF	Results Framework
SC	Steering Committee
SPU	Service Purchase Unit
STEP	Systematic Tracking of Exchanges in Procurement
TA	Technical Assistance
TF	Trust Fund
TOC	Theory of Change
TTLs	Task Team Leaders
U5MR	Under-5 Mortality Rate
UHC	Universal Health Coverage
UN	United Nations
UNRWA	United Nations Relief and Works Agency
USAID	United States Agency for International Development
WB	World Bank
WB&G	West Bank and Gaza
WBG	World Bank Group
WHO	World Health Organization

TABLE OF CONTENTS

DATA SHEET

BASIC INFORMATION

Product Information

Project ID	Project Name
P150481	Health System Resiliency Strengthening Project
Country	**Financing Instrument**
West Bank and Gaza	Investment Project Financing
Original EA Category	**Revised EA Category**
Not Required (C)	Not Required (C)

Organizations

Borrower	Implementing Agency
Ministry of Finance	Ministry of Health

Project Development Objective (PDO)

Original PDO

The project PDO is to support the Palestinian Authority in securing continuity in healthcare service delivery and building its resilience to withstand future surge in demand for effective healthcare coverage.

FINANCING

	Original Amount (US$)	Revised Amount (US$)	Actual Disbursed (US$)
World Bank Financing			
TF-18986	8,500,000	8,500,000	8,462,235
Total	**8,500,000**	**8,500,000**	**8,462,235**
Non-World Bank Financing			
Borrower/Recipient	0	0	0
Total	**0**	**0**	**0**
Total Project Cost	**8,500,000**	**8,500,000**	**8,462,235**

KEY DATES

Approval	Effectiveness	MTR Review	Original Closing	Actual Closing
21-Jan-2015	16-Feb-2015	17-Jul-2017	30-Jun-2020	31-May-2022

RESTRUCTURING AND/OR ADDITIONAL FINANCING

Date(s)	Amount Disbursed (US$M)	Key Revisions
07-Sep-2015	2.75	
17-Jan-2018	4.03	Change in Results Framework
13-Jan-2020	5.44	Change in Results Framework Change in Loan Closing Date(s) Change in Implementation Schedule
27-Oct-2021	7.11	Change in Loan Closing Date(s)

KEY RATINGS

Outcome	Bank Performance	M&E Quality
Satisfactory	Satisfactory	Modest

RATINGS OF PROJECT PERFORMANCE IN ISRs

No.	Date ISR Archived	DO Rating	IP Rating	Actual Disbursements (US$M)
01	27-Mar-2015	Satisfactory	Satisfactory	2.75
02	10-Sep-2015	Satisfactory	Satisfactory	2.75
03	29-Jan-2016	Satisfactory	Satisfactory	2.75
04	08-Jul-2016	Satisfactory	Satisfactory	3.02
05	05-Dec-2016	Satisfactory	Satisfactory	3.88
06	19-Apr-2017	Satisfactory	Satisfactory	3.89
07	02-Oct-2017	Satisfactory	Satisfactory	3.97
08	26-Jan-2018	Satisfactory	Satisfactory	4.03
09	29-Mar-2018	Satisfactory	Satisfactory	4.10
10	29-Jun-2018	Satisfactory	Satisfactory	4.15
11	01-Nov-2018	Moderately Satisfactory	Moderately Satisfactory	4.93
12	18-Dec-2018	Moderately Satisfactory	Moderately Satisfactory	4.93
13	22-Mar-2019	Moderately Unsatisfactory	Moderately Unsatisfactory	5.07
14	11-Sep-2019	Moderately Satisfactory	Moderately Satisfactory	5.33
15	18-Mar-2020	Moderately Satisfactory	Moderately Satisfactory	5.49
16	05-Aug-2020	Moderately Satisfactory	Moderately Satisfactory	5.96
17	17-Feb-2021	Moderately Satisfactory	Moderately Satisfactory	6.43
18	03-Oct-2021	Moderately Satisfactory	Moderately Satisfactory	7.11

SECTORS AND THEMES

Sectors

Major Sector/Sector	(%)
Health	**153**
Public Administration - Health	53
Health	100

Themes

Major Theme/ Theme (Level 2)/ Theme (Level 3)	(%)
Social Development and Protection	**100**
Fragility, Conflict and Violence	100
Human Development and Gender	**0**
Disease Control	0
Non-communicable diseases	30
Pandemic Response	1
Health Systems and Policies	71
Health System Strengthening	60
Health Service Delivery	5
Adolescent Health	3
Child Health	3

ADM STAFF

Role	At Approval	At ICR
Regional Vice President:	Gerard A. Byam	Ferid Belhaj
Country Director:	Steen Lau Jorgensen	Stefan W. Emblad
Director:	Timothy Grant Evans	Keiko Miwa
Practice Manager:	Enis Baris	Rekha Menon
Task Team Leader(s):	Samira Ahmed Hillis	Samira Ahmed Hillis, Denizhan Duran

ICR Contributing Author:	Sherin Varkey

I. PROJECT CONTEXT AND DEVELOPMENT OBJECTIVES

A. CONTEXT AT APPRAISAL

Context

1. **At project appraisal in 2015, the Palestinian economy had slipped into a recession.** High levels of unemployment, rising poverty and vulnerability as well as economic restrictions, in particular restrictions on trade, movement and access, posed binding constraints to economic and social progress. The national poverty rate, measured by households living below the national poverty line[2] was 25.8 percent in 2011. (18 percent in the West Bank and more than double, 39 percent, in Gaza).

2. **Despite progress in improving maternal and child mortality, West Bank and Gaza (WB&G) was still far from achieving the Millennium Development Goals (MDG) targets, and the gains were threatened by the emergency situation and financial crisis.** WB&G was experiencing an epidemiological transition with a rising burden of non-communicable diseases (NCDs). NCDs, mainly cardiovascular diseases, diabetes, and cancers, represented a substantial financial burden for the sector, as they were costly to treat and required more patient interaction with the health system. The health service delivery model was fragmented and based on a complex amalgam of service providers with prevailing inequities between WB&G**.** The public sector, comprised of the Ministry of Health (MOH) and the Palestinian Military Medical Services (PMMS), was the main service provider. The MOH had a network of 460 primary healthcare centers (PHCCs, 404 in the West Bank and 54 in Gaza in 2012), and 25 hospitals (12 in the West Bank and 13 in Gaza). Non-governmental Organizations (NGOs) had historically played an important role in service delivery, especially in providing tertiary, ambulatory and rehabilitative care services, but in the decade preceding the project, as NGO expenditures on health declined, public expenditures had increased to fill the gap. The private sector was limited and mainly provided maternal and child health services. The United Nations Relief and Works Agency (UNRWA) had been playing a critical role in providing services to registered refugee populations, mainly through primary healthcare clinics. The hospitals and health centers in the Palestinian territories suffered from a lack of new technologies, outdated equipment, and a shortage of health personnel.

3. **The escalation of violence in Gaza in 2014 had several negative consequences on the health of the population in Gaza and the ability of the health system to continually deliver health care services.** The escalation of violence which occurred in July and August of 2014 in Gaza had resulted in an estimated 2,145 deaths and 11,231 injuries and had placed significant pressure on an already weak health system[3]**.** In the aftermath of the crisis, an enormous set of needs had emerged due to health sector damages and losses. The funding gaps and depleted capacity had led to serious disruptions in the healthcare system due to significant power outages and the lack of fuel, which negatively impacted the daily operations of healthcare facilities. The lack of sanitation, sterilization, and hygiene at hospitals had severe consequences for public health and had increased the risk of infections and outbreaks of communicable diseases. Prior to the conflict in 2014, the health sector was already in severe arrears, and had reached US$193.2 million in 2013 (excluding salaries) and corresponded to more than half (54 percent) of all the MOH's expenditures. In spite of the relatively high levels of total health expenditure (10.6 percent of Gross Domestic Product (GDP) in 2013 and 10 percent of GDP in 2014)[4],

[3] WB, HSRSP, Project Appraisal Document, West Bank and Gaza, https://documents1.worldbank.org/curated/en/228791468119057716/text/PAD10690P15048010Box385399B00OUO090.txt
[4] https://www.pcbs.gov.ps/statisticsIndicatorsTables.aspx?lang=en&table_id=1303

household Out-of-Pocket (OOP) expenditure accounted for 39.8 percent of the total health expenditure, which put poor households at great risk of impoverishment due to health spending. Public health spending had doubled over the previous decade and relied heavily on unpredictable donor funding. Additionally, the fragmented health financing model along with a growing imbalance between Government Health Insurance (GHI) revenues and public expenditures on health was also undermining the sustainability of the health sector's financing.

4. **Expenditures on Outside Medical Referrals (OMR) had risen sharply over the previous decade.** The rapid population growth and demographic transition had increased the demand for public services, including health care. The continuing restrictions on movement and access, along with the escalations in conflict had weakened the health system and its ability to deliver quality health care services. As a result, the majority of chronic diseases were managed by a complex and expensive system of OMR to private hospitals in WB&G, within the East Jerusalem Hospital Network and other private hospitals in Israel, Jordan and Egypt. These referrals, which catered to all Palestinians seeking care in the public sector regardless of their insurance status with the Government bearing the cost of referrals, accounted for about 40 percent of non-salary government health spending. The number of referrals had consequently increased from 8,123 in 2000 to 61,635 in 2013. The corresponding expenditure has also increased significantly from about US$8 million in 2000 to as much as US$144 million in 2013.[5] There were multiple reasons for the increase in the number of referrals outside the public sector, including a lack of resources and capacity within the MOH facilities (including a lack of pharmaceuticals, inadequate equipment, and an insufficient number of medical personnel), the increase in the prevalence of NCDs, which required long-term and expensive treatments, and the inefficiency of service delivery. The degradation in health infrastructure and the increase in health needs arising from the crisis had put additional pressures on the medical referral system that was already in severe debt and was inequitable and unsustainable. There was an urgent need for immediate cost-cutting measures to improve efficiency in the referral system without compromising access to needed and quality health services.

5. **At the time the project was prepared in 2015, the Palestinian health sector was at a critical crossroad and provided MOH and the Ministry of Finance (MOF) with a strong motivation to address immediate needs and address the fiscal pressures faced by the health sector.** The Palestinian Authority (PA) was committed to re-define changes in the financing, stewardship, and provision roles at the MOH, strengthening the first two roles and gaining efficiency in the third by taking into account the relative comparative advantages of the private healthcare providers at the secondary and tertiary levels through the development of partnership arrangements and improvements in contracting out of healthcare services.

6. **The Health System Resiliency Strengthening Project (HSRSP) offered timely support to mitigate the immediate impact of the situation on the health sector and take actions for sustainability and long-term resilience, while being consistent with the Palestinian National Development Plan (2014-2016) and the World Bank Group's Assistance Strategy for WB&G.** The emergency operation, with a total financing of US$8.5 million over a five year period, was planned to: (i) address the urgent health financing needs which had markedly increased as a result of the recent conflict; and (ii) help contain the ever-increasing gap between revenues and expenditures in the health sector by rationalizing OMRs, which were the most expensive items in the health budget as well as the main source of fiscal deficit. The project aligned with the World Bank Group's Assistance Strategy for the WB&G (AS) for FY15–16 (Report no. R2014-0231/1), and the World Bank's (WB) 2013–2018 Health, Nutrition and Population Strategy for the Middle East and North Africa (MENA) region. [6] In line with the first pillar of the AS, the project aimed to support the PA's efforts to strengthen

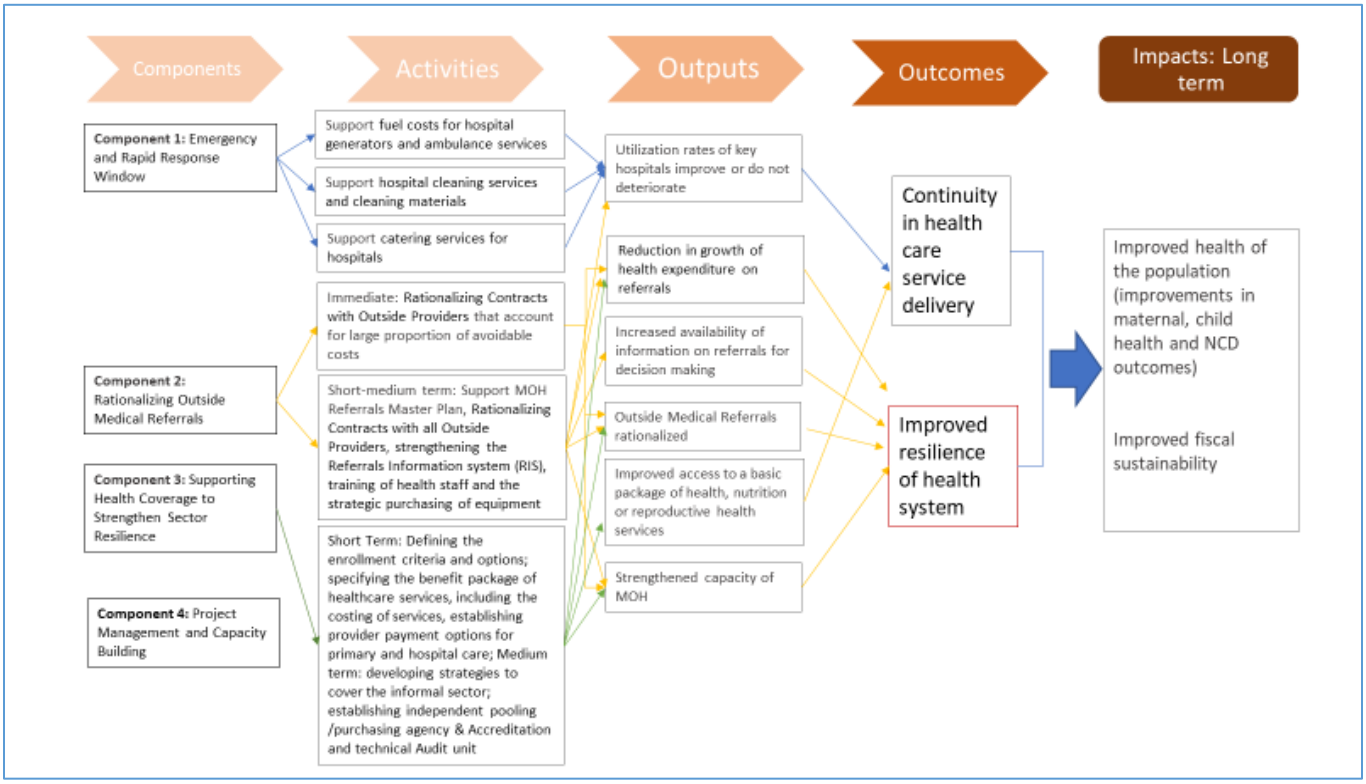
[5] WB. Technical Assistance on Health Financing; Report on the analysis of referral data. June 2013.
[6] Fairness and Accountability: Engaging in Health Systems in the Middle East and North Africa, The Word Bank Health, Nutrition and Population Sector Strategy for MENA (2013-2018); link: www.worldbank.org/mena/healthstrategy

institutions to efficiently manage public finances and ensure services to citizens. It was also consistent with the World Bank Group's (WBG) twin goals of ending extreme poverty and boosting shared prosperity and with the MENA Regional Strategy, supporting the pillars of ensuring economic and social inclusion and strengthening governance.

Theory of Change (Results Chain)

7. **For this Implementation Completion and Results (ICR) Report, a Theory of Change (TOC) (Figure 1) was developed** ex-post and retrofitted to the original project, based on the Project Development Objective (PDO), component descriptions, activities, and the Results Framework (RF) as described in the Project Appraisal Document (PAD). The project specifically aimed to secure continuity in healthcare service delivery through addressing immediate needs of hospitals, while also implementing cross cutting measures to improve health system resilience. The project defined continuity in health care delivery as the sustenance of utilization levels of the major public sector hospitals in WB&G. This included support for non-medical recurrent costs of operating and maintaining health service facilities in the major hospitals of Gaza (Shifa hospital, Nasser Hospital and European Gaza) and support for hospital services in the three major hospitals (Shifa hospital in Gaza, Rafedia hospital in North of West Bank and Alia hospital in south of West bank) through strategic procurement of equipment. The project RF measured occupancy rates of these hospitals as any disruption of service delivery would be reflected in hospital utilization rates. The project also focused on building resilience by improving fiscal sustainability of the sector through reduction in growth of OMR expenditures by improving local public hospital services, enhanced coverage and cross-cutting efficiency measures along with reduction in the inequity in referral costs between WB&G.

Figure 1: Theory of Change



8. The following assumptions were critical for the project to deliver on its outcomes:

- The MOH was able to continue to support operational costs for public health facilities (human resources, drugs and consumables, maintenance etc.) to complement the support provided by the WB.
- The PA and MOH remained committed to implement reforms to reduce fiscal pressure and rationalize health sector expenditures.
- The MOH and private hospitals were willing to implement systemic changes supported by the project.
- The increase in health expenditures because of increasing costs, advances in therapeutic procedures and change in disease burden did not offset the efficiency gains brought about by project interventions.

Project Development Objectives (PDOs)

9. The PDO was to support the Palestinian Authority in securing continuity in healthcare service delivery and building its resilience to withstand future surge in demand for effective healthcare coverage.

Key Expected Outcomes and Outcome Indicators

10. The following indicators were used to measure the achievement of the PDO:

- Utilization rates (out-patient, emergency and obstetrics) in the hospitals of Shifa and Rafedia do not deteriorate or improve up to 10 percent compared to a baseline end-September 2014[7].
- The total cost of referrals reduced by 15 percent (by end of the project) relative to baseline.
- Gap in geographic equity for referral cost (between the WB&G) reduced by 80 percent relative to baseline.

Components

11. The project was financed by a Special Financing Grant from the WB Trust Fund (TF) for Gaza and West Bank in an amount of US$8.5 million and consisted of the following four components:

- **Component 1: Emergency and Rapid Response Window (actual at closing: US$2.07 million)**
  This component was designed to ensure the continuation of basic healthcare services at minimum acceptable levels and avoid such services from experiencing systemic collapse in the aftermath of the Gaza conflict in 2014, and covered select non-medical recurrent costs of operating and maintaining health service facilities in the major hospitals of Gaza, including(i) fuel costs for hospital generators and ambulance services; (ii) hospital cleaning services and cleaning materials; and (iii) catering services for hospitals.

- **Component 2: Rationalizing Outside Medical Referrals (actual at closing: US$3.66 million)**
  This component aimed to support the PA to institute immediate cost-cutting measures in order to improve efficiency in the current system without compromising access to needed and quality health services and included: (i) supporting the review and renegotiations of contracts and other arrangements between the MOH and private health service providers for provision of health services including undertaking a costing study; (ii)

[7] These were the main and largest public sector hospitals in West Bank and Gaza. Shifa hospital is located in Gaza and Rafedia hospital is located in the northern part of the West Bank.

developing a guidance note for medical referrals setting forth rules for the treatment and referral for selected health conditions; (iii) strengthening medical referral information system and developing a medical referrals master plan; and (iv) strengthening public provision of select health services through strategic procurement of critical medical equipment.

- **Component 3: Supporting Health Coverage to Strengthen Sector Resilience (actual at closing: US$1.78 million)**
  This component covered activities designed to support the establishment of national health coverage scheme including considering options for separating the Ministry of Health's roles in financing, service provision and regulation of healthcare and included: (i) defining the enrollment criteria and options; (ii) specifying the benefit package of healthcare services, including the costing of services as well as establishing criteria to include and exclude services in the package; (iii) establishing provider payment options for primary and hospital care; (iv) developing strategies for covering the informal sector; and (v) establishing an independent pooling and purchasing agency to separate financing, pooling, and purchasing functions from service provision.

- **Component 4: Project Management and Capacity Building (actual at closing: US$0.95 million)**
  This component financed costs for strengthening the capacity of the MOH in Project management, monitoring and evaluation through provision of consultants' services, including audit, training and financing of the Operating costs.

B. SIGNIFICANT CHANGES DURING IMPLEMENTATION

12. The project underwent four restructurings during implementation and one re-allocation of funds from Component 3 to Component 2 to strengthen the MOH COVID-19 case management capacity (Table 1).

Revised PDOs and Outcome Targets

13. The PDO was not revised during project implementation.

Revised PDO Indicators

14. Under the second restructuring (approved on January 17, 2018), the following PDO indicators were revised:

- "Utilization rates (out-patient, emergency and obstetrics) in the hospitals of Shifa and Rafedia do not deteriorate or improve up to 10 percent compared to a baseline end-September 2014" was revised to include Alia Hospital**,** as the project supported Alia hospital with strategic purchasing of equipment. The new indicator was, "Utilization rates (out-patient, emergency and obstetrics) in the hospitals of Shifa, Rafedia and Alia do not deteriorate or improve up to 10 percent compared to a baseline end-September 2014. These hospitals were the largest and main public sector hospitals in West Bank (Rafedia Hospital in the north, Alia hospital in the south) and Gaza (Shifa Hospital).
- "The total cost of referrals reduced by 15% by end of the project" was revised as follows: "average annual growth of total expenditure in OMRs of a four-year period lower than the proposed baseline which is the period 2012-2015 (<13.19%)".

15. Under the third restructuring (approved on January 13, 2020), the following PDO indicators were revised:

- The "average annual growth of total expenditure in OMRs of a four-year period lower than the proposed baseline which is the period of 2012-2015 (<13.19%)" was revised as follows "average annual growth of total expenditure in OMRs of three-year period lower than the proposed baseline which is the period 2013-2015 (<16.59%)".
- The baseline figures for "Utilization rates (out-patient, emergency and obstetrics) in the hospitals of Shifa, Rafedia and Alia do not deteriorate or improve up to 10 percent compared to a baseline end-September 2014" have changed based on the project's assessment. Baseline numbers of outpatient department visits at Shifa and Rafedia hospitals were modified as follows: Shifa OPD: 180,000 - Current baseline (578,646 included all outpatient department visits for all hospitals in Gaza, not only Shifa hospital in 2014), Rafedia OPD: 60,000 - Current baseline (163,262 included both cases from the outpatient and emergency medicine departments at Rafedia in 2014). These new baselines were captured in the ISR sequence no. 15, March 2020, following the restructuring.

Revised Components

16. The components were not revised during project implementation.

Other Changes

17. The project was subject to the following changes during the life of the project:

Table 1: Project Changes and Rationales

Type of Change	Date	Purpose	Rationale
First Restructuring	September 7, 2015	Addition of US$1.25 million to the project cost	During project negotiations, it was agreed that the total project cost would be US$8,500,000. However, the WB&G TF (administered by the WB and the source of project financing) only had an available balance of US$7,250,000. Hence, the remaining balance of US$1,250,000 was added to the project through restructuring once the additional funds became available.
Second Restructuring	January 17, 2018	Changes to the RF	Based on the Mid-term Review (MTR), it was concluded that a few indicators and their targets needed to be revised to meet its development objective; and align with the revised scope of some of the activities. Accordingly, the end targets for two PDO indicators were revised. Additionally, one intermediate results indicator (IRI) and end targets for two IRIs were also revised.
Third Restructuring	January 13, 2020	Extending the project Closing Date until December 31, 2021; and changes to the RF	The Closing Date extension from June 30, 2020 until December 31, 2021, was required to enable the MOH to complete the implementation of project activities. The following revisions were made to the RF: (i) revising a PDO indicator, (ii) correcting a typographical error; and (iii) adding three IRIs to (a) measure the impact of training of health personnel on conditions leading to OMRs; and (b) capture how investments in digital tools facilitate and enhance intermediary outcomes of introducing the Family Health Model as part of the Universal Health Coverage (UHC)

			reforms. The MOH requested the addition of the three new IRIs, bringing the total to 17 IRIs.
Re-allocation of funds	March 2020	Re-allocation of US$800,000 from Component 3 to Component 2	Per the MOH request in March 2020, the project re-allocated US$800,000 from Component 3 to Component 2 to strengthen the MOH COVID-19 case management capacity. Support included: Intensive Care Unit (ICU) ventilators, monitors, suction machines, personal protective equipment, swabs, medical consumables, defibrillators, autoclaves, emergency beds, diagnostic kits and other supplies.
Fourth Restructuring	October 27, 2021	Extending the project Closing Date until May 31, 2022	The 2nd extension of the Closing Date was required to enable the MOH to complete the implementation of project activities. Using excess budget from the different components, high priority inputs aligned with the PDO were included, such as procurement of oncology medications and cardiac catheterization consumables, maintenance of PMC IT systems, MOH data centre and GHIMIS systems.

Rationale for Changes and Their Implication on the Original Theory of Change

18. **As explained in Table 1, changes were made to revise certain indicators and targets to align them with the context and revised scope of activities.** The closing date was also extended twice to enable the MOH to complete the implementation of project activities. The above-referenced changes remained well aligned to the achievement of the PDOs.

II. OUTCOME

A. RELEVANCE OF PDOs

Assessment of Relevance of PDOs and Rating

19. **The PDO continues to be very relevant in the current context.** The PDO is aligned with the WBG AS for FY22-25 (Report No. 156451-GZ) and the WBG's enlarged MENA Regional Strategy (2019). The project directly contributed to the first focus area of the AS on achieving better human development outcomes by focusing prioritizing investments in health to promote human capital, particularly in a Fragility, Conflict and Violence (FCV) context and on achieving better human development outcomes and strengthening resiliency across the health system[8]. It is also aligned with the WBG's enlarged MENA Regional Strategy (March 2019), which emphasizes human capital development as well as the WBG Goals to end extreme poverty and promote shared prosperity. The project also aligns with the WB Health, Nutrition and Population (HNP) strategy, which features the strengthening of well-organized and sustainable health systems as a key strategic direction.[9]

[8] https://documents1.worldbank.org/curated/en/627701619710823261/pdf/West-Bank-and-Gaza-Country-Assistance-Strategy-for-the-Period-FY22-25.pdf
[9] *https://documents1.worldbank.org/curated/en/102281468140385647/pdf/409280PAPER0He101OFFICIAL0USE0ONLY1.pdf*

20. **The PDO is aligned with the MOH's continued efforts to achieve UHC.** Article 2(5) of the Public Health Law states that the MOH is committed to providing health insurance to citizens within the available means[10]. The PDO remains aligned with the Palestinian National Development Plan 2021-2023 (National Policy #27 "Providing Quality Health Care Services for All" and the National Policy #28 "Improving Citizens' Health and Well-Being") which centers on developing human capital as part of its core strategy; and is relevant to MOH's current National Health Sector Strategy 2021-2023, which envisions the "comprehensive, integrated high-quality health system towards sustainable enhancement of health status, effective management and responsiveness to crisis and health needs". Fiscal pressures due to rising health expenditures continue to remain a high priority issue for the government, which was further emphasized by the International Monetary Fund (IMF) report[11] to the Ad Hoc Liaison Committee[12] in 2022 highlighting the need to implement spending reform centered on health referrals.

21. **Based on this assessment, the relevance of the PDO is rated High.**

[10] Public Health Law No. 20 of 2004, promulgated in Gaza city on 27 December 2004: *http://www.hdip.org/public%20health%20law%20English.pdf*.

[11] IMF. Report to the Ad Hoc Liaison Committee. West Bank and Gaza. April 26, 2022.

[12] The Ad Hoc Liaison Committee (AHLC) serves as the principal policy-level coordination mechanism for development assistance to the occupied Palestinian territory (oPt). The AHLC is chaired by Norway and co-sponsored by the EU and the US. In addition, the United Nations participates together with the World Bank and the International Monetary Fund (IMF). The AHLC seeks to promote dialogue between donors, the Palestinian Authority and the Government of Israel. (Source: https://unsco.unmissions.org/ahlc-socioeconomic-reports)

B. ACHIEVEMENT OF PDOs (EFFICACY)

22. **The PDO statement was clear and can be broken down into two objectives, which will be assessed separately:** (i) securing continuity in health care service delivery **(PDO 1);** and (ii) building resilience of health care service delivery to withstand future surges in demand for effective health care coverage **(PDO 2)**. The continuity of health care service delivery was defined as the sustenance (or no deterioration) or improvement in hospital utilization rates (measured in terms of occupancy - out-patient, emergency and obstetrics) for the largest public sector hospitals in WB&G. The project defined resilience as the ability of the health system to improve fiscal sustainability through reduction in growth of OMR expenditures by improving local public hospital services, enhanced coverage and cross-cutting efficiency measures along with reduction in the inequity in referral costs between WB&G. The project also tracked the details of results, targets and achievements are provided in Annex 1.

23. **Split rating was not used as the changes in the restructuring did not amount to a change in scope of the project.** The assessment of efficacy did not warrant the use of split rating as the overall PDO remained the same and the scope of PDO indicators either expanded or remained the same. For first PDO indicator, the scope was expanded by adding an additional hospital to the existing two hospitals whose performance was being tracked. For the second PDO indicator, the scope remained the same in terms of monitoring the reduction in cost of referrals, but the indicator was revised twice to clarify the target and make it more realistic. Initially, it was changed from total cost of referrals reduced relative to baseline to average annual growth of total expenditure in OMRs of a four-year period lower than the proposed baseline value. This was subsequently changed to average annual growth of total expenditure in OMRs of a three-year period lower than the proposed baseline value. This revised PDO indicator was deemed to be more realistic to the context by the MOH and WB teams). The reasons for these changes have been explained in the section on rationale for changes (Para 17 above).

Assessment of Achievement of Each Objective/Outcome

24. **PDO 1 - Securing continuity in health care service delivery.** The project supported continuity and prevented the collapse of hospital services in Gaza in the aftermath of the conflict in 2014, through the provision of emergency support for non-medical costs for maintaining hospital operations. It also invested in enhancing the capacity of large public sector hospitals (Shifa hospital in Gaza, Rafedia hospital in northern part of West Bank and Alia hospital in southern part of West bank) through strategic procurement of equipment for improving health care service delivery. Any change or disruption in services was expected to be reflected in the utilization rates of these major hospitals. The utilization rates for these hospitals were measured in terms of occupancy (out-patient, emergency and obstetrics) for the hospitals in WB&G (PDO indicator) and in terms of overall occupancy for the hospitals in Gaza who received emergency support (IRI).

25. **Under Component 1 (Emergency and Rapid Response Window), the project ensured continued service delivery in health facilities in Gaza through emergency support for non-medical expenditures.** This component provided support to MOH to deliver essential health services through the financing of recurrent non-medical expenditures of MOH and health facilities and offered the opportunity to meet immediate and urgent needs. It covered the non-medical costs of operating and maintaining MOH facilities, which was the major gap following the Gaza conflict in 2021, including fuel costs for hospital generators and ambulance services, and hospital cleaning services and materials. The project secured procurement of cleaning materials for the continuity of cleaning services provision in the MOH facilities in Gaza especially at the surgical, intensive care and neonatal intensive care units to a total of 175 health facilities (91 facilities in 2014 and 84 facilities in 2015). Post-intervention assessment in August 2016 showed

substantial reduction in the accumulation of medical waste in critical units. This support helped in preventing outbreaks of communicable disease and increased patient satisfaction levels. A satisfaction level of 85% was registered among MOH employees and patients in 2015 versus 15% during the summer of 2014[13].

26. **The overall occupancy of hospitals in Gaza receiving emergency support registered a consistent increase.** The measure of occupancy in the three largest public sector hospitals in Gaza (Shifa, Nasser and European Gaza Hospitals) was used as a proxy measure for the impact of the project on continuity of healthcare services. Overall occupancy showed a consistently upward trend and was expected to fully achieve the target. However, starting in 2020, the rates decreased due to the disruptions and challenges caused by the COVID-19 pandemic. There was also a relative increase in service utilization following the escalation of violence in Gaza in May 2021. The summary (average) achievement for 2019 (pre-COVID-19) for all three hospitals was 111 percent (i.e., the target was surpassed), while the summary (average) achievement at the end of the project (2021) was 78 percent (i.e., the target was partially achieved).

27. **Under Component 2 (Rationalizing Outside Medical Referrals), the project enhanced the capacity of the main public sector hospitals through strategic procurement of equipment.** The equipment not only helped to improve service delivery (PDO 1) in the public hospitals, but also contributed to the reduction in referrals and thus contributed towards reducing OMR expenditures and improve health system resilience[14] (PDO 2). The project supported the equipping of the six newly built operating rooms at Alia/Hebron Hospital (HH) in order to increase the number of surgical operations (annual number of major surgeries in Alia hospital increased from 5,800 in 2017 to 7,349 in 2019) and support the reduction in the number of OMRs caused by the lack of availability of equipment. It also provided funding for an Ultrasound Doppler machine to establish a complete unit for vascular surgery in the Southern area of the West Bank. Since its installation in March 2017 through May 2022, the machine was used to perform 12,252 diagnostic and intra-operative surgeries and thus avoided OMRs of cases requiring such surgeries leading to savings of over US$ 18.7 million USD. The project also supported the procurement of a sterilizer for the Central Sterile Service Department at Beit Jala Hospital, which serves a large population in the southern governorate. The supply of neonatal medical equipment to four Neonatal Intensive Care Units (NICUs) (Palestine Medical Complex, Jenin, Rafedia and Alia hospital) and training of staff helped improve the availability of neonatal care services. The project tracked the progress in this area through the IR indicator “Health facilities constructed, renovated, and/or equipped”, for which the target was fully achieved.

28. The table below summarizes the extent of achievement the PDO and intermediate level indicator targets relevant to PDO 1. **Based on the discussion above and the table below, PDO 1 is rated as achieved**.

Table 2: Achievement of Indicator Targets for PDO 1

Level	Indicator	Extent of Achievement
IR	Utilization rates (overall occupancy) in the hospitals of Shifa, Nasser Hospital and European Gaza hospital improve by up to 10% or retain the same ratio compared to a baseline end September	**Target partially achieved (78%)** The summary (average) achievement for 2019 (pre-COVID-19) for all three hospitals was 111 percent, while the summary (average) achievement at the end

[13] MOH, West Bank and Gaza, Assessment Report of Component One in Gaza, August 2016

[14] The project defined resilience as the ability of the health system to improve fiscal sustainability through reduction in growth of OMR expenditures by improving local public hospital services, enhanced coverage and cross-cutting efficiency measures along with reduction in the inequity in referral costs between West Bank and Gaza.

	2014	of the project (2021) was 78 percent. Overall, for 2021 the utilization figures were affected by the COVID-19 pandemic; Shifa hospital had an achievement of 98%, while Nasser hospital had an achievement of 84% and European Gaza hospital had an achievement of 53%.
IR	Health facilities constructed, renovated, and/or equipped	**Target achieved (100%)** Two facilities (Alia Hospital and Beit Jala Hospital) were equipped against a target of 2 hospitals
PDO	Utilization rates (out-patient, emergency and obstetrics) in the hospitals of Shifa, Rafedia and Alia Hospital do not deteriorate or improve up to 10% compared to a baseline end-September, 2014 (proxy for the impact of the project on access to health services)	**Target surpassed (104%)** The summary (average) achievement for 2019 (pre-COVID-19) for all the measures was 112 percent, while the summary (average) achievement at the end of the project (2021) was 104 percent.

29. **PDO 2 - Building resilience of health care service delivery to withstand future surge in demand for effective health care coverage.** The project built resilience[15] in health care service delivery by strengthening the fiscal health of the health system by rationalizing OMRs, which was the main reason for payment arrears and accumulated debt of MOH. In addition, it also supported improvements in health coverage and supported actions to enable the separation of health financing functions, with a priority given to the establishment of a strategic purchasing entity and building its capacity to harmonize and standardize the purchasing of health care services to improve quality, while also containing the rate of growth of public health sector expenditures.

30. **Under Component 2, the project supported the PA in rationalizing OMRs and instituting immediate cost-cutting measures to improve efficiency in the system.** Project achievements included:

- **Developing guidance notes for referrals.** Under the project support, the Service Purchase Unit (SPU) developed and operationalized referral protocols and procedures for nine costliest conditions (against a target of 10).
- **Strategic procurement of equipment (discussed under PDO 1).** The provision of equipment helped improve the services available in the large public sector hospitals in WB&G and helped in reducing referrals.
- **Capacity building for specialty skills.** The project supported the training of 600 health staff at four priority MOH hospitals (HH, Jenin, Rafedia and the PMC) on topics such as pediatric pulmonology and neonatology, which were directly linked to reducing referrals. Twelve specialists from West Bank hospitals received remote training from the Health Care Accreditation Council in Jordan on Quality Coordination and Infection Prevention Control.
- **Referral Master Plan.** A Referral Master Plan was developed and endorsed by the Cabinet in September 2016 after extensive consultations within the government and other stakeholders. The master plan is currently being used as a key reference document by the MOH and all the stakeholders involved.
- **Government Health Insurance Management System (GHI MIS):** The project supported the Business Process Analysis, technical assistance, software development, and hardware procurement for establishment of the GHI

[15] The project defined resilience as the ability of the health system to improve fiscal sustainability through reduction in growth of OMR expenditures by improving local public hospital services, enhanced coverage and cross-cutting efficiency measures along with reduction in the inequity in referral costs between West Bank and Gaza.

MIS. The system transformed the process from a registry to a system; provided linkages and integration with other systems at MOH, such as Avicenna, Health Information System (HIS), and Electronic-referral (E-referral)'; and provided linkages with other ministries and government entities, such as the Ministry of Interior, Ministry of Labor (MOL), and other government applications, such as Electronic-government.

Table 3: Achievement of Component 2, Intermediate Results Indicator Targets for PDO 2

Level	Indicator	Extent of Achievement
COMPONENT 2 (IR on hospitals equipped was included under PDO 1)		
IR	Referral protocols and procedures for the ten costliest conditions defined and rendered operational	**Target achieved (90%)** Nine protocols (against a target of 10) were prepared and operationalized.
IR	A consolidated Government Health Information System (HIS) for referrals and health insurance is operational	**Target achieved (100%)** A web-based system operational in all hospitals taking Referrals.
IR	HIS operational in selected hospitals	**Target surpassed (130%)** 13 hospitals have Avicenna HIS against a target of 10.
IR	Ten certified infection preventionists and ten quality improvement practitioners by the Health Care Accreditation Council who will develop infection control plans and implement IP protocols	**Target surpassed (120%)** Twelve Quality Coordinators and Infection Prevention Control specialists (against a target of 10) from all West Bank hospitals were trained online by the Health Care Accreditation Council in Jordan.
IR	Reduction in Device Associated Infections to 11/1000 catheter or ventilator day	**Target surpassed (162%)** Forty-four training sessions were conducted for 491 trainees from all hospitals, resulting in a reduction in device associated infections from 19/1000 to 6/1000 catheter or ventilator day on average (against a target of 11/1000).
IR	Reduction in surgical site infection to 6%	**Target surpassed (150%)** The training sessions indicated above resulted in a reduction in surgical site infections from 12 percent to 3 percent of all surgeries. (against a target of 6 percent).

31. **Under Component 3, the project contributed towards Universal Health Coverage (UHC) in WB&G.** The project defined a roadmap to UHC with a detailed calendar and planned actions to enhance the capacity to deliver the needed services, reducing system losses, and ensuring better quality of services to targeted populations. The project aimed to strengthen the capacity of the Palestinian National Institute of Public Health (PNIPH) in providing intelligence for decision-makers to develop and adopt policies towards strengthening UHC.

- **Strengthening the SPU at MOH.** The project supported the SPU to be proactive in enhancing efficiency in the allocation of resources using a broader scope of tools to benchmark productivity and address the growth in costs, and thus align the incentives of all providers of services to increase sustainability. It supported the contracting of seven support staff for the SPU as part of institution building, which resulted in an increase in the efficiency and quality of financial and medical auditing. Five of these staff were maintained as fixed staff at the SPU with contracts through the MOF. The project also supported technical assistance for the E-referral System to enable it to track the entire process from referral initiation to payment of referral hospitals; it is also

linked to GHI MIS and the MOF financial system. The project also supported the preparation of the National Price Reference (NPR), based on Diagnostic Related Groups (DRGs) which were integrated in the E-referral system. The NPR was piloted in around 1000 cases in five referral hospitals. The NPR will support the SPU to formulate comprehensive, competitive, and transparent contracts with referral hospitals and standardize the use the International Classification of Diseases (ICD-10), Tenth Revision, Procedure Coding System (ICD-10 PCS) as a reference in the billing process. The SPU also worked on establishing MOUs and contracts based in part on the work performed through the NPR.

- **The project also supported the PNIPH through a contract with the World Health Organization (WHO) to strengthen the evidence in the areas of Family Practice, Human Resources for Health (HRH), and Health financing.** The PNIPH provided technical assistance for improving the data generation and reporting systems for Family Health through support for the scale up of the Electronic Health Records. The project provided computers and networking for the implementation of family practice electronic records in 118 clinics in three districts in West Bank and two clinics in Gaza. The family record includes registration of patient with socio demographics profile, health history, child health, as well as immunization, child growth chart, adult file noncommunicable diseases patient file, in addition to the lab, radiology, and pharmacy services. The PNIPH also enhanced the availability and quality of health workforce data, which has become a model for MENA region countries. The website for the HRH was prepared with support from the Bank and other donors: '*http://www.hrho.pniph.org*' and is now an important tool for strategic assessment and planning and management of health staff at MOH, the private sector and NGOs. The generation of evidence on health financing to enhance the efficiency and equity, which included the introduction of tools to define and periodically update rationalization of health care benefits, did not progress due to the lack of technical expertise and overall lack of clarity on the health insurance reforms.

Table 4: Achievement of Component 3 Intermediate Results Indicator Targets for PDO 2

Level	Indicator	Extent of Achievement
COMPONENT 3		
IR	New referral contracts/ MOUs negotiated with all outside providers	**Target achieved (97%)** 29 contracts in place, against a target of 30.
IR	Purchasing agency (either independent or part of the MOH) created, staffed and made operational	**Target achieved (100%)** Project supported the temporary appointment of eight staff, who have since become SPU staff covered by government resources.
IR	People with access to a basic package of health, nutrition or reproductive health services	**Target achieved (100%)** This is a summary average of four indicators over four years (#/percent of institutional deliveries, Access (#/percent) of newborns registered at MCH, Access (#/percent) of pregnant women registered in MCH (1st, 2nd, and 3rd trimester), Immunization # and percent for under 2- year old vaccines). 90.3 percent of the people had access to a basic package of health, nutrition or reproductive health services (against a target of 90

		percent).
IR	The Electronic Health Record for Adult, Child, Vaccination and NCD is functional and generates data in the pilot PHC facilities where service delivery is based on the family practice approach	**Target achieved (100%)** The Electronic Health Records system was rolled out in 118 clinics in five health directorates (three in the West Bank and two in Gaza).
IR	People who have received essential health, nutrition, and population (HNP) services	**Target surpassed (127%)** This is the sum of number of children immunized (cumulative) and number of deliveries attended by skilled health personnel (annual) for the period 2018 to 2021 which was 666,327 (against a target of 526,662).

32. **As a result of the above support, the project was very successful in reducing the annual growth rate of OMRs and reducing the gap in geographic equity between the WB&G on referral costs.** The PDO indicator which tracked the average annual growth of total expenditure in OMRs of a three-year period was significantly lower at 2.04 percent (2019-2021) compared to the baseline of 16.59 percent for the period 2013-2015. In addition, the ratio of referral costs between the WB&G, which was 1.7:1 at baseline, reached 1.25:1 against a target of 1.15:1. This achievement of this PDO level indicator was affected by the restrictions imposed on Gaza residents by Israel[16] and the need for patients from Gaza and their companions to obtain special permits issued by the Israeli authorities to move outside Gaza for treatment. **Based on the discussions above and the table below, and the extent of achievement of the targets of the PDO level and intermediate indicators, PDO 2 is assessed to be achieved.**

Table 5: Achievement of PDO Indicator Targets for PDO 2

Level	Indicator	Extent of Achievement
PDO	Average annual growth of total expenditure in OMRs of a three-year period is lower than the proposed baseline which is the period 2013-2015 (<16.59%)	**Target achieved (100%)** The average annual growth rate remained well below 16.59 percent, and towards the end of the project it was only 2.04 percent (2019-2021), demonstrating a significant reduction in the average annual growth rate.
PDO	Gap in geographic equity for referral cost (between the WB&G) reduced by 80 percent relative to baseline	**Target achieved (82%)** The ratio of referral costs between WB&G, which was 1.7:1 at baseline, reached 1.25:1 against the target of 1.15:1.

Justification of Overall Efficacy Rating

33. **Based on the discussion on, and assessment of the achievement of PDO 1 and PDO 2 summarized in Table 6 below, the overall efficacy of the project is rated as Substantial.**

[16] According to the Government of Israel, these restrictions are for the purpose of enhancing the security of Israel and Israeli citizens.

Table 6: Summary of Achievement

Achievement against target	**PDO part 1: Securing continuity in healthcare service delivery**		**PDO part 2: Building resilience to withstand future surge in demand for effective healthcare coverage**	
	PDO Indicators	Intermediate Outcome Indicators	PDO Indicators	Intermediate Outcome Indicators
Surpassed (>100%)	1			5
Achieved (80% to 100%)		1	2	6
Partially Achieved (65%-79%)		1		
Not Achieved (less than 64%)				
Total	1	2	2	11
% Surpassed and achieved (> 80%)	100%	50%	100%	100%
Rating: **Substantial**	Substantial		Substantial	

C. EFFICIENCY

Assessment of Efficiency and Rating

34. The assessment of efficiency included aspects of design and implementation which contributed to efficiency and a cost benefit analysis undertaken ex-post for the ICR.

35. **The design of the project was efficient by combining emergency response along with measures to reduce OMR expenditures and by focusing on health sector reform.** The project aimed to ensure the continuation of basic healthcare services at minimum acceptable levels and avoid such services from experiencing systemic collapse. In addition to mitigating potential severe consequences for public health from increased risk of infections and outbreaks of communicable diseases due to the collapsing health care services, the project also focused on the rising burden NCDs, which was the leading reason for OMRs. The project contributed to minimize the cost of OMRs by enhancing the capacity of public sector hospitals. The project also aimed to improve the equity of PMR costs between WB&G and ensure that the Palestinian population received the tertiary services they needed in a manner that was costed, prioritized, and based on clear criteria.

36. **The cost-benefit analysis, undertaken ex-post for the ICR included OMR as well as other project investments, determined that the economic benefits generated by the project were positive and went beyond the estimates of the cost benefit analysis carried out at appraisal stage.** The results are summarized below and detailed methodology is provided in Annex 4. The analysis at appraisal estimated that reductions in OMR would result in cost- savings over the lifetime of the project of US$198 million over projected costs in the absence of the project. The indicator was subsequently changed to “average annual growth of total expenditure in OMRs of three-year period lower than the

proposed baseline which is the period 2013-2015 (<16.59%)". This analysis was replicated with a counterfactual annual increase of 16.59 percent. Total savings are estimated to be US$677 million, which surpasses the estimated US$198 million estimated at the project appraisal stage. As other factors have likely contributed to these savings, two additional scenarios were used to arrive at more conservative estimates of savings that can be attributed to the project. First, was replicated with a counterfactual annual increase of 13.19 percent annually, which was the initial target set at second restructuring (January 2018). Second, only 50% of savings were considered as a conservative estimate. It must be noted that in addition to the reforms, as well as improved public sector hospital capacity achieved with the support of the project, some of the decline in referrals could be attributable to the security and movement restrictions (especially for referrals from Gaza) and a significant reason in 2020 was COVID-19, which constrained hospitals' capacities restricting referrals. Despite limitations, these additional counterfactual scenarios show that even when considering only 50% of benefits at the lower growth rate of 13.19%, savings are estimated to be US$222 million, surpassing the savings estimated at the appraisal stage.

37. **As the project contributed to savings beyond reduction in growth of OMR, a more comprehensive assessment of savings was conducted to include savings due to prevented infections, savings in OOP, and benefits from Disability-adjusted Life Year (DALYs) averted as a result of project interventions.** Table 7 below shows a summary of the results of the complete analysis: (i) estimating savings on outside medical referrals; (ii) estimating savings from prevented hospital acquired infections; (iii) estimating DALYs averted due to the additional services provided; and finally (iv) estimating savings in out-of-pocket spending which would have been spent in the private sector. Total savings come out to approximately US$767 million, most of which is driven by the savings on OMR. For all savings, two estimates were calculated, the total estimate, and a more conservative estimate, which is 50% of the savings as the improvements in the services cannot only be attributed to the project.

Table 7: Estimated Savings as a result of project interventions

	Total (US$)	Conservative estimate (50% of benefit) (US$)
Savings on outside medical referrals	677,484,369	338,742,185
Savings on catheter/ventilator infections	2,883,593	1,441,797
Savings on surgical site infections	48,493,557	24,246,779
OOP savings	13,335,728	6,667,864
Total savings	**742,197,248**	**371,098,624**
Benefit from DALYs Averted	24,559,926	12,279,963
Total Savings and benefits from DALYs Averted	**766,757,174**	**383,378,587**

38. **Implementation of the project was efficient.** Despite the various challenges, the project had disbursed at a high rate (99.6%). Considering the need to provide emergency support in response to the crisis in Gaza, the project was processed under paragraph 12 of Operational Policy (OP) 10.00 (Situations in Urgent Need of Assistance or Capacity Constraints) in a relatively short time. The time from Decision meeting to approval of the project was 2.8 months, and the time from approval to effectiveness was just 0.9 months, which was far less than the average for Bank projects. The disbursement in the first few years for the emergency response was quick (component 1) while the other two components took longer as these components were dependent on analytical work as well as procurement of equipment to move ahead. The procurement and delivery of equipment was time-consuming due to various contextual factors. Despite the same, the project was able to meet most of its targets. Challenges during implementation were promptly addressed through consultations between MOH and WB teams and technical gaps were addressed by in-time technical assistance.

The project also requested two cost extensions; the first extending the project closing date from 30 June 2020 to 31 December 2021 to complete the GHI MIS related activities, specialist training, activities related to the capacity building of the SPU, and further strengthening of the e-referral system. Project implementation was progressing well but was expected to slow down due to the COVID-19 outbreak (ISR sequence No. 15, 18 March 2020). The MoH placed all its efforts to combat and contain the outbreak. An urgent MoH request was made to reallocate funds to support the Ministry to respond to the outbreak. Accordingly, and as an emergency response, an amount of US$800,000 was set aside within Component 2 to help support the Ministry in procuring top priority items. This was part of the project's overall development objective to strengthen the MoH's resilience by enabling treatment of cases within MoH facilities and control OMR. Furthermore, a new emergency operation in the amount of US$5 million was urgently prepared to strengthen MOH's capacity in preventing further transmission, detecting cases at an early stage, and providing appropriate and timely care for those affected. With the increase in COVID-19 cases, the health system and MOH staff were put under severe pressure. The second extension changed the project closing date from December 31, 2021 to May 31, 2022 to enable the processing of the final procurement packages and to finalize disbursements for activities which were delayed due to the COVID-19 pandemic.

39. The project did very well in terms of efficiency of design and economic efficiency. Implementation challenges were addressed by the MOH with support from the World Bank. The project extensions were mostly attributable to the delays due to COVID-19 which was an extraordinary event. **Based on this assessment, efficiency is rated as Substantial.**

D. JUSTIFICATION OF OVERALL OUTCOME RATING

40. **Based on the "High" rating for Relevance, "Substantial" rating for Efficacy, and "Substantial" rating for Efficiency, the overall outcome rating of the project is "Satisfactory".** The project was rated as "moderately unsatisfactory" for a brief period in 2019 from March 22, 2019 (ISR sequence no 13) to September 11, 2019 (ISR sequence no 14) due to lags in activities under Component 2. However, within the next six months, significant progress was made, and the ratings were upgraded back to "Moderately Satisfactory". Considering that the unsatisfactory rating was for a short period and the MOH immediately took remedial actions to address the implementation challenges, and the project achieved all its results, it did not affect the ICR overall outcome rating.

E. OTHER OUTCOMES AND IMPACTS (IF ANY)

Gender

41. **The project through its RF tracked utilization of health services by gender.** While the activities were designed to improve delivery and utilization of health services population-wide, the project also tracked women's utilization of health services. Three indicators in the RF specifically focused on improving gender equity. The first indicator measured the proportion of beneficiaries of OMR who were female; at the end of the project, 46 percent of the total referrals were female. The project also tracked the total number of females covered by a basic package of health, nutrition, or reproductive health services. According to data from PCBS 2017 census, 78.3 percent of Palestinians had any type of insurance, of which 79.9 percent were females. By the end of the project, the proportion of females had risen to 79.9 percent among those covered. The project also tracked the number of deliveries attended by skilled health personnel (corporate indicator) and reported that 139,123 deliveries were attended by skilled health personnel in 2021.

Institutional Strengthening

42. **The project had a strong impact on institutional strengthening.** In addition to directly impacting the capacity of public sector hospitals to deliver tertiary care services through training and the provision of equipment, the project also supported capacity building for key MOH staff and strengthened the information management systems (e-referral and GHI MIS). The digitalization of systems improved the MOH's ability for evidence-based decision making and stewardship of the health sector, while the online automated processes helped build trust and improved satisfaction among patients and hospitals. The project also supported: (i) the preparation of a communication strategy; (ii) provision of office equipment to SPU, General Directorate of Health Insurance (GDHI), Continuous Professional Development (CPD) and PMU; (iii) development of the Technical Support Agreement contract for the E-referral system; (iv) the Service Purchase Unit (SPU) at MOH in several activities, including contracting seven support staff for financial and medical auditing; and (v) the Health Education and Scientific Research Unit at MOH (*https://cpd.moh.ps*) in the capacity building of health staff, including a user manual in both English and Arabic.

43. **The project supported the building of evidence base for key health system building blocks.** The project supported the PNIPH through a contract with WHO for strengthening of the evidence base in the areas of Family Practice, Health Financing, and HRH. An observatory for all HRH was completed and resulted in a comprehensive database providing the Ministry oversight of the HRH situation in the Palestinian territories, and the adoption of sound policies to better manage the health workforce. The MOH developed the benefit package of health care services and enrollment criteria, as well as benefit package options. The project also provided computers and networking for the implementation of the family practice electronic health record system in five districts, three in West Bank (Salfeet, Ramallah and north Hebron) and 2 clinics in Gaza strip (Daraj and Sourani).

Mobilizing Private Sector Financing

44. **The commitment of the MOH to reduce OMRs to other countries led to opportunities for the private sector hospitals in WB&G to provide tertiary level health care services.** Efforts to limit referrals outside the Palestinian territories led to spillover demand and private sector hospitals in WB&G have invested in improving their capacity to deliver tertiary care. As an example, some private hospitals in the West Bank and hospitals of the East Jerusalem Hospital Network (EJHN) like Augusta Victoria hospital have invested in building up their diagnostic and treatment capacity for cardiac and cancer cases.

Poverty Reduction and Shared Prosperity

45. **The project contributed to the twin goals of poverty reduction and shared prosperity most notably by strengthening service delivery in public sector hospitals and by addressing the inequity in access to services.** Households' OOP expenditures accounted for 40 percent of total health expenditures, and the poorest groups had a higher share of OOP expenditure compared to their total income and were at the greatest risk of impoverishment due to health spending. All three project components were directly and strongly aligned with the WB's twin goals of eliminating poverty and boosting shared prosperity and were also directly aligned with the HNP Global Practice's orientation towards Universal Health Coverage to ensure that all Palestinians obtain the health services they need without suffering financial hardship when paying for them. The project also focused on ensuring continuity in services in Gaza hospitals and was successful in reducing the inequity in referral expenditures between WB&G.

III. KEY FACTORS THAT AFFECTED IMPLEMENTATION AND OUTCOME

A. KEY FACTORS DURING PREPARATION

46. **The project was prepared in a short period to support immediate emergency needs in WB&G and** strengthen the fiscal condition of the health system. The project was processed as an Investment Project Financing (IPF), under paragraph 12 of Operational Policy (OP) 10.00 (Situations in Urgent Need of Assistance or Capacity Constraints). The project design considered the complex and multi-faceted nature of the emergency in the health sector as well as a number of other factors, including: (i) the immediate impact of the conflict in damaging human and physical assets, facilities, and infrastructure; (ii) a severe and prolonged economic downturn with few immediate prospects for recovery (accompanied by high rates of unemployment and very limited levels of new private investment); (iii) a derailed peace process; and (iv) the unraveling of some of the critical donor assistance and support structures as well as aid flows.

47. **Strong government commitment and a prevailing momentum of reform provided an opportunity to push for necessary health sector reform.** The direct impact of the conflict on human lives and health infrastructure was exacerbated by structural limitations and a fiscal crisis driven by a prolonged economic downturn, reduced aid flows, and political stalemate. The circumstances motivated the MOH to commit to reform, demonstrated through concrete steps such as the appointment of an audit firm, development of referral criteria, and attempts to initiate development of protocols and guidelines for OMRs.

48. **The project built on the lessons learned from the long-term WB engagement in the WB&G health sector.** The design of the project was informed by the lessons learned from previous Bank support to the health sector, including the Emergency Services Support Program and a series of analytical and advisory services implemented over the past few years. Accordingly, the design of the proposed project was kept simple, focusing on a few critical activities which were deemed achievable in a relatively short timeframe, aimed at providing quick impacts. Analytical pieces prepared by the Bank between 2013 and 2016 (for example: Health Public Expenditure Review, Policy Note on Dual Practice, Analytics on OMRs) laid the foundation for the reform efforts on health financing and the rationalization of outside medical referrals.

49. **The project was designed in close consultation with key donors and NGOs.** Project activities were designed to be complementary to activities supported by other donors.[17] The project design team worked in close coordination with other donors to develop approaches where there was room for other donors to finance similar complementary activities. Special attention was given to ensure that activities included during project design were closely coordinated with, and complementary to, the inputs from the other donors in the sector, notably USAID, DFID (now FCDO), and WHO. Consultations were also held with NGOs working in health, who played a key role in informing the project design.

50. **Risks were assessed at preparation to be high overall, because of the significant challenges faced in terms of the wider context of healthcare reform in WB&G.** The MOH had insufficient capacity to implement the reforms because of budget constraints, limited technical capabilities, and fragmentation of the healthcare system between the WB&G. The Bank took several steps to manage these risks, including support for capacity building of PMU staff on fiduciary activities and compliance and supporting the hiring of external consultants in coordination with other development

[17] USAID provided support for specific hospitals for priority health needs as well as improving governance and service delivery. EU financed the mental health and psychosocial support services as well as the payment of arrears of the East Jerusalem Hospital (EJH)network. WHO provided technical assistance and capacity building and the advocacy for the right to health, including monitoring referrals and permits and access to health services. DFID (now FCDO) provided support in the area of OMRs.

partners. The project also supported the setting up of an agency responsible for the strategic purchasing of services from outside providers.

51. **The project also included an adequate monitoring plan and RF.** The RF was well aligned with the objectives and included PDO and IRI indicators with baselines and targets, which (except for the indicator to measure OMR expenditures) were realistic and well designed.

B. KEY FACTORS DURING IMPLEMENTATION

Factors subject to WB control

52. **The WB support, through its flexible design, was responsive to the changing needs of WB&G and the context.** The steady flow of assistance from the Bank helped avoid disruptions and ensured project sustainability. The effects of the delay in donor support following the Gaza conflict in 2014 and 2021 were mitigated to some extent by the flexible financing provided by the Bank, which helped the MOH to quickly respond to the needs in Gaza. The WB also stepped in with support during sudden changes in the donor environment, such as the withdrawal of support by USAID in 2019. Funds were reallocated in March 2020 from Component 3 to Component 2 to strengthen MOH's COVID-19 case management capacity. In addition to financial resources from the project, the PA continued to receive budget support from the Bank and development partners through the Palestinian Reform and Development Plan, based on adherence to the reform agenda and fulfillment of the policy triggers for cost containment under the Development Policy Financing (DPF) mechanism.

53. **The supervision and reporting of the Bank team was adequate, and the team closely monitored the progress** of project activities and documented any delays in the periodic ISR reports and a detailed Mid -Term Review report along with agreed actions to address the delays. The TTL-ship turnover was low and transition arrangements were in place during staff changes. The team also updated the project ratings in line with progress of project activities and associated risks. In November 2018, the ratings of progress towards achievement of PDO and overall implementation progress (IP) were changed to "Moderately Satisfactory" (ISR sequence no 11, 1 November 2018) and further downgraded to "Moderately Unsatisfactory" (ISR sequence no 13, 22 March 2019) due to lags in the introduction of tools such as the National Price Reference list and formal contracts to rein in the annual average rate of OMR costs under Component 2. However, within the next six months, significant progress was made with the MOH rolling out the NPR pilot in select hospitals and finalization of protocols for key OMR conditions, and the ratings were upgraded back to "Moderately Satisfactory" (ISR sequence no 14, 11 September 2019).

54. **The MOH had significant technical and implementation capacity gaps which threatened to derail the reform process.** The WB implementation support plan was therefore characterized by staff presence in the field and the flexibility to provide support from experts in more specialized fields. The Bank was well-placed to provide technical assistance (TA)[18] based on the institution's worldwide experience in improving the efficiency of the health systems

[18] Some of the in-time TA support offered by the Bank included the 'Palestine Health System Financing - Health Expenditures and Financial Protection: Trends, Benchmarking & HSRS Project Implications' completed in February 2019, which made important policy recommendations for the project in the areas of primary health care and public sector expenditures on health; the Bank's needs assessment for the rationale of selecting Alia Hospital for hospital equipment support; an OMR Assessment[18] entitled, 'Towards Effective Chronic Case Management : Improving the Efficiency of Outside Medical Referrals in West Bank and Gaza' completed in April 2021, which provided short term and long term recommendations to improve efficiency of OMRs; and the Rapid Damage and Needs Assessment (RDNA) launched by the WB Group (WBG), the United Nations (UN), and the European Union (EU) immediately after the cessation of hostilities in Gaza in 2021 which highlighted the impact of the conflict on the Gazan health system and the resulting increase in the disease burden and disruption to the delivery of health services. The Recovery and Reconstruction needs of the health sector following the conflict were estimated in the range of US$30–40 million.

and health insurance reforms. The Bank team comprised the appropriate skills mix and experience, including staff both from the Country Office and from Headquarters (HQ) in Washington. The development partners (e.g., USAID, DFID, WHO) also remained committed to providing the necessary technical expertise to support the medical referrals reform process and to building the MOH's capacity in contracting tertiary healthcare services, health management information systems (HMIS), and institutional capacity building.

Factors subject to MOH and Project Management Unit (PMU) control

55. **The MOH and PMU persevered on the path for health reform throughout the project period.** The MOH continued its attempt to contain costs and improve service delivery during the project. The reduction of expenditures on OMR formed the major theme of the National Strategic Health Plans, which also promoted public health measures (e.g., smoking cessation, road safety, cancer screening) to tackle the growing burden of non-communicable diseases and to reduce public spending on specialty referrals. The MOH also ensured engagement of many its departments in project activities. The activity on the communication strategy and its campaign supported the involvement of staff from the SPU, Health Insurance, and the Complaint Department, while other project activities required the engagement of other MOH units, such as the tendering and bidding unit, the Biomedical Engineering Unit (BMEU), central stores, and information technology (IT) department. The Director of the International Cooperation Department was also the head of the PMU, which helped in ensuring coordination with all stakeholders.

56. The MOH faced many challenges during the implementation of the project, which included the following:

- The formation of the PMU was initially delayed, and the PMU faced challenges in identifying and maintaining essential team members. Staff contracts initiated throughout the project had to go through the General Personnel Council (GPC) and the Council of Ministers, which led to delays in filling certain positions. In the absence of a specific team member for Monitoring and Evaluation (M&E), the existing PMU team continued to cover these tasks. During the periods where the financial specialist position was vacant, the project relied on the MOF PMU staff.
- Component 3 had made progress on two of the three areas of work: (i) health workforce observatory and planning; and (ii) digitalization of clinical files and databases for the family health model of primary health care networks). However, universal health coverage financing had not made the expected progress as there was no clear agreement on long-term and comprehensive reform related to the pooling and separation of financing functions within the UHC component. Thus, the progress for Component 3 was downgraded from Satisfactory to Moderately Satisfactory (ISR sequence no 14, 11 September 2019).
- The interoperability and integration of systems remained a challenge. For example, the 'Avicenna' system, which was in place for over ten years and needed various upgrades, was not easily amenable to integration as it was not open source and MOH depended on external support to make any improvements. It also took time for the e-referral system to be in place, as health personnel and hospital staff needed training in its use. It also took time to secure buy-in from participating hospital managers, who were reluctant to adopt the system due to lack of trust initially compounded by the PA's accumulated referral arrears. However, MOH pushed for the use of the system and gradually hospitals realized the benefits and ease of the automated tracking and workflow system, as well as the availability of real time information.
- The Steering Committee (SC) ensured full alignment of the project's activities with MOH strategies and policies and facilitated linkages between the various MOH line units, MOF, and service providers. The technical SC

oversaw the technical aspects of project implementation. However, the lack of regularity in SC meetings during the later duration of the project affected the visibility and information sharing of the project with key stakeholders.

- The MOH was successful in setting up an independent agency for strategic purchasing (Service Purchasing Unit or SPU) which was very successful in entering into contracts with secondary- and tertiary-level clinics and hospitals; however, no progress was made in the pooling function. Responsibility for Accreditation and Technical Audit was subsumed by the Service Purchasing Unit by having specialized staff for audit, due to the bureaucratic challenges and fiscal constraints in creating an entirely separate unit.

Factors beyond WB, MOH and PMU control

57. **The COVID-19 Pandemic placed an unprecedented strain on the health care system.** As of end October 2022, there were over 700,000 confirmed cases and 5,700 confirmed deaths from the COVID-19 pandemic[19]. The conditions that already affected the Palestinian economy, such as the restrictions on trade, movement, and access, recurrent conflict, internal divide, and falling aid inflows, were further exacerbated by the COVID-19 pandemic. The disruptions due to COVID-19 also impacted project results for a short period, especially on hospital utilization rates. As of end 2022, less than half the population has been fully vaccinated, which is lower than many countries in the MENA region.

58. **The focus of the MOH on COVID-19 response also led to delays in project implementation**. The health workers and MOH staff themselves endured significant additional pressures in their work, as they responded to the rise in COVID-19 cases. As a result, a few project activities, such as the Cost Effectiveness Study, Analysis of Fiscal Space Study and the Costing Study, had to be cancelled, while some activities, such as the wide scale adoption of the National Price Reference (NPR), list could not be completed. Items included under Component 1 were crucial in supporting the seven MOH centers designated as COVID-19 treatment centers, as well as 20 other hospitals that needed equipment and consumables, to respond to the pandemic.

59. **The project had to navigate and adapt to an unpredictable donor environment.** The unpredictable nature of the aid flow hindered the MOH's ability to prepare and implement medium- and long- term health reforms and plan allocation of resources. Nevertheless, the project was coordinated with existing donors and partners at the time working on OMR and had activities complementary to those planned by partners. However, in the aftermath of the Gaza crisis in 2014, expected donor financing had not materialized in a timely manner and, therefore, there was a funding gap. The sudden stop of all USAID funded projects in January 2019 affected the continuity of work on the E-referral system that was started through USAID support.

60. **Recurrent conflict and other contextual challenges impeded project activities.** Contextual challenges, such as movement and access restrictions on Gaza, led to critical shortages of medical supplies, such as equipment, drugs, and consumables. The limitations on movement of patients from Gaza and the West Bank to health facilities outside their place of residence also influenced project outcomes.

IV. BANK PERFORMANCE, COMPLIANCE ISSUES, AND RISK TO DEVELOPMENT OUTCOME

A. QUALITY OF MONITORING AND EVALUATION (M&E)

[19] https://ourworldindata.org/coronavirus/country/palestine

M&E Design

61. **The project indicators were measurable and relevant for tracking progress of the development objective, although one PDO indicator was unrealistic at design phase.** The overall PDO was clear and there was a clear line of sight from project activities to outputs and project outcomes. The TOC developed as part of the ICR shows how the project activities were clearly linked to the project development outcome. The first PDO indicator tracked the utilization rates of the large public sector hospitals as a proxy measure of continued access to services. This was designed with the understanding that any breakdown in continuity of health care delivery would reflect in lower hospital utilization rates. This indicator also was a good measure of the outcome of the support provided to these hospitals under Component 1 and Component 2. The remaining two PDO indicators focused on the reduction in growth rate of OMR expenditure and reduction of the gap in geographical equity in referral costs between WB&G. However, the PDO indicator tracking the OMR expenditure reflected a weakness in the M&E design as this indicator was not aligned with the contextual realities and the indicator and target had to be amended twice. This was partly attributable to the lack of data and documentation (especially on OMR) which was not available to the team at design stage.

62. **The project's RF and M&E arrangements were appropriate to measure progress toward its PDO.** The project aimed to monitor progress through: (i) regular/routine monitoring to track progress of project activities against plans; (ii) an MTR to assess early results/effectiveness of project activities; and (iii) periodic progress reports. M&E activities, including training for M&E, were part of the project's design under Component 4. At the design stage, the project had three PDO-level and 14 intermediate to measure the achievement of the project. Three intermediate-level indicators were added subsequently during restructuring, increasing the total to 17.

63. **The Project used information and communications technology (ICT) when possible, to enhance the collection of information and data for monitoring and evaluation**. The PMU team maintained a simple M&E system for data collection, as well as output and outcome monitoring, to ensure proper monitoring, reporting, and evaluation of the project-funded activities. Gender-sensitive monitoring was also included through disaggregation of data for certain indicators. The project support to improve the E-referral system and the GHI MIS was vital to strengthening MOH governance capacity as well as increasing the ability of the PMU to report on the key indicators in the RF.

M&E Implementation

64. **The PMU complied with the required frequency and timeliness of reporting.** The PMU, supported by the MOH's Health Information Center, Medical Referrals, Health Insurance, and Finance Departments managed data collection, aggregation, and periodic reporting on the project's implementation progress. As per the Grant Agreement, the progress reports were to be furnished to the Bank no later than 45 days after the end of the period covered by such a report. The PMU complied with this requirement but was encouraged, during the MTR, to improve the quality of the progress reports, especially regarding Monitoring and Evaluation.

65. **The weakness at design stage in the OMR indicator, was fully addressed during implementation phase** through amendments in the indicator and its baseline and target (See paragraphs 12 and 13). The improvements in the eReferrals system, financed by the WB, enabled increase in accuracy and availability of referral data.

66. **The challenges with data quality were resolved by enhancing capacity of the PMU**. The absence of dedicated staff for M&E tasks and the delays in accessing data from the digital information system posed challenges in data quality during the initial period of the project. To resolve this, the PMU worked with the SPU to clarify data sources and

definitions and to obtain and verify any missing data form the digital information system. Additionally, the PMU contracted a health specialist who performed the M&E tasks which led to improved quality of reports.

M&E Utilization

67. **The M&E data on performance and results progress were used to inform project management and decision making**. The M&E data and the findings of the implementation supervision missions (including MTR), were used to inform project plans and changes. The M&E findings showed lack of progress in Component 3 which led to changes in the design of the component activities. The reporting of M&E data was also used as a critical input for deciding on project ratings for progress towards achievement of PDO and overall Implementation Progress. The technical SC was also formed with the aim of overseeing the technical aspects of project implementation and keeping all stakeholders informed of the implementation progress. In addition, the Bank and MOH teams ensured that the data was disseminated to other stakeholders as well.

Justification of Overall Rating of Quality of M&E

68. Based on the above and given that one of the key PDO indicators was unrealistic at design stage and had to go through two revisions, including changes to baselines and targets, during the life of the project, as well as the challenges in data quality in the initial period of the project, **the overall rating for quality of M&E is Modest.**

B. ENVIRONMENTAL, SOCIAL, AND FIDUCIARY COMPLIANCE

Environmental and Social

69. **The project followed WB procedure under safeguard policies.** No Bank environmental or social safeguard policies were triggered and as such no safeguard documents were prepared and disclosed either during appraisal or during implementation.

70. **The Environmental Category of the project was "C".** The project mainly focused on technical assistance and institutional capacity building activities. It did not include financing of civil works; thus, no environmental or social safeguard issues were anticipated.

71. **While the PAD had not envisaged any environmental risks, some of the social risks considered included the** likely pressure in terms of ensuring that the healthcare system sufficiently covers the poor and marginalized as well as ensures equity within the system. The MOH coordinated efforts with key stakeholders, including other PA ministries (e.g., the Ministry of Social Affairs and the MOL), local NGOs, and developments partners, to ensure adequate coverage of the poor and equitable access within the health system. The M&E framework also included results focused on ensuring equitable access to health care services.

72. **The project also implemented communication activities to raise awareness on the project activities**, especially in health insurance, referrals and complaint 'Grievance Redress Mechanism' (GRM). A MOH working group formed from members from relevant departments, with support from the MOH media unit, supported the production of several media materials (posters, radio spots, video motion, messages on social media, stickers, magnet, etc.). The messages and materials were broadcast on local radios, local TV channels and the MOH website as well as social media in order to promote citizen engagement.

Financial Management

73. **Financial management (FM) had a Satisfactory rating by the Bank at project closure.** The PMU had a dedicated team member (FM specialist) for FM aspects and the overall PMU performance was satisfactory. The PMU had gained experience working on WB-financed projects through the previous project (Third Emergency Services Support Project, which closed in 2011) and its fiduciary management was further strengthened during implementation of the HSRSP. Internal control for the project was strong, and implementation procedures were based on a Project Operations Manual (POM). The project was subject to an annual external audit and all audit reports have been submitted on time. A Financial Manual was prepared in 2017 to reflect financial procedures to be used for the project. A US Dollar Designated Account (DA) was opened at the Bank of Palestine (Ramallah), and WB funds were deposited into this DA. A separate account was also created in the automated accounting system Bisan. The PMU ensured that the account was reconciled and the MOH requested needed funding through the submission of Withdrawal Applications. The PMU checked, monitored, and cleared the project deliverables before processing any payment and the PMU followed the required formal PA procedures for payment approval. Quarterly IFRs were prepared and submitted on a timely basis and were reviewed and cleared by the PMU. After the reports were cleared by the Bank, they were published on the Bank's website. The final financial audit for the period from January 1, 2022, to September 30, 2022 was finalized and shared with the Bank. By the end of the grace period on September 30, 2022, the project had disbursed US$8,462,235 out of the total budget of US$8.5 million.

Procurement

74. **Procurement performance was rated Satisfactory at project closure**. Procurement activities were carried out in accordance with the WB Procurement Guidelines published by the WB in January 2011 and revised in July 2014 ("Procurement Guidelines"). The PMU had a dedicated Procurement Specialist with significant experience in procurement under WB-financed projects. Procurement plans were prepared and updated regularly by the Procurement Specialist using the STEP system and were always cleared by the WB. The Project also supported contracting with UN agency (WHO) for technical assistance for activities under Component 3. Up to the end of the project, 6 ex-post procurement reviews were conducted by the Bank and the latest was conducted in April 2022 on six contracts awarded between November 2020 and March 2022. No indication of possible governance issues and noncompliance was observed during all reviews.

C. BANK PERFORMANCE

Quality at Entry

75. **The WB ensured that the project design was informed by strategic goals, timeline, and risk assessment.** The project was designed in alignment with the WBG's AS for FY15–16 (R2014-0231/1) and the WB's 2013–2018 MENA Health, Nutrition and Population Strategy. As such, the project was also consistent with the WBG's twin goals and with MENA's Regional Strategy, supporting the pillars of ensuring economic and social inclusion and strengthening governance.

76. **The design of the project was simple and considered lessons from previous engagements.** The task team integrated lessons learned from the implementation of previous Bank engagements in the health sector, including the Emergency Services Support Program and a series of analytical and advisory services. The PDO and project activities were designed to address both the immediate needs resulting from the conflict in Gaza as well as the fiscal health of the

system by containing costs and improving equity and fairness in the distribution of limited resources. The design of the proposed project was kept simple, focusing on a few critical activities that were perceived to provide quick impact while also fostering long term policy reform. The project was designed in close coordination with the authorities in WB&G, donors, partners and NGOs, which helped the Bank in ensuring that the project addressed the needs of the people. The appraisal of the project was sound and included economic and financial analysis, technical aspects, financial management, procurement, implementation support to be provided by the Bank, and social aspects. No environmental or social safeguards were triggered. The project design also considered existing levels of poverty in the description of the context and the justification for public sector role in the economic analysis. A PDO indicator was added to track improvements in equity between WB&G on referral costs. The project design also considered the prevailing gender disparities, especially in terms of access to healthcare, which was limited for women in vulnerable communities. Considering the gender gap in OMR, the project RF included an indicator to measure the proportion of beneficiaries of OMR who are female. No Adaptation and Mitigation Climate Change Co-Benefits information was applicable to the project.

77. **The Bank also conducted a thorough risk assessment and proposed strategies to mitigate those risks.** One of the important risks was the insufficient capacity of MOH to implement the reforms because of budget constraints, limited technical capabilities, and fragmentation of the healthcare system between the WB&G. The Bank planned several steps to mitigate these risks, including support for capacity building of PMU staff on fiduciary activities and compliance as well as the hiring of external technical consultants in coordination with other development partners.

78. **The project was reasonable in terms of the activities and results.** The project was ready for implementation upon approval, with implementing agencies staffed and off to a strong start immediately after effectiveness. Both facts—reasonable scope in view of targets to be achieved, together with readiness for implementation—meant that the preparation team designed a project which successfully exceeded most of its achievement targets. The exception was Component 3, as during project implementation, it was concluded that the design of the component was too broad and ambitious, and the activities under this component were narrowed down. While the overall M&E arrangements were adequate, the M&E design had a weakness with regards to the indicator for measuring change in OMR expenditure. Additionally, certain indicators and targets had to be amended during project restructuring to make them more realistic.

Quality of Supervision

79. **WB supervision overall was strong throughout project implementation, including from a fiduciary and safeguards perspective.** During implementation, the project team provided close supervision and used the ISR to document the challenges faced by the project and downgrade the progress ratings in case of delay or lack of progress. This was accompanied by technical advice and support to the MOH to address the challenges. The ratings of progress towards achievement of PDO and overall implementation progress (IP) were changed from “Satisfactory” to "Moderately Satisfactory" (ISR sequence no 11, 1 November 2018) and further downgraded to "Moderately Unsatisfactory" (ISR sequence no 13, 22 March 2019) due to lags in the introduction of tools such as the National Price Reference list and formal contracts to rein in the annual average rate of OMR costs under Component 2. Following close follow up and technical assistance from the WB, the MOH rolled out the NPR pilots in select hospitals. In addition, the MOH has finalized the standard procedures for medical referrals and 18 MOUs were signed with service providers to better organize the purchasing and packaging of services for OMRs. This resulted in the ratings being upgraded back to “Moderately Satisfactory” (ISR sequence no 14, 11 September 2019).

80. **WB also identified the challenges faced by the project during the MTR and agreed on actions to expedite progress.** The Bank identified slow progress in Component 2 on the development and finalization of the pricing schedule for OMRs, due to the lack of essential data at the Ministry. In addition, less progress was registered on the development of the GHI MIS as originally envisaged, and the MTR mission acknowledged that a full-fledged system could not be expected to be finalized under the project. Instead, the mission recommended to reduce the scope of this activity to support an agile, phased approach, rather than aim for the adoption of a full system. Progress was also slow in the Component 3 activity on UHC reforms mainly because there was lack of technical capacity and lack of agreement on the longer term and more comprehensive reform needed related to the pooling and separation of financing functions within the health insurance program. To address this challenge, the WB supported an alternate modality for implementation, through which the MOH entered into a contract with the WHO for enlisting the support of the Palestinian National Institute of Public Health (PNIPH) as an implementing agency to develop a UHC roadmap focusing on strengthening the evidence-based data of MOH in the areas of Health Financing and HRH for UHC as well as Family Practice approach. Of these, the tasks on HRH[20] and Family practice[21] were successfully completed while the analytics on Health financing was dropped due to a lack of agreement on long term reform of the health insurance program. The Bank was also flexible in meeting the arising needs in the Palestinian territories. During implementation of the project, some of the saved and undisbursed funds were reallocated to finance priority needs emerging from the COVID-19 pandemic and the escalation of conflict in Gaza in May 2021, through the procurement of equipment, consumables, and IT support to systems.

81. **The Bank team was proactive in identifying and addressing the risks to achieving development outcomes and provided strong technical support overall.** The task team ensured continuous dialogue, oversight, and monitoring. Task Team Leaders (TTLs) changed twice during the project lifecycle, and the transfers of responsibilities between TTLs occurred smoothly during each transition. During the period of the COVID-19 pandemic when travel restrictions were in place, the Bank team ensured ongoing supervision through regular virtual meetings. Sixteen WB implementation support missions were conducted, and aide memoires were prepared and shared with the MoH.

Justification of Overall Rating of Bank Performance

82. **Overall WB performance is rated Satisfactory.**

D. RISK TO DEVELOPMENT OUTCOME

83. **Despite the project's successes, additional support would be needed to mitigate the risks and sustain and build on the gains achieved.** The May 2021 conflict in Gaza and the contextual challenges have taken a toll on health infrastructure and human resources in the health sector. This is in addition to the prolonged economic crisis, the derailed peace process, and the decreasing aid flow. Despite the significant reductions in the rate of growth of expenditures on OMR, the financial sustainability of the healthcare system remains at risk. OMRs will continue to be needed because of the changes in demography and disease burdens (increase in NCDs which require long term and specialized, costly care). As a result of the economic crisis in the aftermath of COVID-19 pandemic, tax revenues have been falling, resulting in a limited fiscal space to bridge the financing gap of the GHI. To sustain and scale up the

[20] The website on *'Mapping the Palestinian Human Resources for Health'* was launched in June 2020 available at *http://www.hrho.pniph.org.* The Palestinian National HRH Observatory is a web-based application that functions as a data hub to facilitate the collection and analysis of data on practicing health workers in all sectors including the Ministry of Health, UNRWA, the Military Health Services, and private sector and NGO institutions. It helps guide research on health workforce issues, develop national indicators, monitor progress over time, and advocate for evidence-based policies in the West Bank and Gaza Strip.

[21] The family practice approach was launched in Salfeet district, Ramallah and North Hebron. The hardware for the information systems was delivered to the MOH central stores and they were distributed and installed at location in Q1 2021: (Ramallah district: 57 clinics; in North Hebron district: 43 clinics and Salfeet district: 18 clinics) and in Gaza strip (Sorani and Daraj clinics). The networking and internet connections have also been installed.

outcomes of this project, the MOH would need to devise a more comprehensive reform plan with financial support from donors along with continued domestic financing. A new financing by the Bank is under preparation and will build on the lessons of the HSRSP and contribute towards the MOH's reform plans.

84. **The Palestinian health financing system suffers from significant resource constraints and chronic sustainability challenges, are driven by weak pooling and purchasing systems.** The health insurance system in WB&G with fragmented schemes and open entitlements is the main driver of the lack of sustainability in the health system, as there are no limits on services provided, particularly for OMR at private hospitals. In the absence of clear governance and accountability structures, it becomes very difficult for stakeholders to govern and control for different functions of health insurance, from enrollment and eligibility of beneficiaries, to collecting contributions and copayments, to purchasing of health services. There are over 13 insurance schemes, and a centralized repository of information pertaining to the characteristics of each of the schemes currently does not exist. A health chapter in an ongoing PER will use the learnings from the HSRSP and aim to update all existing analyses on health financing, with deep-dive analyses on the pooling and purchasing functions, to inform improvements to the efficiency, equity, and sustainability of health financing in WB&G.

85. **The PA has demonstrated commitment to sustain the development outcomes achieved by the project.** The project supported rationalizing OMRs and has helped pave the way toward increased donor confidence for effective health coverage in the medium term. The project also supported policymakers, health professionals, and technical staff within the MOH through the provision of capacity building, training, and technical assistance and supported improving the overall fiscal sustainability of the sector through the implementation of efficiency and equity measures. Overall, the MOH has developed greater capacity to ensure that these measures are implemented and monitored, thus improving the overall MOH stewardship over the health sector.

V. LESSONS AND RECOMMENDATIONS

86. **In FCV settings like WB&G, it is prudent to keep project design and technical components as simple and flexible as possible.** The success of this project was partly due to the simple and flexible design such as the inherent emergency nature of the project that not only helped in addressing the acute needs in Gaza but also enabled a quick response to the COVID-19 pandemic without the need for further restructuring. The project also made use of the direct contracting modality with UN agencies (contract with WHO for Component 3) for the provision of timely inputs and technical assistance.

87. **Any health sector reform plan must consider contextual factors including political economy as well as path dependence.** The project's plan for health sector reform considered the following: (i) ensuring a robust understanding of country context and dynamics; (ii) providing adequate funding and a road map for capacity building as well as expected activities upfront; (iii) remaining flexible to respond to the dynamic situation on the ground; (iv) focusing on harmonization of donors' work relating to governance and reforms, and (v) understanding the path dependence of the health system. Most importantly, the project supported the implementation of relatively straightforward management systems and reforms, while postponing the introduction of more complex systems to a later phase. This approach, which can be helpful in other FCV settings as well, allows the roll out of reforms incrementally at a pace that permits the institutional structure to absorb and integrate the new systems before moving to the next step.

88. **In addition to addressing acute needs and ensuring continuity of service, building resilience requires a focus on the capacity of the health system to prepare for, manage (absorb, adapt and transform) and learn from shocks.**

The design of the project, which featured an emergency response, was appropriate and necessary at the time to avoid a catastrophe. However, going forward, it is important to have a more holistic approach focusing on wider health system resilience. The COVID-19 pandemic exposed the need for a greater focus on health system resilience globally. The experience from HSRSP points towards the following areas for health systems resilience: (i) importance of addressing health financing challenges and reducing unsustainable health expenditures; (ii) building a strong primary health-care foundation; (iii) increasing domestic investment in health system foundations; and (iv) addressing pre-existing inequities and the disproportionate impact of health shocks like COVID-19 on marginalized and vulnerable populations. The WB is collaborating with the MOH to develop a new operation under which the Bank will finance the strengthening of a package of cost-effective primary health care services and further improve hospital capacity to reduce OMR expenditures.

89. **Digitalization of health system processes can improve evidence-based decision making and efficiency of service delivery.** The data from the digital systems supported by the project like the e-referral (See Box 1)[22] and GHI MIS have continued to support the improvements in service delivery and provide evidence for strategic planning and policy making, even after project closure. These information systems have also enabled evidence-based decision making based on the systematic collection and analysis of data on health services. This experience shows that digitalized systems can support standardization of procedures, inform decisions, and improve efficiency of processes, and can contribute towards improving trust and satisfaction of the public with provided services.

Box 1: Use of eReferrals system to improve efficiency of OMR services. The eReferrals system, supported by World Bank financing, has been helpful in capturing OMR information, in facilitating the automation and support of the referral application process; maintaining the registries of service providers and contracts; integrating referrals, billing and payments into one workflow. The implementation of eReferrals database has enabled detailed and more granular quantitative analysis (on referral patterns, drivers of volume, and costs) which has informed key decisions and has also decreased the time for processing of referral applications, particularly for emergency cases. While the eReferrals database has been instituted and data flows and processes have been defined, there is still a need for integration with routine MOH information systems as well as reduction of reporting burden.

90. **Having implementation arrangements informed by lessons from the previous health project helped to ensure continuity and sustainability.** As recommended, the project had a PMU embedded in the MOH. This helped to improve coordination and ownership and ensured the future sustainability of the project. It was evident that consistent technical and relationship management skills in the PMU were essential throughout the project cycle. The project had an effective PMU Director whose additional role as Director of International Cooperation in the MOH helped in convening and coordinating with stakeholders. However, the project struggled with hiring and maintaining consistent technical expertise due to government salary ceilings. While it is difficult to maintain the same personnel throughout the life of the project, it is recommended that in the future, attention must be paid to the staffing arrangements, including staff retention considerations at the design stage itself.

91. **Supporting health reforms requires a combination of consistent financing, technical assistance, and whole-of-government approach.** The WB, through its in-country and HQ staff as well as external consultants, provided consistent technical support throughout the implementation of the project. The project also engaged partners, donors and NGOs during design and implementation. In addition to these approaches, it is recommended that future initiatives should secure engagement of stakeholders from the wider government beyond MOH, especially MOF and PM office, to

[22] Duran et al, 2021. Towards Effective Chronic Case Management: Improving the Efficiency of Outside Medical Referrals in West Bank and Gaza. *https://openknowledge.worldbank.org/handle/10986/37264*

ensure broad political support. The successes of the project should be documented and disseminated widely to share experience on how a seemingly intractable challenge can be addressed in a sustainable way even in difficult contexts.

ANNEX 1. RESULTS FRAMEWORK AND KEY OUTPUTS

A. RESULTS INDICATORS

A.1 PDO Indicators

Objective/Outcome: Project Development Objectives

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Utilization rates (out-patient, emergency and obstetrics) in the hospitals of Shifa, Rafedia and Alia Hospital do not deteriorate or improve up to 10% compared to a baseline end-September, 2014	Text	Shifa occupancy: 89%, Rafedia occupancy: 85% Obstetrics Shifa: 76% Obsetrics Rafedia: 94% Outpatient Shifa: 180,000 Outpatient Rafedia: 60,000 25-Jan-2015	Same ratio as baseline or improve up to 10% above 25-Jan-2015	Shifa occupancy: 89% Rafedia occupancy: 85% Alia occupancy: 136% Obstetrics Shifa: 76% Obstetrics Rafedia: 94% Obstetrics Alia: 105% Outpatient Shifa: 180,000 Outpatient Rafedia: 60,000 Outpatient Alia: 102,046 17-Jan-2018	Shifa occupancy: 87.3% Rafedia occupancy: 98.5% Alia occupancy: 111% Obstetrics Shifa: 113% Obstetrics Rafedia: 96.1% Obstetrics Alia: 127% Outpatient Shifa: 107,538 Outpatient Rafedia: 83,967 Outpatient Alia: 68,463 31-Dec-2021
Comments (achievements against targets):					

Achievement: 104%. Target surpassed.

The achievement would be even higher if the 2019 (pre-COVID) performance figures are considered. The 2021 performance (end of project figures) were affected by the pandemic. Occupancy rate improved for Rafedia but deteriorated for Shifa and Alia hospitals.

Obstetrics occupancy rate improved in all the three hospitals. Outpatients' numbers improved for Rafedia but deteriorated for Shifa and Alia. Please see project files for a detailed analysis of achievement against each measure. The summary (average) achievement for 2019 (pre-COVID-19) for all the measures is 112% while the summary (average) achievement for end of the project (2021) is 104%. The drop in occupancy rate and OPD utilization in Shifa and Alia was compensated by the significant increase in utilization of Obstetric and Emergency services in all hospitals and OPD use in Rafedia. Overall, for 2021, Rafedia had an achievement of 122%, while Shifa ha an achievement of 108% and Alia had an achievement of 90%.

Note: The initial baseline for this PDO indicator was as following: Shifa occupancy: 89%, Rafedia occupancy: 85%, Obstetrics Shifa: 76%, Obsetrics Rafedia: 94%, Outpatient Shifa: 578,646, Outpatient Rafedia: 163,262. Based on the project's assessment, baseline for numbers of outpatient department visits at Shifa and Rafidia hospitals were modified as follows: Shifa OPD: 180,000 - previous baseline (578,646) included all outpatient department visits for all hospitals in Gaza, not only Shifa hospital in 2014), Rafedia OPD: 60,000 - previous baseline (163,262) included both cases from the outpatient and emergency medicine departments at Rafidia in 2014. These new baselines were captured in the ISR seq no 15, March 2020) following the restructuring. The baseline figures provided did not include any figure for emergenc patients even though this was a part of the PDO indicator and was included in all periodic reports. Also, since the indicator was to ensure that utilization rates do not deteriorate, the targets used were same as the baseline. The Alia Hospital in Hebron was added to this indicator following the second restructuring on January 17, 2018. Accordingly, this analysis evaluated the achievements against all 4 measures (Occupancy rate%, Obstetrics Occupancy rate%, OPD and Emergency utilization) for all 3 hospitals (for Alia hospital, the 2016 figures were used for the baseline and target).

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Average annual growth of total expenditure in OMRs of a three-year period lower than the proposed baseline which is the period 2013-	Text	16.59% 01-Dec-2019	less than 16.59% 01-Dec-2019		2.04% 31-Dec-2021

2015 (<16.59%)					

Comments (achievements against targets):

Achievement: 100%. Target achieved.

Average annual growth for the three years between 2019-2021 is 2.04%.

Average annual growth for the three years between 2016-2018 is 9.73%.

While the average annual growth rate remained well below 16.59%, towards the end of the project it was only 2.04%, which showed a significant reduction in the average annual growth rate.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Gap in geographic equity for referral cost (between the West Bank and Gaza) reduced by 80 percent relative to baseline	Text	1.7:1 25-Jan-2015	1.15:1 25-Jan-2015		1.25:1 31-Dec-2021

Comments (achievements against targets):

Achievement:82%

Target achieved.

The % of achievement is calculated using the difference between what was intended and actual. It is also worth to note that this PDO level indicator was also greatly affected by the restrictions imposed on Gaza and the need of patients from Gaza and their companions for special permits issued by the Israeli authorities to move for treatment outside Gaza Strip.

A.2 Intermediate Results Indicators

Component: Component One: Emergency and Rapid Response Window

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Utilization rates (outpatient, emergency, and obstetrics) in the hospitals of Shifa, Rafedia and Alia do not deteriorate or improve by up to 10% compared to a baseline end September 2014	Text	Shifa occupancy:89% - Nasser occupancy: 74% European Gaza Hospital: 79% 25-Jan-2015	Same ratio as baseline or improve up to 10% 25-Jan-2015		Shifa occupancy: 87.3% Nasser occupancy: 61.8% European Gaza Hospital: 41.5% 31-Dec-2021

Comments (achievements against targets):

*** Error in the Indicator Name:** Should read as: Utilization rates (overall occupancy) in the hospitals of Shifa, Nasser Hospital and European Gaza hospital improve by up to 10% or retain the same ratio compared to a baseline end September 2014

Achievement: 78%

Target partially achieved. Although the utilization rates were showing an upward trend, however starting 2020, the rates started decreasing. The achievement targets were fully met if the 2019 (pre-COVID) performance figures are considered. However, the 2021 performance (end of project figures)

were affected by the pandemic. The summary (average) achievement for 2019 (pre-COVID-19) for all three hospitals is 111% while the summary (average) achievement for end of the project (2021) is 78%. Overall, for 2021, Shifa hospital had an achievement of 98%, while Nasser hospital had an achievement of 84% and EGZ had an achievement of 53%.

Component: Component Two: Rationalizing Outside Medical Referrals

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Referral protocols and procedures for the ten costliest conditions defined and rendered operational	Number	0.00 25-Jan-2015	10.00 25-Jan-2015		9.00 31-Dec-2021

Comments (achievements against targets):
Achievement: 90%

Target achieved.

9 are ready with the one on orthopedic surgery included in neurosurgery. Update of oncology was done.

2 more were identified by the SPU for paediatric surgery and radiotherapy protocols.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
A consolidated Government	Text	0.00	A web-based system		A web-based system

Health Information System (HIS) for referrals and health insurance is operational		25-Jan-2015	operational in all hospitals taking referrals 25-Jan-2015		operational in all hospitals taking referrals 31-Dec-2021

Comments (achievements against targets):
Achievement:100%

Target achieved.

Entering all patients' records on the E-referral system started in January 2019. Further work is required to fully merge the National Price reference List into the E-referral system and then be used for standardizing contracts. In summary, while the systems are operational and in place, effective use will require that agreements are in place. Agreements have been finalized for standardized prices for 81 procedures (related to adult ICU, neonatal ICU etc) with 11 hospitals out of a total of 23 hospitals which provide these services. Additionally, for neurosurgery related procedures (80 procedures) agreements will be signed with standardized prices with 3 hospitals out of a total of 12 hospitals which provide neurosurgery services.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
HIS operational in selected hospitals	Number	0.00 25-Jan-2015	6.00 25-Jan-2015	10.00 13-Sep-2017	13.00 31-Dec-2021

Comments (achievements against targets):
Achievement: 130%

Target surpassed. The 13 hospitals that have Avicenna HIS system are Jenin, Watani, Tulkarem, Tubas, Jericho, Qalqilia, Hebron, Yatta, Salfeet, Beit Jala, Rafidia, PMC and recently Hugo Chavez Ophthalmic hospital. The only MOH hospital that does not have HIS is Al Muhtaseb hospital due to the old

infrastructure of the building. The mental hospital in Bethlehem has HIS only in the laboratory department in order to keep data on patients' files confidential.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Health facilities constructed, renovated, and/or equipped (number)	Number	0.00 25-Jan-2015	5.00 25-Jan-2015	2.00 18-Jan-2018	2.00 31-Dec-2021
Direct project beneficiaries (no), of which female (%)	Percentage	0.00	50.00	53.00	46.00

Comments (achievements against targets):
Achievement: 100%

Target fully achieved.

Alia Hospital in Hebron (6 Operation rooms equipped) and Beit Jala hospital (Sterilizer). Ultrasonography/doppler equipment was moved to Alia Hospital in Jan. 2020)

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Ten certified infection	Text	Zero	10.00		12.00

preventionists and ten quality improvement practitioners by the Health Care Accreditation Council who will develop infection control plans and implement IP protocols		19-Dec-2019	31-Aug-2021		31-Dec-2021

Comments (achievements against targets):
Achievement:120%

Target surpassed

Training of 12 Quality Coordinators and Infection Prevention Control specialists from all West Bank hospitals was done online with the Health Care Accreditation Council in Jordan over 6 months.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Reduction in Device Associated Infections to 11/1000 cathetar or ventilator day	Text	19/1000 catheter or ventilator day 19-Dec-2019	11/1000 19-Dec-2019		6/1000 catheter or ventilator day 31-Dec-2021

Comments (achievements against targets):
Achievement: 162%

Target exceeded.

Through the work of the Quality and Patient Safety Department and the Infection Prevention and Control at the MOH that involved 44 training sessions for 491 trainees from all hospitals, there has been a reduction in device associated infections from 19/1000 to 6/1000 catheter or ventilator day on average

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Reduction in surgical site infection to 6%	Text	12% 19-Dec-2019	6% 19-Dec-2019		3% 31-Dec-2021

Comments (achievements against targets):
Achievement: 150%

Target surpassed.

Through the work of the Quality and Patient Safety Department and the Infection Prevention and Control at the MOH that involved 44 training sessions for 491 trainees from all hospitals, there has been a reduction in surgical site infections from 12% to 3% of all surgeries.

Component: Component 3: Supporting Health Coverage to Strengthen Sector Resilience

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
New referral contracts/ MOUs negotiated with all outside providers	Text	0.00 25-Jan-2015	30.00 25-Jan-2015		29.00 31-Dec-2021

Comments (achievements against targets):
Achievement: 97%

Target achieved. 29 contracts in place: the four new MOUs are with Ibin Sina, a new hospital in Jenin and a diagnostic radiology center in Gaza, and an ophthalmology center in Nablus and Al Hilou hospital in Gaza.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Purchasing agency (either independent or part of the MOH) created, staffed and made operational	Text	0.00 25-Jan-2015	Functional 25-Jan-2015		Functional 31-Dec-2021

Comments (achievements against targets):
Achievement:100%

Target achieved.

HSRSP supported staffing of 8 staff. Currently all staff are covered by government resources.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
People with access to a basic	Percentage	80.00	90.00		90.30

package of health, nutrition or reproductive health services		25-Jan-2015	25-Jan-2015		31-Dec-2021
Direct project beneficiaries (no), of which female (%)	Percentage	0.00 25-Jan-2015	50.00 25-Jan-2015		79.90 31-Aug-2021

Comments (achievements against targets):

Achievement:100%

Target achieved

This is a summary average of 4 indicators over 4 years (#/% of institutional deliveries, Access (#/%) of newborns registered at MCH , Access (#/%) of pregnant women registered in MCH (1st,2nd, 3rd trimester) , Immunization # and % for under 2- year old vaccines). See project files for details

The COVID-19 pandemic caused a reduction in the use of health services in 2020, but the access and utilization recovered by end 2020 and 2021.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
The Electronic Health Record for Adult, Child, Vaccination and NCD is functional and generates data in the pilot PHC facilities where service delivery is based on the family practice approach	Text	Not functional yet 19-Dec-2019	Functional in 5 health directorates (3 in the West Bank and 2 in Gaza) 19-Dec-2019		118 clinics in 5 health directorates (3 in the West Bank and 2 in Gaza) 31-Dec-2021

Comments (achievements against targets):
Achievement:100%

Target achieved. The Electronic Health Records system was rolled out in 118 clinics in 5 health directorates (3 in the West Bank and 2 in Gaza). However, further improvements are needed for streamlining the data generation for NCDs

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
People who have received essential health, nutrition, and population (HNP) services	Number	0.00 01-Jan-2017	526,662.00 01-Jan-2017		666,327.00 31-Dec-2021
Number of children immunized	Number	0.00 01-Jan-2017	414,348.00 01-Jan-2017		527,204.00 31-Dec-2021
Number of deliveries attended by skilled health personnel	Number	0.00 01-Jan-2017	112,314.00 01-Jan-2017		139,123.00 31-Dec-2021

Comments (achievements against targets):
Achievement: 127%

Target surpassed.

This is the sum of number of children immunized (cumulative) and number of deliveries attended by skilled health personnel (annual) for the period 2018 to 2021.

Component: Project Management and Capacity Building

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
External audit (medical and financial)	Text	Not available 25-Jan-2015	Functional 25-Jan-2015		Functional 31-Dec-2021

Comments (achievements against targets):
Achievement:100%

Target achieved.

Audits completed on time. Medical auditing is performed by 3 medical auditors at the SPU.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Health personnel receiving training (number)	Number	0.00 25-Jan-2015	500.00 25-Jan-2015		700.00 31-Dec-2021

Comments (achievements against targets):
Achievement:140%

Target exceeded.

Trainings on pediatric pulmonology, neonatology, NPR (included MOH and non-MOH health staff), training health economist, and training within the UHC component.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised Target	Actual Achieved at Completion
Grievance and Redress Mechanism (GRM) for OMRs and access to Health Care designed and fully operational by end of the project	Text	Not available 25-Jan-2015	Functional 25-Jan-2015		Functional 31-Dec-2021

Comments (achievements against targets):
Achevement:100%

Target achieved.

Indicator Name	Unit of Measure	Baseline	Original Target	Formally Revised	Actual Achieved at

				Target	Completion
Communication strategy on UHC developed and consultation workshops conducted to promote the concept of citizens' engagement	Text	0.00 25-Jan-2015	Consultation workshop conducted 25-Jan-2015		Communication strategy prepared and workshop conducted 31-Dec-2021

Comments (achievements against targets):

Target achieved.

Communication strategy prepared and launched

B. KEY OUTPUTS BY COMPONENT

Outcome1: Securing continuity in health care delivery	
Outcome Indicators	1. Utilization rates (out-patient, emergency and obstetrics) in the hospitals of Shifa, Rafedia and Alia Hospital do not deteriorate or improve up to 10% compared to a baseline end-September, 2014 (proxy for the impact of the project on access to health services)
Intermediate Results Indicators	1. Utilization rates (overall occupancy) in the hospitals of Shifa, Nasser Hospital and European Gaza hospital improve by up to 10% or retain the same ratio compared to a baseline end September 2014 2. Health facilities constructed, renovated, and/or equipped
Key Outputs by Component (linked to the achievement of the Objective/Outcome 1)	1. Utilization rates of key hospitals improve or do not deteriorate (Component 1 &2)
Outcome 2: Improved resilience of health system	
Outcome Indicators	1. Average annual growth of total expenditure in OMRs of a three-year period is lower than the proposed baseline which is the period 2013-2015 (<16.59%) 2. Gap in geographic equity for referral cost (between the WB&G) reduced by 80 percent relative to baseline
Intermediate Results Indicators	1. Referral protocols and procedures for the ten costliest conditions defined and rendered operational 2. A consolidated Government Health Information System (HIS) for referrals and health insurance is operational 3. HIS operational in selected hospitals

	4. Ten certified infection preventionists and ten quality improvement practitioners by the Health Care Accreditation Council who will develop infection control plans and implement IP protocols 5. Reduction in Device Associated Infections to 11/1000 catheter or ventilator day 6. Reduction in surgical site infection to 6% 7. New referral contracts/ MOUs negotiated with all outside providers 8. Purchasing agency (either independent or part of the MOH) created, staffed and made operational 9. People with access to a basic package of health, nutrition or reproductive health services 10. The Electronic Health Record for Adult, Child, Vaccination and NCD is functional and generates data in the pilot PHC facilities where service delivery is based on the family practice approach 11. People who have received essential health, nutrition, and population (HNP) services
Key Outputs by Component (linked to the achievement of the Objective/Outcome 2)	1. Reduction in growth of health expenditure on referrals (component 2) 2. Increased availability of information on referrals for decision making (component 2) 3. Outside Medical Referrals rationalized (component 2) 4. Improved access to a basic package of health, nutrition or reproductive health services (component 3) 5. Strengthened capacity of MOH for UHC (component 3)

ANNEX 2. BANK LENDING AND IMPLEMENTATION SUPPORT/SUPERVISION

A. TASK TEAM MEMBERS

Name	Role
Preparation	
Samira Ahmed Hillis	Task Team Leader(s)
Riham Hussein	Financial Management Specialist
Maged Mahmoud Hamed	Social Specialist
Supervision/ICR	
Samira Ahmed Hillis, Denizhan Duran	Task Team Leader(s)
Ala' Abd Minem Mohammad Turshan, Yash Gupta	Procurement Specialist(s)
Riham Hussein	Financial Management Specialist
Mohammad Ali Mousa Jaber	Financial Management Specialist
Helen Z. Shahriari	Social Specialist
Abdallah Awad	Team Member
Fernando Xavier Montenegro Torres	Team Member
Mariana Margarita Montiel	Counsel
Zlatan Sabic	Team Member
Emeran Serge M. Menang Evouna	Environmental Specialist
Andrianirina Michel Eric Ranjeva	Team Member
Mariam William Guirguis	Team Member
Jessey A. Niyongabo	Environmental Specialist
Khaled Mohamed Ben Brahim	Team Member
Zein Azzam Ibrahim Daqqaq	Team Member
Marian Arakelian	Team Member
Sherin Varkey	Team Member

B. STAFF TIME AND COST

Stage of Project Cycle	Staff Time and Cost	
	No. of staff weeks	US$ (including travel and consultant costs)
Preparation		
FY14	1.550	21,567.18
FY15	29.886	142,218.73
Total	**31.44**	**163,785.91**
Supervision/ICR		
FY15	2.450	29,962.28
FY16	34.161	194,616.51
FY17	13.520	79,739.83
FY18	11.834	118,317.67
FY19	27.310	158,659.74
FY20	21.033	132,669.63
FY21	18.677	112,081.50
FY22	12.301	89,497.97
FY23	1.305	11,224.48
Total	**142.59**	**926,769.61**

ANNEX 3. PROJECT COST BY COMPONENT

Components	Amount at Approval (US$M)	Actual at Project Closing (US$M)	Percentage of Approval (%)
Component 1: Emergency and Rapid Response Window	2.00	2.07	103.50
Component 2: Rationalizing Outside Medical Referrals	3.50	3.66	104.57
Component 3: Supporting health coverage to strengthen sector resilience	2.00	1.78	89.00
Component 4: Project Management and Capacity Building	1.00	0.95	95.00
Total	**8.50**	**8.46**	**99.00**

ANNEX 4. EFFICIENCY ANALYSIS

A. Economic Efficiency

The benefits of the project were analyzed by outcome indicators. Although there were additional indicators related to supporting health coverage to strengthen health sector resilience, data limitations prevented the estimation of the cost-effectiveness in these areas. An attempt was made to provide a more comprehensive estimate of the different workstreams of the project instead of only focusing on outside medical referrals. Considering the available indicators used to monitor the project's success, the approach utilized to estimate total benefits focused on 4 areas: (i) estimating savings on outside medical referrals; (ii) estimating savings from prevented hospital acquired infections; (iii) estimating DALYs averted due to the additional services provided; and finally (iv) estimating savings in out-of-pocket spending which would have been spent in the private sector. For all savings, two estimates were calculated, the total estimate, and a more conservative estimate, which is 50% of the savings as the indicators used are national level indicators and thus savings cannot only be attributed to the project.

At the appraisal stage, a cost-benefit analysis was carried out, estimating that the project would yield significant economic and financial returns by reducing referral costs through an increase in hospital capacity to treat patients. The project initially aimed to achieve a 40 percent reduction from the trend-line in referral costs, resulting in cost- savings over the lifetime of the project of US$198 million over projected costs in the absence of the project. This analysis was replicated with a counterfactual annual increase of 16.59% annually. The project's PDO indicator was to maintain the average annual growth rate of OMR below 16.59%. Using the baseline annual OMR bill (2014) and projecting using this growth rate of 16.59%, the referral bill would have reached ILS 1.837 billion, however the actual bill in 2021 was only ILS 0.974 billion. As other factors have likely contributed to these savings, two additional scenarios were used to arrive at more conservative estimates of savings that can be attributed to the project. First, was replicated with a counterfactual annual increase of 13.19 percent annually, which was the initial target set at second restructuring (January 2018). Second, only 50% of savings were considered as a conservative estimate. It must be noted that in addition to the reforms, as well as improved public sector hospital capacity achieved with the support of the project, some of the decline in referrals could be attributable to the security and movement restrictions (especially for referrals from Gaza) and a significant reason in 2020 was COVID-19, which constrained hospitals' capacities restricting referrals. Despite limitations, these additional counterfactual scenarios show that even when considering only 50% of benefits at the lower growth rate of 13.19%, savings are estimated to be US$222 million, surpassing the savings estimated at the appraisal stage.

Total savings on **outside medical referrals** are estimated to be between US$222 million and US$678 million, depending on which counterfactual rate and estimate is used. This significantly surpasses the US$198 million estimated at the project appraisal stage.

The decline in **hospital acquired infections**, both catheter and ventilator associated infections and surgical site infections was very large. Assuming if these infections were not prevented, they would have caused major complications and would have required referrals. Using the number of hospital days and average length of stay from the MOH Annual Statistics Report, total inpatient stays, and patients catharized were estimated. The number of infections prevented was then calculated based on the decline from 19/1000 to 6/1000 infections. Similarly, for ventilator-associated infections, the number of ICU cases and number of ventilated cases were estimated based on the MOH 2021 annual report. The number of infections

prevented was then similarly calculated based on the decline from 19/1000 to 6/1000 infections. Finally, estimating surgical site infections prevented was more straightforward as MOH reports the number of surgeries performed annually. Using the average estimated cost of referral outside Gaza, which the MOH reports to be 10,607 ILS[23], the total estimated savings are approximately US$2.9 million and US$48.5 million from catheter and ventilator infections and surgical site infections prevented, respectively.

Support was also provided to ensure that **provision of basic health, nutrition, and population** services does not deteriorate. For this analysis, we consider institutional deliveries. Assuming the baseline is the first year of data reported, additional births attended by a skilled physician were calculated, since absent of support, capacity constrains would have likely prevented additional these additional deliveries to be done in a hospital by a skilled physician. The additional institutional deliveries over time are utilized to estimate DALYs averted. DALYs prevented were estimated based on prevalence of conditions from the Institute for Health Metrics and Evaluation (IHME)[24]. From the literature, we assume 25% of these births would have complications and would need a hospital and 60% of these DALYs can be averted with an institutional birth by a skilled physician[25,26,27]. A total of approximately 6,700 DALYs were averted, translating to approximately US$24.5 million of economic returns (US$12.3 million as a conservative estimate). Benefits are considered highly cost effective in accordance to the WHO-CHOICE (Choosing Interventions that are Cost-Effective) Project [28]: an intervention that, per disability-adjusted life-year (DALY) avoided, costs less than three times the national annual GDP per capita, is considered cost effective, whereas one that costs less than the national annual GDP per capita is considered highly cost effective.[29] When considering a total cost of US$8,500,000 and 6,700 DALYs averted, this equates to approximately US$1,269 per averted DALY, which is 0.35 times the GDP per capita.

Finally, additional services were provided to ensure no decline in service provision occurs. These services included emergency visits and outpatient department (OPD) visits. As outpatient department visits can be considered non-urgent and the likelihood of a patient seeking care in the private sector or an NGO with constrained capacity instead of going at a later time is low, changes in OPD visits are not used in the savings estimation. For emergency visits though, the change from baseline is estimated for each hospital then the cumulative change is used with the average OPD visit cost in the private sector to estimate total savings. **Savings in OOP** due to provision of additional emergency services are estimated to be approximately US$29.5 million, which is highly significant and is equivalent to approximately 4.8% of the

[23] State of Palestine Ministry of Health. 2021. Health Annual Report 2020. https://site.moh.ps/Content/Books/mv2fIO4XVF1TbERz9cwytaKoWKAsRfslLobNuOmj7OPSAJOw2FvOCI_DQYaIXdf2i8gCmPHbCsav29dIHqW26gZu9qJDiW2QsifZt6FrdS4H2.pdf

[24] Institute for Health Metrics and Evaluation (IHME). GBD Compare. Seattle, WA: IHME, University of Washington, 2020. Available from http://vizhub.healthdata.org/gbd-compare. (Accessed [October 2022])

[25] Institute for Health Metrics And Evaluation (IHME). GBD Compare. Seattle, WA: IHME, University Of Washington, 2020. Available From Http://Vizhub.Healthdata.Org/Gbd-Compare. (Accessed [October 2022])

[26] Committee On Fetus And Newborn, Kristi L. Watterberg, Lu-Ann Papile, Jill E. Baley, William Benitz, James Cummings, Waldemar A. Carlo, Praveen Kumar, Richard A. Polin, Rosemarie C. Tan; Planned Home Birth. *Pediatrics* May 2013; 131 (5): 1016–1020. 10.1542/Peds.2013-0575

[27] Review to Action (2020). Report From Nine Maternal Mortality Review Committees. Available at https://www.cdcfoundation.org/sites/default/files/files/ReportfromNineMMRCs.pdf

[28] The CHOICE (CHOosing Interventions that are Cost-Effective) project is a WHO initiative developed in 1998 with the objective of providing policy makers with evidence for deciding on interventions and programs which maximize health for the available resources

[29] Marseille E, Larson B, Kazi DS, Kahn JG, Rosen S: Thresholds for the cost–effectiveness of interventions: alternative approaches. Bulletin of the World Health Organization 2014, 93:118-124.

total OOP spent in 2020[30]. The table below shows a summary of the results of the complete analysis: (i) estimating savings on outside medical referrals; (ii) estimating savings from prevented hospital acquired infections; (iii) estimating DALYs averted due to the additional services provided; and finally (iv) estimating savings in out-of-pocket spending which would have been spent in the private sector. Total savings come out to approximately US$767 million, most of which is driven by the savings on OMR.

Table A4.1 Estimated Savings as a result of project interventions

	Total (US$)	Conservative estimate (50% of benefit) (US$)
Savings on outside medical referrals	677,484,369	338,742,185
Savings on catheter/ventilator infections	2,883,593	1,441,797
Savings on surgical site infections	48,493,557	24,246,779
OOP savings	13,335,728	6,667,864
Total savings	742,197,248	371,098,624
Benefit from DALYs Averted	24,559,926	12,279,963
Total Savings and benefits from DALYs Averted	766,757,174	383,378,587

B. Implementation Efficiency

The project's strategic focus included addressing immediate emergency needs in Gaza. The project aimed to ensure the continuation of basic healthcare services at minimum acceptable levels and to avoid such services from experiencing systemic collapse. In addition to mitigating potential severe consequences for public health from increasing the risk of infections and outbreaks of communicable diseases, this approach contributed to minimize the cost of outside medical referrals by decreasing need for OMR due to delayed or foregone care. The project aimed to improve the equity and efficiency of OMRs and address longer term sustainability by supporting improvements in existing health coverage. The project also aimed to reduce costs related to referrals while ensuring that the Palestinian population received the tertiary services they needed in a manner that was costed, prioritized, and based on clear rules. The combination of emergency response along with measures to reduce OMR expenditures and focus on health sector reform improved the project's overall efficiency.

Comparison of Actual and Estimated Costs

At appraisal, the estimated project was US$8.5 million, comprising Component 1 (US$2 million), Component 2 (US$3.5 million), Component 3 (US$2 million), and Component 4 (US$1 million) respectively. Available actual expenditure data at closing showed that US$2.07 million (104 percent of appraisal estimate), US$3.66 million (105 percent of appraisal estimate), US$1.78 million (89 percent of appraisal estimate), and US$0.95 million (95 percent of appraisal estimate), were spent on Components 1, 2, 3, and 4 respectively. Despite the various challenges, the project disbursed at a high rate.

Staff turnover. The costs of the PMU were shared between the various projects financed by the WB. The Head of the PMU and the Procurement Specialist remain in their posts. However, there were turnovers in the positions of Health Specialist and Finance Specialist. The absence of the Health Specialist position affected the timely availability of information on project progress. However, the absence of a Finance Specialist was managed by securing temporary support from the MOF PMU. Several other MOH staff

[30] Palestinian Central Bureau of Statistics. 2020. *https://www.pcbs.gov.ps/site/lang__en/797/default.aspx*. Accessed October 2022

remained in the PMU throughout the project, even if their roles within the MOH changed. This consistency was important for the efficiency of the project implementation. For the WB, the project had two TTLs and did not suffer from extended periods of TTL replacement due to smooth transitions between the TTLs. Additionally, following the transition to a new TTL, the previous TTL took on the role as Program Leader of Human Development in WB&G which provided continuity and retention of institutional memory for the project.

Time overrun/underrun. The time from Decision meeting to approval of the project was 2.8 months, and the time from approval to effectiveness was just 0.9 months, less than the Bank average of five months. And time from effectiveness to first disbursement was 0.9 months, much less than the Bank average of four months. Towards the end, the project had requested for two no-cost extensions, the first extending the project end date from June 2020 to December 2021 to complete the GHI MIS related activities, specialist training as well as activities related to the capacity building of the SPU and further strengthening of the e-referral system, and the Second extending the project end date from December 2021 to 31 May 2022 to enable the completion of procurement processes and finalize disbursements for activities which were delayed due to COVID-19.

Table A4.3. Processing Times

	Decision Meeting to Approval	Approval to Effectiveness	Effectiveness to First Disbursement
HSRSP project	2.8 months	0.9 months	0.9 months
WB average	14 months (concept note to approval)	5 months	4 months

ANNEX 5. RECIPIENT COMMENTS

Below is the Recipient's ICR prepared by Project Management Unit (PMU), Palestinian Ministry of Health

INTRODUCTION

The Health System Resiliency Strengthening Project (HSRSP) was one of the WB financed Projects implemented in partnership with the Palestinian Ministry of Health (MoH) from February 2015 to 31 May 2022 (*see Annex 1 for List of Acronyms*).

For the preparation of the HSRSP Implementation Completion and Results Report (ICR), several documents have been reviewed including: the Project Appraisal Document (PAD); Semi-annual Reports submitted by Project Management Unit (PMU) and MoH to the WB including Interim Financial Reports (IFRs), Procurement Plans (PPs), communications between the MoH and the WB, Procurement Post Review reports, WB's Supervision Missions and Aide Memoires, and Mid-term Review Report of 2017 including Restructuring decisions, Requests for extension and all documents produced throughout the project. Additionally, several interviews have been held with the different involved MoH departments, partners, PMU staff and part of the WB staff members who were involved in the project activities and attended the last mission in June 2022 *(see Annex 2 for list of interviewees and attendees of HSRSP June 2022 mission).*

1. Project Description and Context

1.1. Background on Palestine and the Palestinian Healthcare System

In mid-2022, Palestine has a population of around 5.23 million of which 49.2% are females. The population is distributed at 3.12 million in the West Bank and 2.11 million in Gaza Strip of which 41% are refugees. The percentage of individuals aged 0 to 14 years constituted 38% of the total population in mid-2021, of whom 36% is in the West Bank and 41% in Gaza Strip. The percentage of elderly population aged 65 years and above reached 3.4% of the total population[i].

Despite the series of crises Palestine had been through over the past years, it managed to improve a number of health indicators, such as: life expectancy (from 68.1 in 1990 to 74.2 years in 2021), infant mortality rate (from 35.7/1000 in 1990 to 9.6/1000 in 2021), under-five mortality (from 44.6/1000 in 1990 to 11.8/1000 in 2021), and maternal mortality rate (from 96/100,000 in 1990 to 28.5/100,000 in 2020)[ii]. However, Palestine has been confronting (NCDs and their economic and social burden increasingly as they have become from the top leading causes of death over the last few years. It was estimated that nearly two-thirds of Palestinian elderly complain of NCDs[iii].

The expenditure of the MoH in the year 2021 was 2,597,711,160 ILS distributed as follows: 974,782,080 ILS (37.5%) on OMRs; 966,470,279 ILS (37.2%) on salaries; 503,710,600 ILS (19.4%) on medications, vaccines and medical consumables; and on running and administrative costs was 152,748,201 ILS (5.9%).

The MoH total general revenues were ILS 142,240,233 of which 104,792,988 ILS (73.7%) from primary health care centers; 35,634,447 ILS (25%) from governmental hospitals; and 1,812,798 ILS (1.3%) from administrative centers. The total health insurance revenues for the year 2021 were 317,928,166 ILS of which: 249,108,913 ILS (78.3%) from health insurance; 56,855,885 ILS (17.9%) from primary health care and 11,963,368 ILS (3.8%) from administrative centers[iv].

Palestine as other countries struggles for coping with social determinants of health to reform, improve and develop the health care system with a view to realizing the right of access to good quality health services for all, both equitably and equally. Hence, several international aid and United Nations (UN) organizations have been involved, as well as local and international non-governmental organizations, to meet the priorities of the MoH; those have been issues affecting the health care system, such as strengthening primary health care,

securing needs (human resources and material) in PHC centers and hospitals, health insurance and introduction of the road to universal health coverage, health financing and capacity building of health care staff members.

1.2. Project Context

The Palestinian MoH took over the management of the health sector, first in Gaza Strip and Jericho, and later in the rest of the West Bank governorates in 1994. The MoH undertook an assessment study of health facilities, covering primary and secondary health services. Technical support was provided to this assessment by UN agencies, as well as by the donor community.

Since 1994, the MoH started developing its own health plans and the National Health Strategy for the years 1999-2003 was developed by the MoH with wide participation from civil society organizations and with technical and financial support from the WB and the WHO (WHO)[v]. Later, National Health Strategies of 2008-10, 2011-13, 2017-22 and 2021-2023 were developed by the MoH Planning Unit respectively. Two additional plans were developed within the health sector: the Sexual and Reproductive health strategic plan for the period from 2018 to 2022 and the National Strategy for Suicide Prevention for the years from 2021 to 2026. The National Health Strategy for the Youth and Adolescents Health was launched recently for the years 2022-2026. Another National Electronic Health Strategy has been prepared jointly by MoH and the WHO for the coming eight years and will be launched in the third quarter of 2022.

The implementation of these plans resulted in a major development of quality health services, enhanced capacity of health workers, and an improved network of government services. Nevertheless, Palestine has been facing challenges in health expenditures mainly on curative care and fiscal space issues, caused primarily by the increasing cost of Outside Medical Referrals (OMRs), and so the expenditure on health put a heavy burden on the budget of the MoH in the past few years. The referral bill amounted to about 70% of the ministry's total operating expenses, especially on oncology cases for certain types of diagnostic and treatment procedures which are not available at the MoH facilities. Apart from the burden of the OMRs, there has been a continuous increase in the percentage of the Out of Pocket (OOP) expenditure by citizens on healthcare between the year 2000 and 2018 to reach an average of 39.1% though with an increase between 2011 and 2017 to above 41%; it was 38.4% for the year 2020.

The WB had several projects being implemented in the WB&G Strip in different sectors including the health field. Therefore, the immediate emergency situation resulting from the conflict and war in Gaza in 2014 addressed the emergency need for additional health financing. The Palestinian Liberation Organization, for the benefit of the Palestinian Authority (PA), and the International Development Association (IDA), the WB acting as an administrator of the TF for Gaza and West Bank, signed a grant agreement, dated February 4, 2015, whereby the WB made a grant, to the Palestinian Authority, in an amount of $7,250,000 to finance a project entitled "Health System Resiliency Strengthening Project" (HSRSP), to be managed by the Palestinian Ministry of Health (MoH). Thereafter, on September 15, 2015, an amendment to the Agreement was signed to increase the grant amount to $ 8,500,000 by adding additional funds of $ 1,250,000.

The table below summarizes the changes on HSRSP project throughout its implementation:

Project change	***When***	***Type of change***
Amendment on agreement	*In September 2015*	*Increase the project budget by $1,250,000 to become $8.5 million*
Restructuring 1	*In 2017 after MTR*	*Revision on two PDO-level indicators 'see Section 2.1'*
Request of extension and Restructuring 2	*In December 2019*	○ *No cost extension of closing date to become 31 December 2021 instead of 30 June 2020 (18 months) 'see Section 2.1'* ○ *Revision on one PDO-level indicator* ○ *Including three new intermediate results indicators*

Request of extension	*In September 2021*	*No cost extension of closing date to become 31 May 2022 instead of 31 December 2021 (5 months) 'see Section 2.1'*

1.3. Project objectives

The WB Assistance Strategy (AS) for WB&G FY2015-2016 highlighted health expenditure as a key area of engagement that aims to strengthen public institutions to ensure services to citizens, and the AS noted that "the proposed program will help create increased fiscal space that will allow the PA to generate enough financial resources to fund public services. The Bank's assistance will concentrate on revenue and expenditure management in general, with a special focus on improved management of health and electricity sector expenditures"[vi].

Within the framework of the HSRSP, the Project Development Objective (PDO) was stated to be: '*To support the Palestinian Authority in securing continuity in healthcare service delivery and building its resilience to withstand future surges in demand for effective healthcare coverage'.*

The project had three PDO-level results indicators: a) *Utilization rates (out-patient, emergency and obstetrics) in the hospitals of Shifa and Rafedia do not deteriorate or improve up to 10% compared to a baseline end September, 2014; b) The total cost of referrals reduced by 15% relative to baseline; c) and Gap in geographic equity for referral cost (between the WB&G) reduced by 80% relative to baseline (The three PDO-level results indicators, their restructuring/revision after the MTR in 2017 and in 2019 with their achievements will be presented in Section 2).*

1.3.1 Rationale and Relevance of Objectives during preparation and implementation

During preparation and implementation of the HSRSP, the project aligned well with both the MoH strategies' goals and with the WBG's Assistance Strategy (AS) for the WB&G for FY15–16 which supported its *relevance* to the Palestinian context. The project was based on the WB's 2013–2018 Middle East and North Africa (MENA) Health, Nutrition and Population Strategy, which focused on fairness and accountability as key priority areas for the WB's engagement in the region[vii]. In line with the first pillar of the AS, the project directly supported the PA's efforts to strengthen institutions in order to efficiently manage public finance and ensure services to citizens: "The National Development Plan (NDP) prioritizes the development of a health insurance system to generate sustainable financing of the health sector"[viii].

As such, the HSRSP project was consistent with the Palestinian NDP, the MoH goals and the WBG's goals and of ending extreme poverty and boosting shared prosperity and with MENA's Regional Strategy, and supporting the pillars of ensuring economic and social inclusion and strengthening governance.

The HSRSP considered several context factors to alleviate immediate needs and to address the fiscal pressures faced by the health system for the aim of supporting the necessary reforms. The main factors that provided *rationale* for the HSRSP objectives included:

- The emergency situation of the War on Gaza in 2014 has provided the MOH and Ministry of Finance (MoF) with a strong motivation and rationale to address immediate needs and to address underlying challenges facing the health sector.
- The proposed Project components provided a set of activities to address immediate sector needs and improve quality and efficiency in health expenditures because the MoH kept in deficit of revenues and in debt over several years. The rationale for public intervention was demonstrated by inequities in health outcomes between the WB&G and between urban and rural areas, which are matched by inequalities in quality and access to health services.
- High proportion of the health expenditure was and continued to be on curative care. Expenditures on OMRs have risen sharply over the last ten years; the number of referrals has increased from 8,123 in 2000 to 99,310 in 2021. The corresponding expenditure has also increased significantly from 731.4 million ILS in 2015 to around 970 million ILS in 2018. Reasons for the increase in the number of referrals included lack

of medical services within the MoH facilities (pharmaceuticals, equipment, and specialized medical personnel), the increase in the prevalence of NCDs, and the overload on health facilities.

The *relevance of the PDO* remained High in the past and current national priorities of Palestine and the MoH throughout the project period; this was confirmed by the ISRs prepared by the Bank and the regular progress reports prepared by the PMU. Specifically, the PDO directly supported Palestine priorities and the MoH strategy for achieving strengthened health system, fiscal space and long-term institutional development by creating fair and accountable health systems (specifically for health insurance and referrals) that are part of the needed reform.

2. Assessment of Project Outcomes

2.1. Achievement of Project Development Objective (PDO) Level Outcomes

The WB conducted missions confirmed that the Project had good performance and continued to achieve progress towards the achievement of the Project Development Objective *'to support the Palestinian Authority in securing continuity in health care service delivery and building its resilience to withstand future surge in demand for effective health care coverage'.* By the end of the project and with evidence from the WB, the achievement of the PDO was satisfactory.

Since the launch of the HSRSP in February 2015 till May 31 2022, there has been support to the MoH in the health sector with specific attention to responding to emergency situation (especially in Gaza), availability and access to health care services, targeting aspects that will support rationalization of OMRs and supporting the work towards UHC *(see Annex 3 for PPT presentation for summary of achievements of the PDO level indicators and the intermediate level indicators presented by PMU during the WB June 2022 mission)*. Progress toward the PDO was monitored through three PDO results indicators; of which two were revised after the Mid Term Review (MTR) in 2017 and another revision on one in 2019 *(see Annex 4 for a summary table of revisions on the PDO level results indicators, Annex 5 for the MTR Aid Memoire, Annex 6 for December 2021 request of extension and restructuring and Annex 7 for October 2021 request of extension).*

The HSRSP fully met the first above two PDO-level indicator targets: the first indicator was met as the utilization rates in the three hospitals did not deteriorate all through the project implementation period except for the years of Covid-19 pandemic due to the cancellation of Outpatient Department (OPD) appointments. The second indicator was also met; it had a value of 9.73% for the three years from 2016 to 2018 and a value of 2.04% for the three years from 2019 to 2021. As for the third PDO-level indicator on the gap in geographic equity in referral cost, although the MTR recommended to drop it, the PMU kept monitoring it due to its close link with the work on the referral component; it was close to be fully met by the end of the project as the cost gap was reduced from 1.7:1 in 2016 to 1.25:1 in 2022. The target to reach was 1.15:1 and in 2021, around 37% of the cost on referrals was on patients from Gaza Strip. It is also worth to note that this PDO level indicator has been greatly affected by the siege on Gaza and the need of Gazan patients and their companions for special permits issued by the Israeli authorities to move for treatment outside Gaza Strip.

By the end of the project, almost all the project goals and activities have been achieved:

The **first** component of the project ***"Emergency and Rapid Response Window"*** specifically allocated for Gaza hospitals was successfully implemented and achieved according to allocated budget. The contribution secured procurement of cleaning materials for the continuity of cleaning services provision in the MoH facilities in Gaza especially at the surgical, intensive care and neonatal intensive care units by 100% compared to 55% before the intervention (91 facilities in 2014 and 84 facilities in 2015, so total 175 facilities). Prior to intervention, cleaning services were only made available in the emergency units due to the strike of cleaning companies at that time. Post-intervention assessment in August 2016 showed substantial reduction in the accumulation of medical waste in critical units hence decreasing the probability of infection outbreak from 60% to 10% during the time of conflict in 2014. Additionally, a satisfaction level of 85% was registered among MoH employees and patients in 2015 versus 15% during the summer of 2014 *(see Annex 8 for Impact Assessment Report of component one in Gaza, August 2016).*

The **second** component "***Rationalizing Outside Medical Referrals (OMRs)"*** has achieved almost all the planned activities with re-allocation of budget to meet arising needs. Achieved activities included:

a. Equipping the newly built six operating rooms at Alia/Hebron Hospital (HH) for the aim to increase the number of surgical operations performed at the public system and support reductions in the number of OMRs caused by unavailability of equipment or needed services *(see Annex 9 for Bank's needs assessment for the rationale of selecting Alia Hospital for being equipped).* The intervention had short- and medium-term implications on outside medical referrals (OMRs) in the West Bank including: a) increased number of **major** operations by 14.7% in 2017 (5,800 in 2017 compared to 5,055 in 2016); an increase of 16% in 2018 compared to 2017 and an increase of 9% in 2019 compared to 2018 (6,728 operations in 2018 and 7,349 operations in 2019), but the number dropped to 4,767 operations in 2020 due to Covid-19 pandemic and the cancellation of scheduled operations[ix]; b) reduced waiting time for surgical operations as a substantial number of surgeries scheduled in 2018 were advanced to 2017 instead, resulting in increased public satisfaction; c) improved the working environment and safety measures; d) and improved of team morale and job satisfaction. Long term impacts included improving equitability in access to health care services and improving efficiency and structural quality of tertiary care provided by Alia Hospital and improving the financial standing of the MoH by reducing referrals caused by unavailability of services *(Source: qualitative data through conducted hospital field visits and interviews with hospital staff members)*.

b. Ultrasound Doppler for Beit Jala Hospital which was moved to Hebron Hospital (with the operating surgeon) in January 2020 in order to have a full unit for vascular surgery in the Southern area of the West Bank including peripheral surgeries and avoiding their referrals to outside MoH hospitals. Since its installation in March 2017 till May 2022, the machine was used to perform 12,252 diagnostic and intra-operative surgeries with savings of over USD 18.7 million USD thus reducing the need for costly OMRs. This machine is considered a success story by the project as it had value for money 'comparing achieved results and savings with the price of the machine' *(Source: qualitative data through conducted hospital field visits and interviews with hospital staff members)*.

c. Sterilizer for the Central Sterile Service Department at Beit Jala Hospital to replace an old equipment. The new sterilizer showed efficiency, effectiveness, reduction in workload and high satisfaction of operators as having the machine reduced the need to move instruments to other hospitals for sterilization *(Source: qualitative data through conducted hospital field visits and interviews with hospital staff members)*.

d. Interventions and analytical documents including the Referral Master Plan which was endorsed by the Cabinet on September 27, 2016 and efforts have been made by the MoH with support from stakeholders working on different components of the referral reform to comply with a unified MoH plan. The master plan formed a reference document and basis for the development of referral guidelines, referral procedures and referral protocols 'e.g. oncology, nephrology and urology, cardiac catheterization, liver transplantation, ophthalmology…. etc.' by the SPU staff members and the formed regional and central referral committees.

e. Implementation of the Communication Strategy Activities to raise awareness on projects' various activities; especially in health insurance, referrals and complaint 'Grievance Redress Mechanism' (GRM). The MoH working group formed from members in the three units with support from the MoH media unit supported the production of several media materials (posters, radio spots, video motion, messages on social media, stickers, magnets…etc.) of which part was broadcasted on local radios, local TV channels and the MoH website and social media in order to promote citizen's engagement.

f. Supply of neonatal medical equipment to four Neonatal Intensive Care Units (NICUs) (PMC, Jenin, Rafidia and HH) based on the needs identified within the training on neonatology and through the reallocated budget within this component. Equipment included portable echo machine, neonatal monitors with central station, cooling mattress with amplitude integrated EEG monitor and open resuscitators. Availability of equipment at those major hospitals will support reducing referrals caused

by unavailability of equipment and will also enforce the capacities of health staff who are the operators of those machines.

g. Emergency response to COVID-19 pandemic: Upon discussions and agreement between the MoH and the Bank, savings from the project of $800,000 were allocated for the procurement of urgently needed equipment and consumables as a response to the pandemic. Those included: ICU ventilators, monitors, suction machines, personal protective equipment, swabs, medical consumables, defibrillators, autoclaves, emergency beds, diagnostic sets, …etc. The procurement of those items highly supported the MoH in responding to the pandemic and the sharp rise in cases during waves, especially that MoH designated 7 MoH centers as Covid treatment centers as well as 20 (MoH and non-MoH) hospitals that needed equipment and consumables to respond to the pandemic *(see Annex 10 for the list of procured equipment as emergency response to Covid).*

An additional activity was conducted by preparing an OMR Assessment *through direct support from the WB which supported the work on this component at the SPU (see Annex 11 for the final draft of the assessment).*

The impact of this component on referrals is that the MoH had two major systems to organize the work on referrals (GHIMIS and E-referral) and continued with its strategy on the nationalization of health services by contracting new services at local hospitals. Therefore, the referrals to Israeli hospitals sharply declined from 40,191 in 2016 to 5,185 in 2021, and so the referrals to WB and East Jerusalem hospitals increased by 14.6% in 2021 compared to 2016: there were 73,914 referrals to WB and EJ hospitals in 2016 which increased to 84,772 referrals in 2021. Additionally, the supply of equipment supported responding to needed services, reducing referrals related to their need, and high satisfaction of patients and staff members.

On component **three** **"Supporting Universal Health Coverage (UHC) to Strengthen Sector Resilience"**: This was done through a contract with the WHO Palestinian National Institute of Public Health (PNIPH) focusing on strengthening the evidence-based data of MoH in the areas of Family Practice, Health Financing and Human Resources for Health (HRH). The project provided computers and networking for the implementation of family practice electronic record in 118 clinics in three districts in the West Bank (Salfeet: 18, Ramallah: 57 and north Hebron: 43 clinics) and 2 clinics in Gaza strip (Daraj and Sourani); these clinics 120 clinics form 77.7% of level III PHC centers which is 153 clinics and 24% of the total number of PHC centers in Palestine which is 491 centers[x]. The training was conducted to over 120 staff members as TOT and for end health staff users in a number of districts through support from other donors, such as Norway, Denmark and Belgium. The family record includes: registration of patient with socio demographics profile, health history, child health, as well as immunization, child growth chart, adult file noncommunicable diseases patient file, in addition to the lab, radiology, and pharmacy services. The PNIPH reported that Palestine is considered a success story for other countries (Ethiopia) in the family health record and was approached by the Bank to present its experience using the District Health Information Software 2 (DHIS 2). The website for the HRH was prepared with support from the Bank and other donors: 'http://www.hrho.pniph.org' and it forms a tool for strategic assessment and planning for employment of health staff at MoH, private and NGO sectors.

Component four on "Project Management and Capacity Building": Progress under this component included: a) forming a PMU team for the management and follow up of all project activities, supporting WB missions and Reporting (IFRs, Procurement Plans, Progress Reports). The PMU team was composed of a coordinator, a procurement specialist, a financial specialist, a health specialist and an administrative assistant 'though latest position was filled temporarily in 2015 for few months and then in April 2022 in the last few months of the project'; b) Financial audits of the project; c) Preparation of communication strategy; d) Office equipment to SPU, GDHI, Continuous Professional Development (CPD) and PMU; e) Technical Support Agreement contract for the E-referral system and f) CPD system to support the Health Education and Scientific Research Unit at MoH https://cpd.moh.ps for the capacity building of health staff including a user manual in both English and Arabic.

Over the project implementation period, HSRSP had the following prepared: Ten progress reports (bi-annual and annual) including progress of work, successes, challenges and work plans; Sixteen WB missions for which aid memoires were prepared by the Bank and shared with the MoH; One mid-term review in July 2017; Two requests for no- cost extension and restructuring: one in December 2019 to have the closing date on 31/12/2021 instead of 30/06/2020 and the second in October 2021 to have the closing date on 31 May 2022 instead of 31/12/2021 (total extension period is 23 months); Six cleared ex-post reviews by the Bank; Quarterly cleared and approved IFRs; Regular updated cleared procurement plans; and Seven cleared and approved financial audits and the 8th will be prepared in October 2022 and submission of draft will be in November 2022.

The MoH discussed with the Bank to include high priority tasks that align with the objectives of the project for using excess budget from the different components, which included:

- Procurement of Oncology medications and cardiac catheterization consumables due to urgent need after the May 2021 war and attacks on Gaza that led to severe shortage in drugs and materials.
- Data Center Switches at PMC and Firewall for all MoH hospitals and data center to support the follow up of new systems, volume and security of data.
- Maintenance contract for the GHIMIS for two years, which was a high priority given the data load and the plan to continue linking with additional ministries, bodies and commissions.

2.2. Achievement of Intermediate Outcomes

The MoH requested to add three new intermediate indicators in the request of extension and restructuring in December 2019 to the already 14 previous ones (so total 17 indicators) due to the modifications on some of the activities and to also enable measuring their impact. All indicators have been monitored till the end of the project in May 2022 and all were fully achieved except for a number of them that were slightly affected by Covid-19 pandemic *(see Annex 3 for update on intermediate indicators)*; examples are: the target for the new referral contracts/MOUs was 30, but 29 could be initiated; and the target for female beneficiaries from referrals was 53% and the project could reach 46% of the total referrals.

3. Key Factors/ Events Affecting Performance and Outcomes

3.1 Opportunities during preparation and implementation

During preparation

- Interventions and analytical pieces prepared by the Bank between 2013 and 2016 provided an opportunity to work for investment in the health sector that laid the foundation for all reform efforts on health financing and the rationalization of outside medical referrals over the past few years.
- Clear and simple design of the project with structured components, objectives and indicators; the project came as a rapid response to needs to prevent deterioration of the health outcomes of the Palestinian people and to assist the MoH strengthen its systems and build its capacity to respond to emergency.
- Opening of a Designated Account for the project was done in early stages of the project for immediate response to the Emergency needs in Gaza.
- Formation of the Steering Committee, PMU in addition to defining baseline values and targets in close collaboration with the MoH at early stages of the project supported the ownership of the project and its implementation.
- Capacity building of PMU staff on fiduciary activities and compliance was a crucial preparatory step before project implementation, such as on STEP system, procurement regulations and Client Connection.

During implementation

- Long-term gains for the healthcare system in addition to fully achieving the majority of the development targets, which will support organizing the work and increasing financial savings and or revenues.
- Engagement of MoH Departments: In addition to focused activities, the component on the communication strategy and its campaign supported the involvement of staff from the SPU, Health Insurance and the Complaint Department. Other activities required engagement of other MoH units, such as tendering and

bidding unit, Biomedical Engineering Unit (BMEU), central stores, Computer and information technology department, …etc.

- Regular jointly conducted missions by the WB and the MoH supported monitoring progress, strengths and challenges as well as joint decisions on the needed re-structuring or re-allocation of budget based on arising needs.

3.2 Challenges during preparation and implementation

During preparation

- Delay in PMU formation, including identifying and maintaining essential team members. However, the project relied on the MoF PMU staff till the position of the financial specialist was filled. The PMU team continued to function including covering the Monitoring and Evaluation (M&E) tasks while securing the required coordination support from the International Cooperation Unit.
- Unclear agreement on a long and comprehensive reform related to the pooling and separation of financing functions within the UHC component: so, the decision of the MoH and the Bank was to focus on a narrower, more realistic lines of action, oriented to inform evidence-based policy-making to achieve the broader goals of UHC. Additionally, lack of local expertise in the field also added to the challenges in this sub-component.

During implementation

- Lengthy contracting process: all staff contracts initiated throughout the project had to go through the General Personnel Council (GPC) and the Council of Ministers processes, which were lengthy.
- Irregular Steering Committee (SC) meetings: the SC had to meet on a monthly basis (then later was revised to be bi-monthly), which affected the visibility and coordination between stakeholders, such as USAID, Department for International Development (DFID), and WHO
- Perceived short project implementation period: introduction of new systems needed intensive preparation, data migration, training, piloting, testing and transition period, especially that the change happened during the working process without aiming to disrupt the daily work.
- Covid-19 pandemic affected all project activities and a number of project activities had to be cancelled, such as the Costing study of health services, cost effectiveness study and other activities within the third component with the PNIPH/WHO.
- Sudden stop of all USAID funded projects in January 2019 as per USAID management decision to cease all activities in WB&G affected the continuity of work on the E-referral system that was started through the PHCP, but then was taken over by the Bank.
- Additional factors, such as electricity blackouts and weak internet connection in some locations that affected training; delay in submission of invoices by referral hospitals that delayed the auditing process at the SPU; delay in some payments as BISAN financial system is based in Nablus with no link to MoH in Ramallah.

4. Evaluation of the borrower's own performance during the preparation and implementation of the project

The project met all set objectives satisfactorily and had full disbursement of the total allocated budget by the closing date. The overall management of the implementation of project activities was carried out by the PMU at the MoH through planning, supporting implementation, monitoring and supervision and reporting on all the components of the project. In the framework of the preparation, implementation and completion of the HSRSP, the MoH and MoF successfully cooperated with the WB, timely resolving emerging issues all through the seven years of implementation. Changes proposed by MoH and made to project components/subcomponents during implementation were consistent with the initial objectives of the project.

Immediate response to MoH inquiries through opinions of experienced experts and technical comments and suggestions from the WB team were very important for the successful implementation of the project components and the MoH values the effective collaboration with the WB.

4.1. During project preparation

- Formation of a technical steering committee to oversee the technical aspects of project implementation and to keep all stakeholders informed of the implementation progress. It was chaired by the Minister of Health or a designee of the Minister of Health, and comprised of director of the MoH international cooperation department, the director general of health insurance, the director of the SPU, the director general of financial affairs, the director general of hospitals, the director of procurement, as well as representatives from the MoF and PMU unit.
- Coordination with other stakeholders (USAID, DFID, WHO) formed a step to organize the work and to avoid duplication of activities.
- Recruitment of the PMU members had significant groundwork in preparation for the project and core staff members were trained on systems of procurement (STEP) and finance (client connection and Bank's financial manual) as well as on BISAN MoF system.
- Preparation of M&E plan with support from the WB which covered the follow-up on the central and the field levels. The plan added new activities where needed and captured data beyond the RF.
- The UHC component had a broad and extremely ambitious set of outputs and outcomes on addressing immediate, emergency cost-drivers in the PAD[xi], and so it needed an action during project implementation (below).

4.2. During project implementation

- The project had strong support and active interest from the MoH throughout its implementation with collaboration between the PMU, MoH involved departments, the MoF, WHO/PNIPH and other stakeholders.
- According to discussions of the Bank and the MoH during the MTR in July 2017 (*see Annex 5*), it was agreed that one of the critical bottlenecks towards advancing the UHC agenda in Palestine is the lack of data and evidence to help guide and/or justify decision making in addition to the fact that there was still not a full agreement around the longer term and the reform needed under the pooling and separation of financing functions. Therefore, it was agreed to focus on narrower, more realistic (and less ambitious) lines of action, oriented to inform evidence-based policy-making in order to achieve the broader goals of UHC.

  This was done through a contract between the MoH and the WHO/PNIPH focusing on the roadmap towards UHC covering family health, human resources for health and health financing. Substantial progress was done in family health and human resources for health; however, minimal results were achieved in the health financing part. The PNIPH was requested to submit a revised work plan and a proposal was received end of 2019 with proposed changes in the component, but they were not approved by the MOH and the WB as they were not considered priorities at that time.
- Procurement plans, IFRs, project audits and progress reports were prepared and submitted by the MoH to the Bank on time. Additionally, the PMU members took part in all formed committees by MoH on activities related to HSRSP, such as recruitment of staff, procurement, approval of reports, plans, and revision and acceptance of deliverables.
- As the OMR has been a major component, the MoH continued holding referral thematic group meetings on biannual basis. As the HSRSP supported the new E-referral database, this helped using the tool by the SPU and the formed group to do more proper analysis on referrals.

4.2.1. Monitoring and implementation

The MoH was the implementing agency and had the primary responsibility for all technical, operational and fiduciary aspects related to the HSRSP project. The project relied on MoH's existing organizational structure and departments, including the SPU, health insurance, complaint, media, engineering procurement and financial management.

The PMU team implemented the M&E activities and communicated the needs that arose throughout the project implementation to the Bank. The MoH raised the need for new activities that were not originally planned to ensure that the project reaches the desired targets and responding to emergency situations, such as to Covid-19 pandemic and to the medical needs that resulted from war on Gaza in May 2021.
The PMU also prepared semi-annual and annual reports with inputs from all MoH involved departments and assessed progress and impact of work. Other M&E tasks included regular meetings with MoH and also with the WB technical team; preparing for all reviews (ex-post reviews, annual audits…. etc.); preparing and supporting the WB missions; revising Aide Memoires after conducted missions; and being part in all formed committees, such as tendering and procurement committees, staffing and contracting, …etc. for efficient follow up of the activities. The ISRs prepared by the Bank were part of the monitoring modalities on the progress of work, indicators, impact and achieving targets.

4.2.2. Procurement

Procurement plans were prepared and updated regularly by the procurement specialist using the STEP system and were always cleared by the WB. Procurement processes followed the MoH procedures and were done in cooperation with the involved MoH departments using different procurement methods. Up to the end of the project, 6 ex-post procurement reviews were conducted by the Bank and the latest was conducted in April 2022 on six contracts awarded between Nov. 2020 and March 2022. All reviews were cleared by the MoH. The Specialist also introduced tracking sheets for the status of delivery of procured items through the project. The procurement performance was rated satisfactory at project closure.

4.2.3. Financial Management

A Financial Manual was prepared in 2017 to reflect financial procedures to be used. A USD Designated Account (DA), under the Central Treasury Account was opened at the Bank of Palestine (Ramallah). WB funds were deposited into this DA. A separate account was also created in the automated accounting system Bisan. The PMU ensured that the account was reconciled and the MoH used to request needed budget through Withdrawal Applications.
All project deliverables were checked, monitored and cleared before performing any payment and the PMU followed the formal Palestinian procedures for payments' approval. Quarterly IFRs were prepared on timely basis and were reviewed and cleared by the MoF. After the reports were cleared by the Bank, they were published on Bank's website. The project had yearly financial audits, and the final audit for year 2022 will cover the period from January to September and the audit will start in October 2022 and should finish by November as a first draft. Up to the end of the grace period on 30/09/2022, the project will have disbursed the complete allocated budget of 8.5 million USD. The financial management had satisfactory rating by the Bank at project closure.

5. Lessons learned

The following are key areas of learning from the HSRSP WB financed project:

- **Sufficient time for systems implementation:**
  The extension of the project for around 2 years served various purposes to allow the MoH consolidate results in the field, systematize and disseminate project results and key lessons learned, and strengthen long-term sustainability of the main project results. Moreover, the introduction of Digitalization of national systems and linkages with other systems at MoH and with other ministries need adequate time for data migration, piloting, testing, application and implementation.
- **Digitalization of systems has an impact on effective public services processes and emphasizing governance:**
  Indicators that will come from the developed digital systems will support the daily work improvement and will have an impact on setting strategic planning and policies based on analysis and accurate data. Additionally, digitalized systems support standardization of procedures and having clear work flow and governance, trust and satisfaction of the public with provided services. The experience that will come out

from the currently created systems provides lessons learned for scaling up of digitalization to additional districts, services and also other sectors.

- **Investment in institutional and capacity building:**
  Having the PMU as part of the MOH has been a successful method to enable smooth implementation of project activities and transfer of knowledge. The PMU, appointed staff at the SPU, with the technical support from the involved departments supported the follow up of project activities in the HSRSP as well as other WB financed health projects (Early Childhood and Development, and Covid-19 Emergency Response Project). The successful experience of institutional building by contracting staff at the SPU and then absorbing them at the Unit brings the attention to the need to replicate it for the GHIMIS by contracting staff at the GD of IT Department and GD of Health Insurance to support the system and its backup.
- **Flexibility in meeting arising changing needs affected by the situation in Palestine (adaptive strategic approach):**
  During implementation of the project, part of the saved and undisbursed funds of the project were reallocated to implementation of arising priority needs identified by the MoH in agreement with the WB, such as after Covid-19 pandemic and the attacks on Gaza early May 2022 through delivery of equipment, consumables, and IT support to systems.
- **Production of Reference documents and materials:**
  The project produced a number of reference documents and materials (supporting documents on public expenditure review, protocols, GRM, Referral Master Plan, NPR, Business Process Analysis of the GHIMIS, communication strategy and materials to raise awareness on GDHI, SPU and Complaint unit) which can be referred to in strategic planning and in proposing future projects. Production of those materials has also strengthened the linkages of the MoH with other ministries and the private/NGO sector which is complementary to the role of the MoH.
- **Direct and Indirect impacts from the implementation of activities emphasize value-based procurement framework:**
  Monetary outcomes and the value for money appeared to be tangible impacts from implementation of part of HSRSP activities, such as: the procedure performed using the Ultrasound machine secured over 18 million USD since its installation in March 2017; the introduced reforms at the SPU and the negotiation of agreements with the Israeli hospitals led to a reduction of 17.5 Million ILS in the monthly Israeli gross invoice with Hadassah Hospital in 2019; and the implementation of the GHMIS led to controlling financial leakages and increased revenues by 16.8% in 2021 compared to 2020. So, the financial benefits and savings that emphasize the implementation of value-based procurement framework in future projects.

6. Description of the proposed arrangements for future operations/sustainability of results

- The HSRSP project responded to emergency situations and the MoH will continue monitoring future arising situations for immediate response with the support of stakeholders.
- The project supported Palestine in creating sustainable health systems through the development and implementation of GHIMIS, E-referral, Family Record, CPD, HRH, GRM in addition to improved provision and quality of services through the procurement of needed equipment and materials. These interventions in addition to the performed studies, assessments and plans will provide an opportunity for the MoH for result-oriented strategic planning, and increased fiscal space and financial management on expenditures and revenues. So, the HSRSP created a conceptual model and groundwork for health system reform that can satisfy the population's needs and will continue to benefit Palestine even after project closing.
- There is more realization at the MoH of the importance of digitalization of health systems that will support work organization and planning at both peripheral and central levels. The SPU established linkages of the E-referral with the GHMIS and BISAN financial module which will develop more indicators for work organization and strategic purchasing and contracting. However, more support is needed at the SPU on the E-referral financial module and also the need to strengthen the methodology of medical auditing on the Israeli Hospitals

deductions. The gains are important at this stage as the UHC is on the reform agenda of the recent government's National Development Plan. For this, the costing study, cost effectiveness, cost benefit analysis and health financing are still priorities and the MoH will consider in future activities.

- In order to continue steps toward the road to UHC, the Family Health Record needs to be installed and implemented in all PHC centers. Additionally, having the new GHIMIS is a step towards UHC but needs to be accompanied by working on a reform for the health insurance schemes and the package of service.
- Strengthening institutional building is an achievement for the sustainability of the work that has started at the SPU by having additional staff, working on strategic purchasing, negotiations with private hospitals using the NPR and the standardized coding of ICD-10 PCS based on DRGs and being part of a high-level pricing committee that has been formed and will continue to work on the efficiency in OMRs.
- The project invested in the capacity building of MoH staff in different departments, which will support the sustainability of work through the experience gained and shared through. Regular preventive maintenance will also continue on procured equipment to support functionality and continuity of work.
- The newly introduced systems are linked to Avicenna system which has been in place for over ten years, and the MoH raised the need to upgrade and re-engineer it, especially the financial module; linking it to the supply stores of drugs, consumables and general supplies; and upgrading it from a desktop to a web application for easier access. The re-engineering of the system will assure completeness and quality of data that will be used for analysis and planning as well as paving the road for additional steps, such as costing of health services that can be part of the financial module.
- The MoH is working on setting a development plan for all MoH hospitals and facilities including: site visits, satisfaction of patients and employees, identification of needs, fixing weaknesses and focusing on strengths.
- Risks and inclusivity measures need to be kept in mind in project preparation and implementation for identification of early mitigation measures.

The Government of Palestine and MoH through the implementation of HSRSP with support from the WB has established ground for reform in the health sector which is a national priority step to ensure durable and sustainable health system development in Palestine.

7. References

[i] *https://www.pcbs.gov.ps/site/512/default.aspx?lang=en&ItemID=4024*.
[ii] *https://palestine.unfpa.org/sites/default/files/pubpdf/national_maternal_mortality_report_2020_0.pdf*
[iii] Ghosh HA, Shaar A, Mashal J, et al. Diabetes control in 3 villages in Palestine: a community-based quality improvement intervention. J Ambul Care Manage 2007; 30(1): 74–78: *https://journals.lww.com/ambulatorycaremanagement/Citation/2007/01000/Diabetes_Control_in_3_Villages_in_Palestine__A.10.aspx*.
[iv] MoH. Annual Health Report, 2021: *https://site.moh.ps/Content/Books/Hqgu4D5vfT6bDhDUtl36GHhx9oYlCS9JplXYDfOMKrnDt6YoDPkPdl_I6mhnD3xb5MaPpX1mx6k6J4WowTnGUc1135KRHMmuMwEi1Zh1QUmFY.pdf*
[v] Abu Mughli, F. Health System Development Project 1999-2004.
[vi] The WB. Assistance Strategy FY2015-2016 for the West Bank and Gaza; 2014: *https://documents1.worldbank.org/curated/en/817581468321831929/pdf/895030CAS0CORR010Box385333B00OUO090.pdf*.
[vii] Fairness and Accountability: Engaging in Health Systems in the Middle East and North Africa, The Word Bank Health, Nutrition and Population Sector Strategy for MENA (2013-2018): *www.worldbank.org/mena/healthstrategy*
[viii] State of Palestine. National Development Plan 2014-2016: State Building to Sovereignty; 2014: *http://planipolis.iiep.unesco.org/sites/planipolis/files/ressources/palestine_ndp_state_final.pdf*.
[ix] MoH Annual Reports for the years 2016, 2017, 2018, 2019 and 2020: *https://site.moh.ps/index/Books/BookType/2/Language/ar*
[x] MoH. Annual Health Report, 2021: *https://site.moh.ps/Content/Books/Hqgu4D5vfT6bDhDUtl36GHhx9oYlCS9JplXYDfOMKrnDt6YoDPkPdl_I6mhnD3xb5MaPpX1mx6k6J4WowTnGUc1135KRHMmuMwEi1Zh1QUmFY.pdf*
[x] WB; HSRSP Project Appraisal Document (PAD). 2015.