Report Number: ICRR0023083

## 1. Project Data

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|---|---|
| **Project ID**<br>P151425 | **Project Name**<br>Lao Health Governance and Nutr.Dev.Proj |
| **Country**<br>Lao People's Democratic Republic | **Practice Area(Lead)**<br>Health, Nutrition & Population |

| **L/C/TF Number(s)** | **Closing Date (Original)** | **Total Project Cost (USD)** |
|---|---|---|
| IDA-56760,IDA-61450,IDA-D0730,TF-A5620,TF-A6106 | 31-Dec-2020 | 41,134,741.36 |
| **Bank Approval Date** | **Closing Date (Actual)** | |
| 23-Jun-2015 | 31-Dec-2021 | |

| | IBRD/IDA (USD) | Grants (USD) |
|---|---|---|
| Original Commitment | 26,400,000.00 | 5,000,000.00 |
| Revised Commitment | 41,400,000.00 | 4,999,177.33 |
| Actual | 41,156,367.08 | 4,999,177.33 |

| Prepared by | Reviewed by | ICR Review Coordinator | Group |
|---|---|---|---|
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## 2. Project Objectives and Components

### a. Objectives

The objective of the project was to help increase coverage of reproductive, maternal and child health, and nutrition services in target areas in the Recipient's territory (Financing Agreement, August 17, 2015, p. 5).

A Level-2 Restructuring approved by the Regional Vice President on September 6, 2017 provided additional financing (AF) to scale up existing activities and added a contingent emergency response to an eventual crisis or emergency, for which the objective was stated as follows: to provide immediate and effective response in

case of an Eligible Crisis or Emergency (Financing Agreement for providing AF and restating the original financing agreement, November 6, 2017, p. 6). As no funds were allocated to such a contingent emergency response and no response was officially triggered during the implementation period, this ICR Review did not address this objective.

The 2017 project restructuring updated the 2015 baselines using more accurate data, and two outcome targets were revised. One outcome target was revised upward, and both original revised targets were exceeded. The other outcome target was revised downward, and both original and revised targets were essentially achieved or fully achieved. Therefore, this ICR Review did not apply a split rating that would have no value added in this case.

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

**Did the Board approve the revised objectives/key associated outcome targets?**
No

**c. Will a split evaluation be undertaken?**
No

**d. Components**

**I. Health Sector Governance Reform (Appraisal: US$0.5 million; after AF: US$2 million; Actual: US$2.2 million)**

1.1 (a) Development, implementation and maintenance of an improved health management information system (HMIS) of the Ministry of Health (MOH); and (b) technical support, capacity building, and training for MOH staff at the central, provincial, and district levels in the use of this system.

1.2 Development and implementation of improved business processes for the notification of births, and related training for MOH staff.

**II. Service Delivery (Appraisal: US$19.4 million; after AF: US$30.4 million; Actual: US$24.9 million)**

2.1 Carrying out of a program of activities designed to strengthen the Recipient's health system management at the *central level* to support and oversee the implementation of decentralized health and nutrition service delivery.

2.2 Carrying out of a program of activities designed to strengthen: (a) the Recipient's health system administration, management, financial management, and monitoring and evaluation at the *provincial level*; and (b) the delivery of reproductive, maternal and child health (MCH), and nutrition services at the provincial, district, village, and health facility level in Target Provinces.

This service delivery component used a performance-based approach using relevant Disbursement-Linked Indicators (DLIs). The project had 12 DLIs: (i) four DLIs were targeted at the central level to promote

management and health systems actions in support of decentralized service delivery; and (ii) eight DLIs at the provincial level focusing on service delivery (about 72 percent of the component funding):

Central level DLIs:

- DLI C1: Percentage of HMIS data reports from the target provinces provided on time and fully completed in accordance with the national guidelines for the District Health Information System (DHIS2) implementation.
- DLI C2: Number of target provinces that have two quarters' stock of Essential Family Planning and Nutrition Commodities in the provinces or regional stores.
- DLI C3: Number of target provinces in which the number of health centers without a community midwife as reported in DHIS2 has been reduced.
- DLI C4: Number of women in the target provinces who receive free maternity health care services.

Provincial level DLIs:

- DLI P1: Number of women who deliver with a skilled birth attendant at home or at a health facility.
- DLI P2: Number of pregnant women who receive four antenatal care contacts.
- DLI P3: Number of new women ages 15-49 years adopting long-term methods of family planning (for Y2); Number of women ages 15– 49 years who are continued users of long-term methods of family planning (for Y3 and Y4).
- DLI P4: Number of children under 5 years in the target provinces who are weighed and measured at least four times in the year and their growth is plotted in the child's growth chart (for Y2). Number of children under 2 years in the target provinces who have at least four growth monitoring and promotion sessions in the year and their growth is plotted in two specific growth charts (for Y3 and Y4).
- DLI P5: Number of villages in zones 2 and 3 in which Integrated Outreach Sessions are conducted at least three times during the year and reported in DHIS2.
- DLI P6: Percentage of health centers and district hospitals in target provinces that score more than 50 percent on the Standard Supervision Checklist every six months of the year.
- DLI P7: Percentage increase in target provinces' non-salary health recurrent expenditure allocated to the district.
- DLI P8: Number of immunization target districts that have increased their coverage of pentavalent 3 and measles and rubella immunization.

**III. Nutrition Social and Behavioral Change Communication (Appraisal: US$4 million: after AF: US$5.2 million; Actual: US$6.7 million)**

3.1 Development of an integrated national strategy and implementation plan for social and behavioral change communication to improve nutrition.

3.2 Implementation of the above strategy at the national level and at the village level in selected priority districts, including promotion of nutrition-specific and sensitive activities, development and production of marketing and communication tools and materials, and facilitation of training and communication sessions at the village level with a focus on sanitation, personal and environmental hygiene, maternal and child health, and/or other determinants of health and nutrition.

**IV. Project Management, Monitoring and Evaluation Communication (Appraisal: US$2.5 million; after AF: US$3.8 million; Actual: US$7.2 million)**

4.1 Provision of technical and operational assistance for the day-to-day coordination, administration, procurement, financial management, environmental and social safeguards management, and monitoring and evaluation of the project, including the development of checklists for supervision of health facilities, the conduct of third-party verifications of the achievement of DLIs, and the carrying out of financial audits of the project.

4.2 Provision of technical assistance for capacity building of MOH staff at the provincial and district level for the monitoring and reporting of DLIs, capacity building of MOH staff at the national, provincial, and district level for health program planning and implementation, and carrying out of studies and surveys necessary to inform the implementation of project activities.

**V. Contingent Emergency Response: no upfront allocations were made**, but design arrangements allowed rapid reallocations to respond to an eligible crisis or emergency, if any, without restructuring (ICR, p. 15) under streamlined procurement and disbursement procedures (ICR, p. 10).

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

**Costs and financing:** At appraisal, the project cost was estimated at US$26.4 million equivalent, consisting of an International Development Association (IDA) Credit of US$13.2 million and an IDA Grant of US$13.2 million. No direct financial contributions from the Borrower were envisaged. An AF amount of US$15 million was provided on September 6, 2017 (see details below). The actual cost was US$41.2 million, reflecting full disbursement.

**Dates:** The project was approved on June 23, 2015. A first restructuring on August 14, 2015 was related to a legal covenant that extended the effectiveness deadline due to delays in compliance with effectiveness conditions. The project became effective on October 12, 2015.

The second restructuring on September 6, 2017, introduced an AF of US$15 million consisting of (i) an IDA Credit of US$10 million to finance DLIs; (ii) a US$4 million grant from the Government of Australia through the Multi-Donor Trust Fund for Integrating Donor Financed Health Programs to strengthen immunization and outreach activities; and (iii) US$1 million grant from the Japan Policy and Human Resources Development Fund to strengthen the HMIS. The restructuring also introduced a contingent emergency response in the objective statement and revised the results framework and component costs.

A Mid-Term Review was carried out on November 13, 2018. A third restructuring on May 18, 2020 extended the closing date by one year, and changed component costs, the results framework, and allocations between disbursement categories. The project closed on December 31, 2021, one year beyond the original closing date of December 31, 2020.

## 3. Relevance of Objectives

### Rationale

Although Lao PDR had made substantial progress in key health outcomes over the past decades, significant challenges remained. Prior to the project, 44 percent of children under five years of age were stunted. The prevalence of stunting among children from the poorest households was three times higher than that in the richest households. Income disparities with low coverage and use of services had a negative impact on reproductive, maternal, neonatal and child health (MNCH) outcomes. Utilization of services ranged from 11 percent in the poorest quintile to 91 percent by the richest. Skilled birth attendance, a key determinant for preventing maternal mortality, was 42 percent (PAD, p. 1). In recent years, the government had introduced free care for MCH and financial protection mechanisms for the poor, such as health equity funds. These programs helped in reducing financial barriers, but issues related to the availability of quality health services remained. Vitamin A distribution, for example, did not reach 41 percent of children aged 6-59 months. Primary health centers were typically understaffed, also compromising outreach activities. On the demand side, barriers such as ethno-linguistic barriers, cultural barriers, and physical access remained (PAD, p. 1).

Around appraisal, the objective was consistent with the inclusive development theme of the World Bank Group's Country Partnership Strategy (FY12-16), the Health Sector Reform Strategy (2013– 2025), and the Multi-sectoral Food and Nutrition Security Action Plan for accelerating actions to address the crisis of undernutrition (PAD, p. 2).

At closing, the objective remained closely aligned with the World Bank Group's Country Partnership Framework (CPF for FY2017–2021), specifically under Focus Area 2: Investing in People and with CPF Objective 2.1: "Reducing the prevalence of malnutrition," under which the CPF highlighted that malnutrition is the key area in Lao PDR where Millennium Development Goals were not achieved; and with CPF Objective 2.3: "Improving access to and quality of health services," where the CPF noted that, in line with the government's Health Sector Development Plan 2016-2020, Lao PDR aims to deliver free MCH care and to focus on primary health care, hygiene promotion, health financing, and improved human resources and governance in the sector.

Furthermore, there were commonalities between CPF indicators and project indicators. Two CPF objective Indicators included skilled birth attendance and family planning indicators that were used by the project; and antenatal care and child immunization indicators were also used as supplementary progress indicators by the CPF.

### Rating
High

## 4. Achievement of Objectives (Efficacy)

### OBJECTIVE 1
#### Objective

Help to increase coverage of reproductive, maternal and child health, and nutrition services in target areas

### Rationale

This ICR Review and the ICR assessed achievement of a single objective, as its core elements were closely interlinked in terms of both substance and service delivery, commonly provided as packages of integrated services.

Explanatory note on coverage in the PDO statement: The use of the word "coverage" is aligned with monitoring progress toward universal health coverage (UHC): Framework, Measures, and Targets, World Health Organization (WHO), and World Bank, 2014 (PAD, p. 3).

Explanatory note on target areas in the PDO statement:

- The project targeted 14 out of 18 provinces in the country with approximately 5.1 million people, or 70 percent of the country's total population. The remaining four provinces were not included because three were supported by Lux-Development, and the fourth, Vientiane, had high coverage rates, according to the PAD, p. 4.
- For intensified nutrition-related interventions, 12 priority districts were targeted in the four northern provinces of Oudomxay, Huaphanh, Xiengkhuong, and Phongsaly, where child stunting rates were highest. This covered approximately 0.39 million people, or 35 percent of population in the four provinces (ICR, p. 7).

**Theory of change**

It was reasonably expected that: (a) using DLIs to incentivize improved health service delivery performance and system management; (b) developing and utilizing the District Health Information System, and strengthening the process of birth notification; (c) developing and implementing social and behavioral change communications for nutrition; and (d) providing operational and technical support to the project in financial management, data verification, monitoring, and evaluation would lead to: (i) more pregnant women, mothers, family planning users, and children benefiting from health services with enhanced capacities and readiness of facilities to deliver MCH services; and (ii) data completeness, timeliness, and quality in support of related programs. All of the above results would plausibly contribute to increased coverage of reproductive, MCH, and nutrition services, that would be measured by increases in selected indicators that are known to be sufficiently representative of the PDO, such as skilled birth attendance, ante-natal care, family planning, breast-feeding, and vitamin A administration.

**Outputs and intermediate results**

- The number of women who received free maternity health care services increased from a baseline of 453,350 women in 2017 to 619,394 women in December 2021, exceeding the target of 544,000 women.
- 2,080 female village facilitators were trained in social and behavior change communication, exceeding the target of 1,200 female village facilitators.

- 78,591 children under 2 years had at least four growth monitoring and promotion sessions in the year and their growth plotted in growth charts, exceeding the target of 40,000 children.
- 34 districts increased by 8 percent their coverage of pentavalent 3 vaccine (DPT-Hepatitis B-Hib) and measles and rubella immunizations (DLI P8), short of the target of 40 districts.
- 514 villages were declared "open defecation free" in target districts, exceeding the target of 100 villages.
- As an additional activity, the project set the stage to expand the monitoring of service quality aspects at health centers by developing a Quality Performance Scorecard or QPS (that would complement DLI P6 on service availability under the Standard Supervision Checklist). The project intended to pilot the QPS in health centers in the four nutrition convergence provinces listed above, but it could not pursue the piloting because of the COVID-19 pandemic. The QPS was adopted by the follow-on operation, the Health and Nutrition Services Access Project (HANSA, US$36 million, 2020-2025) (see section 7).
- The number of newborn children provided with birth notification in target provinces increased from a baseline of 20,224 newborns in 2017 to 78,296 newborns in December 2021, exceeding the target of 28,300 newborns.
- The percentage of provincial data reports provided on time and fully completed in accordance with the National Guidelines for DHIS2 Implementation increased from a baseline of 89 percent completeness and 54 percent timeliness in 2015 to 99 percent in completeness and 92 percent timeliness in December 2021, exceeding the target of 90 percent for both criteria.
- The number of health centers directly entering DHIS2 data increased from a baseline of 17 centers in 2017 to 613 centers in December 2021, exceeding the target of 200 centers.
- 895 villages conducted integrated outreach sessions at least three times during the year, exceeding the target of 800 villages.
- The project introduced a supervisory checklist of health facilities that contributed to improved hygiene and sanitation at health centers: the percentage of health centers with access to clean water increased from 60 percent in 2017 to 91 percent in 2021. Almost all health centers (98 percent) had a toilet or hygienic latrine. About 89 percent of health centers had wastewater collection and on-site treatment facilities, representing a significant improvement when compared with 54 percent in 2017.

**Outcomes**

Evidence showed that intended results were largely achieved, though most results were output oriented. This was explained by the Task Team (October 11, 2022) as follows: first, the provinces did not have accurate population data to derive reliable denominators; and second, the project was expected, by design, to harness country systems and government-used indicators (PAD, p. 9; and ICR, p. 28), while concurrently strengthening DHIS2. Therefore, the project chose indicators that were already being used.

The number of direct project beneficiaries (women and children) reached 1.63 million beneficiaries in 2021, exceeding the target of 1.4 million beneficiaries.

The number of women who delivered with a skilled birth attendant at home or at a health facility increased from a baseline of 62,505 women in 2015 (and from an updated baseline of 60,281 in 2017) to 86,386 women in 2021, exceeding the target of 84,400 women.

The number of pregnant women who had four ante-natal care contacts increased from a baseline of 45,985 pregnant women in 2015 (and from an updated baseline of 56,292 in 2017) to 84,187 pregnant women in 2021, exceeding the target of 78,800 in 2021.

The number of women ages 15–49 years who were continuing users of long-term methods of family planning increased from a baseline of 186,556 women in 2017 to 212,186 women in 2021, moderately short of the target of 223,900 women.

The number of children 6–11 months who received a first dose of vitamin A declined from a baseline of 123,389 children in 2017 to 90,285 children in 2021, short of the target of 140,000 children. The ICR (p. 17) noted that the reason for this low achievement was the interruption of outreach efforts caused by the COVID-19 pandemic.

The percentage of children 0–6 months in targeted high-priority nutrition districts who were exclusively breastfed increased from a baseline of 56.2 percent in 2017 to 83.9 percent in December 2021, exceeding the target of 60 percent.

### Rating
Substantial

## OVERALL EFFICACY
### Rationale
The objective of the project to help increase the coverage of reproductive, maternal and child health, and nutrition services in target areas was almost fully achieved, consistent with a substantial rating for overall efficacy.

### Overall Efficacy Rating

Substantial

## 5. Efficiency
At appraisal, the PAD did not carry out any traditional measure of efficiency but provided valid arguments based on international experience that demonstrated the high cost effectiveness of MCH interventions (PAD, p. 13).

The ICR's economic analysis carried out a cost-benefit analysis that adequately monetized the benefits largely from lives saved. Assuming an annual growth of 5.35 percent in GDP per capita from 2016 and constant quality of care, and using a discount rate of 4 percent, the analysis estimated that the project's investment of US$41 million would generate economic benefits with a Net Present Value of US$373.4 million and an associated Internal Rate of Return of 10.36 percent (ICR, p. 25). A sensitivity analysis (ICR, p. 62) was also

conducted to alter key assumptions and concluded that the project remained economically beneficial in cases where either the discount rate was increased to 6 percent, or GDP per capita growth was lowered to 3 percent, or if only 10 percent of changes in service utilization were attributed to the project. The ICR also reported that further analysis indicated that the project was cost effective in terms averted disability-adjusted life years based on WHO thresholds.

At the same time, there were several aspects of implementation that moderately reduced efficiency. The ICR reported on collaboration deficiencies between different departments and divisions within MOH, and between MOH and the provinces, noting that these challenges provided lessons that were incorporated in the design of the follow-on HANSA operation through promotion of stronger ownership within the technical departments and assigning of shared responsibility across different sectoral levels to achieve specific DLI targets (ICR, p. 29). Poor internet connectivity at the health center level delayed the uploading of data. There were delays in fund transfers for input-based financing to subnational levels, including transfers for Component 3 activities (Nutrition Social and Behavioral Change Communication). Although staff turnover among MOH officials was high, there was stability and continuity at the National Program Coordination Office (NPCO), whose leadership and staff remained the same throughout the project life, resulting in staff who were fully engaged and who provided training and handholding to subnational levels.

Important reallocations were made at the third project restructuring of May 18, 2020, at which time five DLI rounds had been completed as planned. Out of a total budget of US$30.4 million allocated to DLIs under Component 2 on service delivery, an unused balance of US$4.7 million remained (Restructuring Paper, Report No. RES38446, para. 4). This remaining amount consisted of “accumulated savings” from underachieved or unachieved targets over the five years of DLI rounds. The project intended to carry out an additional round to use these accumulated reserves of previous years (Task Team clarifications, October 11, 2022), but, per government request, the World Bank and the government agreed to reprogram the undisbursed balance to (i) support post-flood rehabilitation activities to ensure continued delivery of key MCH and nutrition services; and (ii) to support preparatory activities of the new Bank-supported Health and Nutrition Services Access Project (HANSA), particularly in the areas of rolling out the quality and performance score card and strengthening financial management capacity at subnational levels. The floods occurred in September 2019 and have significantly affected six southern project provinces. To mitigate the risk of disruption of health service delivery in these areas, it was agreed that the remaining undisbursed funds would support input-based activities, including essential drugs and medical supplies, in the affected project provinces according to a costed plan to facilitate continued delivery of MCH and nutrition services. The Restructuring Paper (para. 6a) stated that the continuation of activities was critical to the achievement of both the PDO and the National Assembly indicators.

## Efficiency Rating

Substantial

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

| | Rate Available? | Point value (%) | *Coverage/Scope (%) |
|---|---|---|---|

| | | | |
|---|---|---|---|
| Appraisal | | 0 | 0<br>☐ Not Applicable |
| ICR Estimate | ✓ | 10.36 | 100.00<br>☐ Not Applicable |

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

## 6. Outcome

Relevance of objectives is rated high as objectives were fully aligned with the Country Partnership Framework (CPF, FY2017–2021) at project closing. Efficacy is rated substantial, as objectives were almost fully achieved. Efficiency is also rated substantial in view of high cost-effectiveness of project interventions, but with aspects of implementation that moderately reduced overall efficiency. The aggregation of these findings is consistent with a satisfactory outcome rating.

### a. Outcome Rating

Satisfactory

## 7. Risk to Development Outcome

Key development outcomes are likely to be sustained through the follow-on operation, the Health and Nutrition Services Access Project (HANSA, P166165), that was approved in 2020. HANSA continues to support government efforts to improve MCH and nutrition status with: (a) a stronger focus on results by continuing the DLI approach; (b) stronger emphasis on improving the quality of services; and (c) increased alignment of support among key donors, including the Global Fund, which has embraced the DLI mechanism and is co-financing HANSA, and the Australian Government, which continues its support.

Improvements in the HMIS are expected to be sustained. The information system continues to expand and to gradually integrate other health programs, including information related to the management of pharmaceutical and medical equipment distribution, health financing, and human resources (ICR, p. 35). The information system provides a supportive platform to development objectives.

On the other hand, there are risks that resulted from changes in the focus of some DLIs under the follow-on operation. For example, the DLI for ensuring the numbers of community midwives in target provinces was no longer supported by the successor project, with a recent decreasing trend in the number of community midwives posted at the health center level. The focus of the DLI was replaced by the number of clinicians instead. Another concern is the long-term sustainability of the village facilitator networks.

Also, some of the effects of the COVID-19 pandemic on service delivery may continue. The pandemic has overwhelmed the country's health system and has reduced overall utilization of health care services. Changes in health care seeking behavior resulting from lockdowns and fear of getting infected in health facilities may require a long time to recede.

## 8. Assessment of Bank Performance

### a. Quality-at-Entry

The project design was in line with the government's priority agenda toward achieving UHC by 2025 through coverage expansion of essential health care services. Preparation benefited from other partners' engagement in the sector, including the Asian Development Bank (ADB), Lux-Development, UNICEF, UNFPA, and WHO. The Task Team mobilized additional expertise from the World Bank to inform project design, including the design of DLIs, health financing aspects, governance, and operational support. The team was led by two task team leaders, one international staff and one local staff, thus further facilitating communication on the ground. The design benefited from lessons learned from past engagement with the World Bank, ADB support, and various analytical and advisory work on public expenditures, out-of-pocket expenditures for MNCH, and nutrition. Main lessons included the following: keep it simple; focus on results; avoid fragmentation and parallel systems; and use sector indicators (PAD, p. 9).

The project was to be implemented by MOH, supported by its technical departments and by 14 Provincial Health Offices. NPCO was established to support MOH in the execution of the project, including financial management, procurement, environmental and social safeguards management, and communications. In turn, Provincial Health Offices would be responsible for project implementation at the provincial level, and District Health Offices at the district and village levels (PAD, p. 10). Arrangements for fiduciary compliance, safeguards, and M&E were adequately prepared and would use government systems and government fund flow procedures (PAD, p. 14).

The identified risks had mitigation measures put in place, although shared responsibilities among actors to catalyze further collaboration toward achieving DLI targets could have been promoted at the outset. The risk of not reaching underprivileged ethnic groups residing in difficult-to-reach areas was to be addressed by incentivizing integrated outreach services. The risk that women would be encouraged to use long-term family planning methods without sufficient knowledge would be mitigated by using the existing cadre of family planning volunteers supported by UNFPA to provide counseling, and by additional training of midwives on family planning counseling. The risk that health officers may take time to understand the new DLI mechanism would be addressed by extensive capacity building activities at central and provincial levels. Verification of DLI achievement would be undertaken by an independent academic institution.

#### Quality-at-Entry Rating

Satisfactory

### b. Quality of supervision

The Task Team reportedly extended effective efforts in coordination and proactiveness. A total of 13 implementation support missions took place over the six-year implementation period. Supervision and implementation support missions involved development partners, including WHO, UNICEF, UNFPA, and Japan International Cooperation Agency to further promote alignment. The ICR (p. 34) stated that the close

supervision by the World Bank Task Team was matched by the effective role played by NPCO and facilitated by strong commitment of MOH technical departments. The Task Team was reportedly proactive in identifying and resolving arising issues. Quality reporting included Aide Memoires and Implementation Status and Results Reports that were detailed with a full recording of issues encountered along with proposed actions. There was close follow-up during subsequent missions.

The project team mobilized qualified staff with a variety of global technical expertise. Team members effectively collaborated with government counterparts in various areas, including nutrition, service provision, information technology, and health economics. The project Task Team Leader changed several times, but according to the ICR, the transitions were smooth since core team members remained, and successor Task Team Leaders were part of the same core team with prior exposure and in-depth knowledge of the project.

The Task Team successfully mobilized additional resources through AF to deepen development impact, support project implementation, and provide additional technical assistance. In addition to grants from Australia and Japan, the team mobilized Bank-Executed Trust Fund (BETF) grant resources that complemented the operation. A total of six grants in the amount of US$3.2 million were made available to contribute to project supervision and technical aspects. BETFs supported technical work through analytical and advisory activities. Deliverables included a Health Financing and Systems Assessment; an assessment of media appropriateness for nutrition and health that was related to nutrition social and behavioral change communication; a knowledge, attitudes, and practices (KAP) qualitative survey to complement a KAP quantitative survey; technical assistance to support implementation of the KAP quantitative survey, and technical assistance on health care waste management. Moreover, the Task Team organized pre-mission field visits to health centers and villages with the participation of relevant stakeholders as part of the supervision missions (see section 9b).

Importantly, the Task Team extended substantial efforts to facilitate and manage a smooth transition to the follow-on project HANSA (see section 7) and facilitated the inclusion of HANSA preparatory activities in the third project restructuring of 2020, particularly for preparatory steps related to quality aspects that were to be enhanced by the follow-on operation.

As no shortcomings were identified, and in view of the extent to which the Bank proactively addressed threats to the project's trajectory toward intended outcomes, mobilized additional resources to support supervision, technical assistance, and additional analytical work, and ensured a favorable transition with supportive preparatory activities for the follow-on operation after project closing, this ICR Review rated the Quality of Supervision as highly satisfactory.

### Quality of Supervision Rating
Highly Satisfactory

### Overall Bank Performance Rating
Satisfactory

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

### a. M&E Design

The development objective was clearly stated and sufficiently reflected by the selected indicators, most of which were routinely available. Baselines were available. The DLIs constituted a subset of a wider list of indicators that were to be monitored (PAD, p. 11), and for which independent verification arrangements were planned. The ICR (p. 30) noted that project indicators were aligned with the government's National Assembly Indicators to improve health and nutrition outcomes of the country's population.

### b. M&E Implementation

The ICR (p. 31) reported that M&E was rigorously implemented, and results were tracked and regularly updated, including information on DLI indicators and the results framework indicators, and DLI verification by an independent academic institution. A supervisory checklist was applied to periodically review performance of health centers and district hospitals, and three rounds of independent surveys were carried out during the project's lifetime. Implementation support missions included pre-mission field visits to health centers and villages with the participation of relevant stakeholders. Issues that were identified during these field visits formed the basis for subsequent discussion at MOH level, indicating transparency in following up on relevant issues. M&E findings were reviewed by the Task Team during every implementation support mission. Analysis of verified results was extensively discussed with counterparts. A quantitative KAP survey focusing on nutrition interventions provided a baseline and end line information, which contributed to the follow-on project baselines. However, there were delays in the procurement of consultant services, and the baseline survey was completed only in December 2017, two years after project effectiveness. The subsequent KAP survey in 2020-21 provided end-project data. A qualitative KAP survey complemented the quantitative study.

### c. M&E Utilization

M&E findings were used for regular project monitoring and were shared with stakeholders. Concurrently, DHIS2 was strengthened and expanded. According to the ICR (p. 31), the strengthening of the country's health information system helped MOH to move to the forefront of cutting-edge innovation in DHIS2, using the direct data entry option and pioneering the creation of an offline data entry tool.

### M&E Quality Rating

Substantial

## 10. Other Issues

### a. Safeguards

Overview: Overall safeguards performance and compliance were satisfactory (ICR, p. 32; and Operations Portal). The ICR stated that overall environmental safeguards performance under OP 4.01 was satisfactory and that the project was compliant with Safeguard Policy OP 4.10 on Indigenous Peoples.

The project triggered Safeguard Policy OP 4.01 – Environmental Assessment Category B – in view of medical waste risks, although the Integrated Safeguards Data Sheet at the appraisal stage stated that any

potential environmental impact was expected to be minimal. MOH had a safeguard committee. According to the ICR, the project improved health care waste management practices in health centers: by 2021, 94 percent of health centers had no hazardous waste in their courtyards, compared to 58 percent in 2017, and 86 percent of health centers had standard waste bins. Seventy five percent of health centers used a hygienic waste pit, and 29 percent maintained a functional and clean incinerator. NPCO facilitated the development and dissemination of Sharp Waste Management Guidelines, along with extensive training. The ICR (p. 32) reported that the supervisory checklist for health facilities significantly improved environmental hygiene in health centers. The percentage of health centers with access to clean water increased from 60 percent in 2017 to 91 percent in 2021. Almost all health centers (98 percent) had a toilet or hygienic latrine. About 89 percent of health centers had wastewater collection and on-site treatment facilities, representing a significant improvement from 54 percent in 2017.

The project also triggered OP 4.10 on Indigenous Peoples. The ICR (p. 32) stated that the project was committed to improving equity in the "availability and accessibility" of health services, explicitly targeting ethnic minority people in project areas. An Ethnic Group Development Plan was effectively implemented and monitored. No major issues or new risks were identified. The project had a positive impact by creating conditions for ethnic minorities to benefit more from its activities, and NPCO completed a list of "hard-to-reach" ethnic groups and shared this list with other projects to improve their own outreach programs. In addition, the project safeguards committee, with additional support provided by provincial safeguard consultants, completed safeguards-related training at both provincial and district levels in all 12 target districts of the four convergent provinces. Under the feedback resolution mechanism, 6,039 items were received and recorded in DHIS2. The safeguard committee developed a work plan to continue training beyond target districts and to maintain the support provided by provincial safeguard consultants to pursue additional training and safeguards monitoring under the follow-on project.

### b. Fiduciary Compliance

Financial management performance was rated moderately satisfactory. Financial management arrangements were adequately defined and prepared at appraisal (PAD, pp. 13-14) in a context of high financial management and procurement risk because of capacity weaknesses at lower sectoral levels and health centers. Performance was satisfactory during the first three years, after which delays were encountered in submitting audit reports. Nevertheless, by project closing, there was no overdue audit reports. All audits were unqualified with unmodified opinions (Task Team clarifications of October 11, 2022).

Procurement performance was also assessed as moderately satisfactory. At the initial stage, implementation constraints were largely related to slow approval processes of procurement packages due to a lack of effective cooperation across different departments (ICR, p. 34). Identified weaknesses were addressed and performance improved, along with increasing familiarity with the Systematic Tracking of Exchanges in Procurement (STEP). Procurement aggregating at US$7.2 million was conducted at the central level, and all 92 packages, including goods and consultant services, were completed. NPCO uploaded milestones for all contracts into STEP tracking, and there were no red flags in the system (ICR, p. 33).

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

None reported.

### d. Other

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## 11. Ratings

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

## 12. Lessons

The ICR (pp. 36-38) offered several lessons, including the following lessons restated by IEG Review:

**Performance-based financing operations provide an opportunity to strengthen a country's health management information system.** Under this project, several preconditions were in place, including strong government ownership and alignment of the operation and its M&E with national plans that facilitated project support to the expansion of DHIS2. The latter evolved to become the backbone of MOH's monitoring and reporting system. In addition, the incentivization of data accuracy and timeliness through DLIs heightened overall attention to the importance of improving data quality. The project offered close hands-on support and extensive capacity building for strengthening the information system. Meeting the needs for comprehensive technical support at the outset can be considered when planning similar future projects.

**Performance-based approaches using DLIs are effective modalities both to enhance focus on results and to channel funds to the frontline service level.** The use of DLIs with 80 percent of funds directly channeled to the implementing level provided a first-hand understanding and appreciation of the concept of results-oriented management. The positive experience of this project contributed to a government decision to continue the use of this financing modality in its follow-on operation.

**Intersectoral collaboration at the local level allows effective responses to undernutrition.** This project promoted nutrition-specific interventions and nutrition-sensitive interventions to achieve results in changing behaviors, improve knowledge of mothers and caregivers, and

improve environmental health and sanitation. The project established village-level platforms for providing community-level preventive and promotive health messages, actions, and intersectoral collaboration. Further, village facilitators trained by the project expanded the scope of their nutrition efforts by contributing to the pandemic response at the community level, as they played an important in providing correct information about COVID-19 prevention and in promoting COVID-19 vaccinations in the villages.

## 13. Assessment Recommended?

No

## 14. Comments on Quality of ICR

The ICR provided a comprehensive overview of the project, and the arguments were anchored in a well-established theory of change. It was candid and aligned to development objectives. Its analysis was thorough. The evidence was adequate and illustrated well by the ICR's data presentations. Lessons were derived from project experience. The ICR explained the steps that were taken to facilitate transition to the follow-on operation that would contribute to sustaining development outcomes while providing an added focus on service quality aspects. The ICR followed established guidelines, but it was lengthy and had lapses in clarity.

**a. Quality of ICR Rating**
Substantial