



## 1. Project Data

<b>Project ID</b> P113349	<b>Project Name</b> HEALTH SYSTEM IMPROVEMENT PROJECT	
<b>Country</b> Uzbekistan	<b>Practice Area(Lead)</b> Health, Nutrition & Population	
<b>L/C/TF Number(s)</b> IDA-48960,IDA-52310	<b>Closing Date (Original)</b> 31-Dec-2016	<b>Total Project Cost (USD)</b> 115,266,344.59
<b>Bank Approval Date</b> 07-Apr-2011	<b>Closing Date (Actual)</b> 31-Dec-2019	
	<b>IBRD/IDA (USD)</b>	<b>Grants (USD)</b>
Original Commitment	93,000,000.00	0.00
Revised Commitment	129,659,097.53	0.00
Actual	115,266,344.59	0.00

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## 2. Project Objectives and Components

### a. Objectives

According to the Financing Agreement (p. 4), the project's original objectives were to: "(a) improve access to quality health care at the primary level and at rayon medical unions (RMUs); and (b) strengthen the government's public health response to the rise in non-communicable diseases (NCDs)." RMUs linked rural physician centers, multidisciplinary outpatient clinics, and rayon hospitals into single functional units.

At a 2013 restructuring and additional financing (AF), the objectives were revised to: "(a) improve access to quality health care at the primary level, at RMUs, and at selected city medical unions (CMUs); and (b)



strengthen the government's public health response to the rise in NCDs." CMUs perform the same function as RMUs, but in urban areas. This revision reflected a decision to cover all RMUs and add some CMUs. As the scale-up was commensurate with the AF, no split rating is necessary, and the project will be assessed using the revised statement of objectives.

At a 2018 restructuring, one outcome target was revised to reflect results of a survey that adjusted the baseline. This change did not represent a revision in the indicator's scope, and therefore a split rating is not performed.

It is standard IEG practice to unbundle distinct objectives in a PDO statement, which normally would dictate separate assessments of achievement in improving access to health care and quality of health care. However, in this case, the project's context and design clearly indicate that the issue was not access to care in and of itself, but instead access to better-quality care. For this reason, only two objectives, as delineated in the financing agreements, are assessed in this review.

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

Yes

**Did the Board approve the revised objectives/key associated outcome targets?**

Yes

**Date of Board Approval**

07-Mar-2013

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

No

**d. Components**

The project contained four components. Project design was not changed as a result of the 2013 AF, as originally planned activities were scaled up.

**1. Improving health service delivery** (appraisal: US\$ 82.17 million; AF: US\$ 171.12 million reflecting an additional US\$ 88.95 million; actual: US\$ 133.27 million). This component was to improve service planning at RMUs, refurbishing them with modern biomedical equipment and improving skills and competencies of clinical staff in disease case management and treatment. It was to focus on the most frequently recurring pediatric and NCDs. It was to enhance primary health care (PHC) reforms by expanding the general practice PHC model to urban areas, strengthening the referral system, and improving skills and competencies of medical personnel in early diagnosis, screening, and treatment of priority NCDs. It included three subcomponents:

- Hospital services improvement, through refurbishing at least 100 selected central rayon hospitals with up-to-date diagnostic and waste management equipment and medical furniture; improving health service planning at RMUs, including the revision of construction specifications and standards and the development of referral guidelines and equipment maintenance systems; and providing



study tours for health administrators. Participating hospitals were chosen according to geographic, epidemiological, socioeconomic, and demographic factors.

- Primary health care development, through expanding the general practice health care model to all urban polyclinics in three pilot oblasts and Tashkent city; continuing ten-month general practice training programs; and providing opportunities for skills development and training on NCD diagnosis and treatment.
- Clinical quality enhancement, through providing on-site training of RMUs' pediatric and internal medicine doctors and nurses in new clinical treatment standards; training in clinical case management and hospital administration; developing and introducing up-to-date relevant and effective practical treatment standards for RMUs' internal medicine and pediatrics staff; and establishing quality improvement mechanisms to monitor implementation of the new clinical treatment standards.

At the AF, this component was scaled up to cover an additional 57 RMUS and 15 selected CMUs.

**2. Strengthening health financing and management reforms** (appraisal: US\$ 4.45 million; AF: US\$ 5.95 million, reflecting an additional US\$ 1.50 million; actual: US\$ 1.48 million). This component was intended to consolidate and institutionalize per capita-based primary health care financing and management reforms by developing a strategy for health sector financing and appropriate regulatory measures for the implementation of that strategy. It was also to strengthen the role of the Ministry of Health (MOH) in health financing policy formulation and monitoring and local capacity building by conducting health sector expenditure analysis and medium-term projections; developing national health accounts (NHAs) and studies on hospital utilization patterns; training relevant staff at MOH, rural PHC clinics, and RMUs on financial management; and developing a health financing information system to support the implementation of a hospital financing pilot.

**3. Institutional strengthening for NCD prevention and control** (appraisal: US\$ 2.98 million; AF: US\$ 3.38 million, reflecting an additional US\$ 0.40 million; actual: US\$ 1.88 million). This component was to strengthen the capacity of public health institutions in effective prevention and control of NCDs, with activities implemented in two pilot oblasts and a third oblast serving as a control. It included two subcomponents:

- Health promotion and NCD prevention, intended to strengthen the capacity of public health institutions in effective prevention and control of NCDs by increasing awareness of and changing behaviors associated with increased risk for hypertension, diabetes, and other chronic diseases.
- Strengthening health surveillance systems, through developing an epidemiological surveillance system for NCDs, improving the public health system's ability to use collected data in effective policy making and program planning, and developing effective health promotion and disease prevention programs.

**4. Project management** (appraisal: US\$ 3.4 million; AF: US\$ 5.55 million, reflecting an additional US\$ 2.15 million; actual: US\$ 4.37 million). This component was to strengthen the capacity of MOH and project



implementation bureaus for project management and implementation, monitoring and evaluation (M&E), environmental management, procurement, and financial management.

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

**Financing, costs, and government contribution:** The project was originally to be financed by a US\$ 93 million International Development Association (IDA) Credit. The government was to be responsible for parallel financing of hospital construction and repair costs as well as US\$ 10.1 million in local taxes on the project, bringing the original total project costs to US\$ 103.1 million. An additional IDA Credit of US\$ 93 million was approved in 2013. An amount of US\$ 45 million was cancelled in 2018, and a further US\$ 7 million was cancelled in 2019, all from the first and fourth components, as a result of reallocation of funds to another health sector project and savings from undertaking international competitive bidding for the procurement of medical equipment. Actual total project costs (excluding the government's contribution to local taxes) were US\$ 115.3 million, reflecting some exchange rate fluctuations. The government covered costs of hospital construction and repair, as well as US\$ 32.5 million for other local costs, including taxes.

**Dates:** The project was approved in April 2011 and became effective in November 2011. A mid-term review was held in November 2015. The project was restructured three times:

- March 7, 2013: to revise the objectives and add AF, adjust the wording of some indicators (replace "treatment standards" with the more precise "clinical guidelines"), raise targets commensurately with the AF, and extend the closing date by 24 months to December 31, 2018.
- February 8, 2018: to cancel US\$ 45 million from the project in order to re-commit Bank resources to a proposed Emergency Medical Services project, following some delays in procurement processes throughout 2017 and a resulting unused balance; adjust some intermediate results indicators accordingly; and extend the closing date by another 12 months to December 31, 2019.
- December 18, 2019: to cancel an additional US\$ 7 million, as all project activities had been completed, and there were savings (due to efficient procurement processes) that could not be used by the closing date.

The project closed on December 31, 2019.

### 3. Relevance of Objectives

#### Rationale

The objectives were relevant to country context, though they did not advocate for the kind of deep restructuring of the hospital network that was recommended by most analyses at the time of appraisal. Uzbekistan's main health challenges centered around NCDs, which accounted for about 90% of all deaths in 2009. Poor access to high-quality preventive and treatment services, especially in rural areas, was greatly affecting health and mortality outcomes. The Bank had been supporting the health sector since the mid-1990s through reforms aimed at restructuring primary care and establishing an emergency medical care network. The primary care reforms encouraged efficiency as patients shifted to lower-cost outpatient



services and helped orient health facilities toward local needs and improved accountability. Issues remained, however, with the configuration and quality of inpatient service provision. There was fragmentation and duplication of services across too many separate hospital facilities, resulting in poor quality of secondary care services, lack of institutional and managerial focus on prevention and management of chronic illness and non-acute services, and lack of coordination of services for patients with multisystem diseases.

The government's "Welfare Improvement Strategy 2008-2012" identified inpatient and specialized care as key areas for the next phase of health care reforms, with the goal of improving the quality of secondary care at the rayon and city levels. According to the Project Appraisal Document (PAD, p. 14), the Bank and other development partners recommended consolidation of the hospital network into a smaller number of larger multiprofile general hospitals, which would be autonomous units operating under case-based financing, in order to achieve gains in both efficiency and quality of care. However, that option was considered to be too "radical and politically challenging," and the government opted instead for an evolutionary approach to addressing hospital reform, adopting a program for renewal of RMUs and CMUs to promote access of rural and other communities to good-quality health services at reasonable cost. The project's objectives were reflective of this evolutionary strategy, though the inclusion of a health financing information system to support a hospital financing pilot under the second component indicated that the Bank was continuing to advocate for more far-reaching health financing reforms. The government's public health strategy for the period 2010-2020 had objectives to improve health promotion, especially related to NCDs, and to reduce the mortality rate from cardiovascular disease in people under 65 years of age by at least 20 percent between 2010 and 2020, indicating that the project remained relevant to government strategy at project closing.

The objectives were well aligned with Bank strategy across the project's lifetime. They were responsive to two of the four pillars of the Bank's Country Assistance Strategy at appraisal (FY09-FY11): enabling an environment for shared growth (including increasing the efficiency of public financial management for more effective service provision), and improving human development and social protection through improved basic services delivery. They remained relevant to the Country Partnership Framework (CPF) at closing (FY16-FY20), through its third focus area (public service delivery) and objective 3.1 (improved access to quality education and health services). The CPF (p. 21) also identified improved efficiency of health services delivery as an important area for Bank support.

## **Rating**

Substantial

## **4. Achievement of Objectives (Efficacy)**

### **OBJECTIVE 1**

#### **Objective**

Improve access to quality health care at the primary level, at RMUs, and at selected CMUs



### **Rationale**

The theory of change for this objective, developed by the ICR (p. 7), held that reconstruction and equipment of RMUs and selected CMUs, training of staff in those facilities, implementation of enhanced clinical protocols, and strengthening of MOH capacity in stewardship and management of the sector would lead to improved quality of PHC services as well as more rational referral of patients from the PHC level to RMU/CMU hospitals. With better-equipped PHC and RMU/CMU facilities following improved clinical practice guidelines, there would plausibly be improved access to higher-quality health care at both the primary level and at RMUs and participating CMUs.

### Outputs

All RMUs and 15 CMUs were reconstructed, primarily with government financing. The project supported the design and layout of this construction. The project also equipped 748 hospitals with medical and waste management equipment, exceeding the original target of 100 and the revised target of 516 hospitals. A Republic Training and Production Center for Maintenance of Medical Equipment was established, and RMUs reported that they are facing no problem with medical equipment maintenance (ICR, p. 16). 933 hospital core staff received training on waste management, exceeding the original target of 300 and the revised target of 516 staff, though waste management equipment was not purchased until the end of the project period.

22 new clinical guidelines related to NCDs (cardiovascular disease, diabetes, etc.) were developed and adopted by the MOH by 2019, not meeting the original target of 25 guidelines, but exceeding the revised target of 20. These guidelines were developed by 11 local experts who were trained by the World Health Organization (WHO) and U.S. Centers for Disease Control and Prevention (CDC). RMU and CMU staff were trained for internal monitoring of clinical protocol implementation.

3,067 doctors in urban and rural PHC facilities received training under a ten-month general practitioner training program, not meeting the original target of 3,670, but exceeding the revised target of 3,000 doctors.

14,824 doctors and 50,018 nurses at PHCs received training under continuous professional education, partially meeting the original target of 6,000 doctors and 57,000 nurses, and exceeding the revised target of 9,400 doctors and 40,500 nurses.

Some progress was made on laying the groundwork for further health care financing reform. Two Public Expenditure Review reports and two NHA reports were published, meeting the target. 155 urban family polyclinics were converted to a per capita financing system following the planned pilot of this model, an increase of 130 over the 2013 baseline of 25 clinics, meeting the target of 155; this financing system is now being applied to all RMUs. However, volume and cost contracts were not introduced in three pilot hospitals in Fergana oblast, not meeting the target of three hospitals doing so, due to lack of adequate in-country capacity to implement such a complex payment mechanism.

### Outcomes



The proportion of diabetic and hypertension patients referred from PHC facilities to RMUs in accordance with clinical protocols increased from zero in 2012 to 88% in 2019, surpassing the original target of 10% and the revised target of 80%.

The perceived quality of PHC and secondary care services in intervention areas met or exceeded targets. For PHC, patient satisfaction levels improved from 85.5% in 2011 to 90.7% in 2019, meeting the target of 90%. For secondary care, satisfaction rose from 69.5% in 2011 to 86.8% in 2019, meeting the target of 85%.

In addition, intermediate results described above on improved and better equipped PHC and RMU/CMU facilities, and improved clinical guidelines and staff skills, captured the extent of contribution of the operation's activities and outputs toward achieving improved access to quality health care.

### **Rating**

Substantial

## **OBJECTIVE 2**

### **Objective**

Strengthen the government's public health response to the rise in NCDs

### **Rationale**

The theory of change for this objective, developed by the ICR (p. 7), held that the development and monitoring of enhanced clinical protocols, in conjunction with the training of public health staff, healthy lifestyle promotion activities, and the implementation of WHO NCD prevention, treatment, and counseling protocols at PHC facilities, would plausibly lead to increased NCD awareness and strengthened data collection as well as improved implementation of NCD-related referral pathways and protocols, ultimately contributing to an improved public health response to the rise in NCDs.

### Outputs

In addition to the outputs noted under the first objective:

3,833 doctors and 6,158 nurses were trained on clinical case management for NCDs and pediatrics, exceeding the original target of 2,200 total personnel and the revised target of 1,002 doctors and 2,064 nurses.

177 public health specialists (surveillance staff) and health promotion specialists were trained, not meeting the original target of 300, but exceeding the revised target of 140.

### Outcomes



The number of hospitals following NCD clinical guidelines developed under the project increased from zero in 2012 to 172 in 2019, exceeding the original target of 100 and meeting the revised target of 172 hospitals. The ICR (p. 18) reported that, due to new laboratory equipment, appropriate training, and application of practice guidelines, the detection of diabetic patients has improved, with incidence rates moving from 5% at the beginning of the project to closer to the international average of 25-30% at project closing.

A profile of NCD risk factors and burden of disease was published on the MOH website in December 2018, meeting the target.

**Rating**

Substantial

**OVERALL EFFICACY**

**Rationale**

The project's interventions were logically and plausibly connected to observed outcomes, which met targets for improved access to quality care for NCDs as well as strengthening the public health response. Although the PAD and the ICR noted that other donors were engaged in Uzbekistan's health sector, and the government was responsible for reconstruction of health facilities under the project, there was no direct discussion in the ICR of attribution. The ICR (p. 19) noted that, at its peak year of disbursement (2016), the project accounted for only 1.77% of general government spending on health. Given the integrity of the project's results chain, however, the financed activities are reasonably considered to have contributed significantly to achievement of both objectives. Efficacy is therefore rated Substantial.

**Overall Efficacy Rating**

Substantial

**5. Efficiency**

At appraisal, it was estimated that the project's interventions would avert over 980,000 disability-adjusted life years (DALYs) over the 2011-2030 period. The main direct benefit of the project derived from the economic value of those averted DALYs. The costs and benefits of the project were estimated over 20 years, including the five years of project implementation. The future stream of annual DALYs saved (benefits) was discounted at 3%. The baseline conservative estimate produced a net present value (NPV) of US\$189.6 million and internal rate of return (IRR) of 24%. Both NPV and IRR analyses were highly sensitive to the value of a DALY; increasing this value from one to three times per capita GDP increased the IRR nearly threefold. By contrast, the IRR was only mildly sensitive to the discount rate for DALYs, and minimally sensitive to the deflator (inflation) rate of the discount rate for DALYs averted. The IRR was also minimally sensitive to a reduction of 50% in intervention



effectiveness. It was assumed that the overall reduction in DALYs from cardiovascular disease would be only about five percent over 20 years, which was a modest assumption.

The ICR (pp. 44-52) updated the PAD's analysis, again deriving benefits from the health gains produced primarily by the first and third components, measured in terms of DALYs averted, using a discount rate of 3%. Under the most realistic scenario, net benefits were US\$ 879.2 million in real terms, translating into an NPV of US\$ 176.5 million and IRR of 199%. The benefit-cost ratio was estimated at 13.7. These results varied with sensitivity analysis but remained highly positive in all cases. These highly positive results are not surprising, given the high costs of NCDs.

The ICR (p. 18) also noted that the project's allocative efficiency was high, through its focus on health promotion and prevention (saving higher-level hospitals from having to provide costly services), clinical quality of care (a necessary step for converting services to better health outcomes), and the most critical health conditions facing the country (NCDs).

Financial management and general project implementation were smooth and efficient. Notwithstanding procurement savings on medical equipment (discussed below), however, there were procurement inefficiencies, primarily related to two factors: delays in physical construction/reconstruction of facilities and approval of bidding documents for equipment, driven by long lags gaining required approvals from an inter-ministerial commission and lengthier-than-expected timelines for actual construction; and a lengthy process of price verification for import contracts that was in place until 2017 (a process carried out by the Ministry for Foreign Economic Relations, Investments and Trade (MFERIT) for all Bank-financed projects that was in violation of Bank procurement guidelines). In 2017, the government adopted a reform agenda that modernized the bureaucratic system, restructured MFERIT, and abolished the price verification practice. Ultimately, procurement of medical equipment for all facilities constructed or renovated under the project produced significant savings through the use of international competitive bidding (ICR, p. 13).

Due to evidence of strong economic returns, high allocative efficiency, and moderate implementation issues that imposed some opportunity cost but were eventually resolved, efficiency is rated Substantial.

## 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	✓	24.00	100.00 <input type="checkbox"/> Not Applicable
ICR Estimate	✓	199.00	100.00 <input type="checkbox"/> Not Applicable

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



## 6. Outcome

The project's objectives were strongly relevant to the country's disease burden, government strategy, and Bank strategy at appraisal and closing, though -- given capacity and political constraints -- they did not follow recommendations from the Bank and other development partners to pursue hospital rationalization. Relevance of objectives is rated Substantial. Efficacy was Substantial, as the project's interventions contributed to achievement of improved access to quality health services and an improved government public health response to NCDs. Efficiency was also Substantial, with high rates of return, strong allocative efficiency, and moderate implementation inefficiencies. These ratings indicate that there were only minor shortcomings in the operation's relevance, achievement of objectives, or efficiency, leading to an overall Outcome rating of Satisfactory.

### a. Outcome Rating

Satisfactory

## 7. Risk to Development Outcome

The government's and health institutions' ownership and commitment to sustaining the gains achieved by the project are strong. The Bank continues to support the sector through the Emergency Medical Services project (US\$ 100 million, 2018-2021) and health financing advisory services and analytics. Ongoing maintenance of the medical equipment provided by the project is supported by dedicated maintenance training centers and processes. The project's achievements in institutional strengthening, including building MOH capacity to produce public expenditure reviews and NHAs, will continue to give health decision makers thorough insights into the financial status of the health sector. Increased capacity to monitor the burden of disease, including NCDs, should contribute to the sustainability of a coordinated and informed response to addressing this challenge. The primary risks are two-fold: technical and political risks stemming from the reluctance of key actors to pursue further health financing reforms at the secondary level of care, and the effect of the COVID-19 pandemic on the functioning and financing of the health care system. The Bank is mitigating the latter risk through a US\$ 95 million Emergency COVID-19 Response Project (2020-2022), with US\$ 4 million in AF approved later in 2020.

## 8. Assessment of Bank Performance

### a. Quality-at-Entry

The project's objectives and design were responsive to the situation in Uzbekistan's health sector at appraisal, the government's policy priorities, and the advice and knowledge of the Bank on international experience in undertaking similar reforms in similar contexts. Implementation arrangements were specified in detail (PAD, pp. 43-45). Key lessons learned from previous Bank projects in the country, and from reviews of health care reforms in other transition countries in the region (PAD, pp. 24-25), included: the need to enhance efficiency of the supply side by changing clinical protocols, reforming outpatient care, changing the skill set of the labor force, and strengthening providers' managerial capabilities; the importance of strengthening the government's use of budgetary and regulatory instruments by improving



public budget management and supervisory capabilities; and design and implementation mechanisms to meet demand. Unsuccessful experience with previous case-based hospital pilots in Uzbekistan had demonstrated that there were not yet sufficient preconditions for case-based financing at rayon-level hospitals, requiring more preparation and a longer transition period. However, in other areas where the government had already initiated reform, such as the development and implementation of new standards for clinical practice and management, progress could be rapid. Earlier project experience had also demonstrated the importance of keeping the project's objectives and key monitoring indicators specific and limited in number, and limiting the scope of public health activities, in recognition of capacity constraints. The Operational Risk Assessment Framework at appraisal (PAD, pp. 54-55) rated the project's overall risk level MI (low likelihood of risks materializing, but high impact if they did), based on concerns about the government's commitment to the health sector reform agenda, challenges with donor coordination, and the risk of implementation delays due to weak procurement and financial management capacity. Mitigation measures, which proved generally effective, included continued policy dialogue and advocacy for reform, a communication strategy to engage stakeholders with the reform agenda, and close monitoring and timely advice on procurement and project monitoring/oversight arrangements.

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

Satisfactory

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

According to the ICR (p. 25), supervision was "intense," with frequent missions and consistent policy dialogue. There were two task team leaders (TTLs) over the project's lifetime, and the engagement of Bank staff in-country provided continuity and responsiveness. Project monitoring documents were candid and consistent. M&E and safeguards were well supervised. The Bank team adapted appropriately to the need for AF, and then with further restructuring and reallocation of loan proceeds when implementation delays arose in 2015-2016. The ICR (p. 25) noted in particular that both TTLs were fluent in Russian and had deep understanding of the Soviet and post-Soviet health systems, helping to build trust with the government and facilitating discussions on challenging issues.

### **Quality of Supervision Rating**

Satisfactory

### **Overall Bank Performance Rating**

Satisfactory

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

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

The project's objectives were clearly stated, and the theory of change was well established and plausible. Results indicators were relevant and manageable, with data sources and responsibility for data collection well specified for each indicator; baselines and targets were to be determined primarily through beneficiary



population and other surveys to be completed within six months of effectiveness. Progress was to be tracked using the Central Project Implementation Bureau's (CPIB's) M&E system, which drew on multiple information sources and instruments. The CPIB system was also to track data on behavior risk factors related to NCDs, the satisfaction of patients and providers with health services, and the quality of health services through studies and surveys. The M&E specialist of the CPIB was to be responsible for overall data collection, analysis, and reporting, working with Regional Institute of Health Monitoring Departments in project oblasts. Semiannual Project Management and Progress Reports prepared by the CPIB in consultation with the MOH were to verify the project's compliance with established operational procedures and document performance.

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

The M&E framework was implemented as designed, with some indicators adjusted at the restructurings to improve the clarity of wording and adapt baseline values in light of new data. Some the planned studies on health services quality were not conducted, and the ICR (p. 23) raised questions about the reliability of the data that were collected but did not elaborate on the nature of possible shortcomings. The project team (6/3/2021) later explained that overall data collection and reliability of any data was a generic issue in Uzbekistan, but that data presented on the project indicators were provided by the MOH and deemed acceptable by the project team.

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

The project's M&E data and analysis were used as management tools to assess the status of implementation throughout the project's lifetime. This ICR Review concurs with the ICR's conclusion (p. 23) that "the project's M&E framework was sufficient to assess achievement of project objectives, to inform the direction of the project, and was effective for strategy development and/or future projects."

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

Substantial

## **10. Other Issues**

### **a. Safeguards**

The project was rated Environmental Assessment category "B" and triggered OP/BP 4.01, Environmental Assessment, as it was to indirectly support the rehabilitation of health facilities, with potential improvements in health care waste management. An Environmental Management Framework was prepared and disclosed, as was an Environmental Management Plan prior to beginning construction at each site. The ICR did not specify whether there was compliance with environmental safeguards. The project team later confirmed (6/3/2021) that there was full compliance with safeguard policies.

OP 4.12, Involuntary Resettlement, was triggered during implementation, as the scope of civil works went beyond initial floor plans and required the relocation of some small businesses. In order to ensure



compliance, the project prepared a Resettlement Audit and Action Plan, Resettlement Policy Framework, and Resettlement Action Plan. An independent audit was conducted in 2016 to assess all private sites located within the potential territory of RMUs. The audit showed that no involuntary resettlement took place, and that only two private sites carried ongoing potential risk in this area; construction on the territory of those two sites was not permitted.

**b. Fiduciary Compliance**

The CPIB was responsible for both financial management arrangements and procurement. An Action Plan was agreed to with the CPIB to ensure that adequate financial management systems were in place before implementation began. According to the ICR (pp. 23-24), CPIB prepared annual budgets on a timely basis, and internal controls were consistently found to be reliable. Financial management reports were submitted on time and found to be satisfactory, and independent audits were carried out regularly. Although the ICR did not discuss the acceptability of the audits, the project team confirmed (6/3/2021) that audits were clean and on time.

At appraisal, a procurement capacity assessment was carried out and concluded that the CPIB had adequate staffing and experience to carry out proposed activities (PAD, p. 26). There were issues with procurement that led to implementation delays (see Section 5), but these were outside the control of the project, and they impacted projects across the entire country portfolio. The ICR (p. 24) stated that these challenges related to discrepancies between the Bank's procurement guidelines and national procurement procedures, and government unwillingness to recognize the seniority of the Bank's guidelines. As a result, the Bank team spent time encouraging the government to adhere to this principle throughout the life of the project, and the CPIB had to balance the incorporation of Bank comments with compliance with local requirements. Repeated instances of non-acceptance of Bank comments on bidding documents or bid evaluation reports caused protracted procurement processes, delaying contract awards and disbursements.

**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	



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Bank Performance	Satisfactory	Satisfactory
Quality of M&E	Substantial	Substantial
Quality of ICR	---	Substantial

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## 12. Lessons

The ICR (pp. 26-27) provided a series of useful lessons, some of which are adapted here:

**Health reform relies heavily on government commitment and political processes.** In this case, government ownership was critical to supporting reforms through legislative processes, but political reluctance and opposition to more far-reaching hospital rationalization constrained the scope and approach of project design.

**Close coordination with other technical agencies can produce important benefits and synergies.** In this case, work with the World Health Organization and U.S. Centers for Disease Control and Prevention was central to the development of clinical protocols and national health accounts reports.

**Continuous and long-term engagement of the Bank in a specific sector pays off,** though in this case, it is a work in progress. Engagement through the previous Health I and Health II projects, which supported comprehensive reform of primary care and piloted case-based payments for hospitals, both laid the ground work for the investments supported by this project and sustained an ongoing dialogue about pathways for engaging in more difficult financing and structural reforms in hospital care.

## 13. Assessment Recommended?

No

## 14. Comments on Quality of ICR

The ICR was well-written, concise (at 22 pages of main text), and carefully adherent to guidelines. It effectively reconstructed the project's theory of change discussions and meticulously described the revisions in the project's objectives, financing, activities, and indicators over its lifetime. The ICR was results-oriented, explaining how the implemented activities contributed to achieved outcomes. It was candid in its assessment of the government's reluctance to pursue more ambitious hospital reform and the project's challenges with procurement. However, there were some minor shortcomings and inconsistencies in M&E. The risk to development outcome and M&E discussions were thin, and there was no statement about the quality of financial audits or compliance with the Bank's safeguard policies.



**a. Quality of ICR Rating**  
Substantial