



## 1. Project Data

Project ID  
P088716

Project Name  
BR Health Network Formation & Quality Im

Country  
Brazil

Practice Area(Lead)  
Health, Nutrition & Population

L/C/TF Number(s)  
IBRD-76320

Closing Date (Original)  
30-Jun-2014

Total Project Cost (USD)  
676,800,000.00

Bank Approval Date  
29-Jan-2009

Closing Date (Actual)  
31-Dec-2015

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	235,000,000.00	0.00
Revised Commitment	170,000,000.00	0.00
Actual	93,852,870.04	0.00

Sector(s)  
Health(87%):Public Administration - Health(13%)

Theme(s)  
Health system performance(100%)

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## 2. Project Objectives and Components

### a. Objectives

According to the Loan Agreement (p. 5), the project's objectives were: "(i) to improve the quality and efficiency of the Borrower's *Sistema Único de Saúde* (unified health system, SUS) regional health care networks (RHCNs) with emphasis on secondary-level health care, specialty, diagnostic and emergency centers, and logistical systems serving the Borrower's territory and population; and (ii) improve the effectiveness of the Borrower's SUS RHCN's delivery system to prevent, detect and treat priority health conditions in the Borrower's territory and population."

The project was originally intended as the first phase of a two-phase, ten-year Adaptable Program Loan (APL). The overall APL program objectives were to: "(a) improve the quality, efficiency and effectiveness of the SUS-financed delivery system, through the development of integrated regional health care networks, with emphasis on the integration among basic health care and high and medium-complexity health



care providers, support services (e.g., diagnostics), and logistical systems (e.g., transport); and (b) contribute to improving the continuity of care by strengthening the prevention, detection, and treatment of diseases and conditions with the greatest impact on the country's disease burden, including hypertension, diabetes, and cancer" (Project Appraisal Document, PAD, p. 7). The second phase of the APL is no longer contemplated.

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

No

- c. Components

The project contained three components:

1. Development of regional health care networks and strengthening of health care facilities (appraisal, US\$ 646.1 million, with IBRD financing of US\$ 205 million; actual US\$ 409.6 million). This component was to support two related categories of activities. The first involved the development and implementation of regional and organized arrangements for coordinated or integrated health care (the RHCNs). The second consisted of upgrading, quality enhancement, organizational reform, and strengthening of management practices in facilities within the RHCNs. Both types of activities were to be incorporated into up to 15 demand-driven RHCN subprojects aimed at developing and implementing RHCNs in a subset of the country's states to raise the effectiveness of care provision and strengthen the performance of health and support services. These subprojects were to finance works, goods, training, and technical assistance, including upgrading and equipping existing health facilities and procurement of medical and non-medical equipment. Each participating state was to select interventions based on a diagnosis of population needs, local conditions, and implementation capacity. Emphasis was to be placed on both "fundamental" areas (development of network and facility policies for establishing RHCNs; network configuration; network and facility governance, management, and financing/payment mechanisms; monitoring and evaluation systems; and support and logistics) and "functional" areas (development of evidence-based care practices or clinical guidelines; disease and care management; organized management of referrals, bed assignments, diagnostic exams, specialty consultations, and urgent/emergency care; contracting arrangements; patient communication and health promotion; continuous quality improvement; efficiency enhancement; continuing education for professional and auxiliary staff; information and communication systems; and change management).
2. Systems development for performance enhancement (appraisal, US\$ 26.3 million, with IBRD financing of US\$ 26.3 million; actual, US\$ 32.7 million). This component was to support the creation of an enabling institutional and systems environment to support the implementation of RHCNs to improve quality and care management, promote alternative payment systems, and strengthen monitoring and impact evaluation. It was to have a national focus and be implemented directly by the Ministry of Health (MOH). Supporting studies, consultancy services, goods, training, and travel expenses, the component was to support network formation, the development of clinical pathways in support of care coordination, quality enhancement activities, studies in support of technological innovation and assessment, development of mechanisms related to health financing and performance, and monitoring and impact evaluation.
3. Project management (appraisal, US\$ 3.8 million, with IBRD financing of US\$ 3.1 million; actual, US\$ 8.0 million). This component was to strengthen MOH capacity to implement and supervise the project. It intended to finance full-time consultants to support MOH staff in procurement, financial management, and administrative tasks associated with daily project implementation, as well as facility upgrading and operating expenses.

- d. Comments on Project Cost, Financing, Borrower Contribution, and Dates

Project cost: Total estimated project costs were US\$ 676.8 million, including a front-end fee of US\$ 0.6 million and physical and price contingencies of US\$ 143.8 million. Actual total costs were US\$ 450.9 million.

Financing: The project was to be financed by a US\$ 235 million IBRD loan. Actual financing was US\$ 93.9 million. The project incorporated a pooled financing approach, with loan proceeds under the first component channeled through the MOH's financial subsystem in which grants were transferred to sub-national entities to co-finance health programs and service delivery. The arrangement was to incorporate a performance-based financing scheme that was to reward states for achieving agreed benchmarks related to results and implementation at specified intervals, while reducing (or even canceling) financing for non-performers (PAD, p. 24).

Borrower contribution: The government made US\$ 357 million of an expected US\$ 441.8 million contribution.

Dates: The project was approved on January 29, 2009 and became effective on February 29, 2010. The mid-term review took place as scheduled in late May 2012. There were three Level 2 restructurings. The first, on June 23, 2014, extended the closing date from June 30, 2014 to December 31, 2014, and cancelled US\$ 65 million of loan proceeds. The second, on December 1, 2014, extended the closing date by an additional twelve months to December 31, 2015. Both of the 2014 restructurings were done with the expectation that a Level 1 restructuring, including a revision of the project's objectives, would soon follow. In view of the proximity of the closing date,



however, the Bank decided not to proceed with a Level 1 restructuring. Instead, a third Level 2 restructuring, on June 19, 2015, revised the results framework to align with government indicators and data availability, reallocated funds across categories, and revised some project activities to reflect delays in implementation and changes in government priorities.

### 3. Relevance of Objectives & Design

#### a. Relevance of Objectives

The objectives were relevant to country conditions at the time of appraisal. At that time, Brazil had made significant progress in improving the health status of its population. Because health care was a highly political issue and a large component of public spending, increasing efficiency and effectiveness in the use of health resources were perceived to be the country's most important health challenges. Non-communicable diseases and injuries had become the leading causes of mortality, threatening accelerated burdens on health care spending without aggressive actions to improve coordination of health services promotion and delivery. In addition, neonatal mortality remained a challenge, reflecting the need for effective health care referral systems and improvements in the quality of hospital care. Initially, the objectives were also relevant to World Bank and government strategy. A new set of government reforms launched in 2006 set regionalization as the foundation of the health care delivery system and mandated the creation of RHCNs, along with corresponding inter-municipal government structures to support network formation (Regional Management Councils). The Bank's more recent Country Partnership Strategy (2012-2015) called for improvement in the provision of public services for low-income households, as well as the expansion of those services through both public and private channels. In 2011, however, the MOH assigned high priority to primary health care, with specific emphasis on maternal/child health and emergency care, out of synch with the project's objectives, although there was continued focus on regional health networks as the preferred delivery model. The objectives have therefore not remained relevant to current government strategy.

Rating  
Modest

#### b. Relevance of Design

The project's planned activities were logically and plausibly connected to achievement of its objectives. Quality and efficiency of the RHCNs was to be enhanced through demand-driven subprojects, with specific elements linked to local needs and implementation capacity. The capacity to prevent, detect, and treat priority health conditions was to be increased through studies, technical assistance, and institution-building. The APL instrument was selected due to the long-term nature of the proposed activities, the need for a phased approach given the complexity of the envisioned interventions, and the long-term commitment of the health ministry to health network formation. However, the project was far too complex given available capacity and time, and some key foundational elements were not specified during preparation: sequencing of capacity-building at the federal level prior to using that built capacity to support regional development, and criteria for selection of subprojects.

Rating  
Modest

### 4. Achievement of Objectives (Efficacy)

#### Objective 1

##### Objective

Improve the QUALITY of the Borrower's SUS RHCNs with emphasis on secondary-level health care, specialty, diagnostic and emergency



centers, and logistical systems serving the Borrower's territory and population

**Rationale**

**Outputs:**

Regional subprojects were approved for 16 states and the Federal District, under the framework of 15 approved RHCN subprojects prepared by State Secretariats of Health. These subprojects focused on anywhere from one to all five of five priority areas: primary health care, thematic networks (maternal and child health or emergency care), diagnostic and therapeutic support systems, logistical support systems, and regional governance strengthening. Nine subprojects were for RHCNs in metropolitan areas, three were for interstate RHCNs, two addressed coordination with the indigenous health system, and one was in a border area. All of the participating regions implemented new governance mechanisms to support regional coordination and collaboration, surpassing the target of 80%.

The project helped establish the legal framework for RHCN formation through a series of directives, guidelines, policy, and legislation covering organizational structure, action plans, maternal and child health care, emergency/urgent care, home care, HIV and syphilis testing, and quality assurance. Five planned national studies aimed at developing strategic guidance for the establishment of RHCNs were never carried out due to delayed in procuring the studies and issues with following Bank procurement guidelines. Instead of these five studies, the MOH issued a special publication through the Unified Health System to provide analysis and guidance to state Secretariats of Health on the topic of regional network formation. Nine of Brazil's states and the Federal District contributed to the publication, encompassing 295 research projects (mostly from universities) in the areas of regionalization, networks, and planning; health care delivery; human resources; monitoring and evaluation; and financing.

Of the 15 approved RHCN subprojects, three were never implemented, and none of the remaining 12 was implemented in its entirety.

Overall, only 34.5% of resources committed to RHCN subprojects were disbursed. Of those resources that were disbursed, almost half (45.02%) were spent on medical equipment, with other significant expenditures on capacity building/training (13.9%) and appliances and vehicles (10.73%).

Training and seminars were conducted in the areas of architectural/engineering design for health facilities, transport systems for elective care, hospital cost management, management of medical technologies in hospitals, pharmaceutical management, and basic health care information systems. 64 architects and engineers were trained in parameters and technical criteria for construction and renovation of hospital units, exceeding the target of 50.

**Outcomes:**

88% of participating regions had at least 70% of their primary care teams certified by external evaluation of the Improvement of Care and Quality Program, not reaching the target of 100% of participating regions.

The percentage of participating regions with at least 80% mobile emergency care coverage increased from 50% in 2010 to 67% in 2015, not reaching the target of 90%. However, some of this progress was made in regions that did not use project funding.

36% of participating regions implemented a rapid test for diagnosing syphilis in pregnant women and their sex partners, not reaching the target of 80%. Many factors other than activities financed by the project contributed to this outcome.

**Rating**

Modest

## Objective 2

**Objective**

Improve the EFFICIENCY of the Borrower's SUS RHCNs with emphasis on secondary-level health care, specialty, diagnostic and emergency centers, and logistical systems serving the Borrower's territory and population

**Rationale**

**Outputs:**

In addition to the outputs listed above:

All of the project's participating regions implemented a new pharmaceutical management system, covering 198 municipalities. In another 84 municipalities, staff have been trained on the system and its introduction is in progress. 4,680 professionals were trained on the system, exceeding the target of 2,420. However, only 45% of participating regions had at least 85% of their municipalities implement the system, not meeting the target of 100% of participating regions reaching that level of municipal implementation.

Only 9% of hospitals in the project's participating regions introduced a planned hospital cost management system intended to identify and manage health care costs according to standard parameters, not meeting the target of 15%.

Only three RHCNs implemented patient transportation systems. An additional nine planned to do so, but the systems were never



implemented due to delays in execution and difficulties in coming to agreements on cost sharing and management. 45% of participating regions procured equipment to implement regional referral and counter-referral systems, not meeting the target of 70%, and even those that did establish the technical infrastructure are not yet operational. 88% of municipalities (430 municipalities) in the participating regions now use a system of electronic medical records in primary health care. 17 additional municipalities are in the advanced stages of rolling out this system. Only 5% of municipalities in the participating regions have not begun processes to adopt this system.

**Outcomes:**

No outcome data are provided on efficiency of the RHCNs, though it is plausible that some of the training and capacity development provided could have contributed to some modest level of institutional and network efficiency.

Rating  
Modest

### Objective 3

**Objective**

Improve the EFFECTIVENESS of the Borrower's SUS RHCN's delivery system to prevent, detect and treat priority health conditions in the Borrower's territory and population

**Rationale**

**Outputs:**

National legislation and policy were developed on regional health care networks, maternal/infant care, and emergency care. The MOH, through a special publication issued through the SUS's Research Program, provided analysis and guidance to state Secretariats of Health on regional network formation and the implementation of relevant legislation and directives. Nine states and the federal district contributed to this publication. 295 other research studies were completed in the areas of regionalization, networks, and planning; health care delivery; human resources; monitoring and evaluation; and financing.

**Outcomes:**

No outcome data are provided specifically for this objective. No results chain is articulated linking any progress in developing and implementing RHCNs with the prevention, detection, and treatment of health conditions.

Rating  
Negligible

## 5. Efficiency

The PAD (Annex 9) estimated that the project would save over 10,000 lives representing 281,000 years of life over a ten-year horizon, producing direct economic benefits of reduced hospital admissions alone valued at US\$ 44.2 million (before discounting). During the implementation period (five years), the calculated Net Present Value (NPV) was negative (US\$ - 278.32 million), but under the full ten-year period of analysis and most likely scenario, the NPV becomes positive at US\$ 97.55 million, with an Internal Rate of Return (IRR) of 6.5% and benefit:cost ratio of 1.18. The main factors seen as contributing to the economic impact of the project under this scenario were the scale of the subprojects and the definition of outcome variables directly related to target conditions. The assumptions underlying these calculations are explicit and reasonable, and the PAD (p. 104) presents a reasonable sensitivity analysis.

The ICR does not conduct a formal economic analysis, stating that insufficient information was collected (p. 27). The ICR points out that much of the loan was not disbursed, and most of the allocated funds were spent on covering ad hoc equipment needs prioritized by individual RHCNs, making it impossible to specify benefits in economic terms. There were major implementation inefficiencies, including start-up delays, shifts in government policy, and failure to restructure to match project focus with changing government priorities.



Efficiency Rating  
Negligible

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	✓	6.50	100.00 <input type="checkbox"/> Not Applicable
ICR Estimate		0	0 <input type="checkbox"/> Not Applicable

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

## 6. Outcome

Relevance of objectives is rated Modest due to a mismatch that developed, and was not corrected, between government strategy and the project's objectives. Relevance of design is also rated Modest due to the project's complexity in relation to its time frame and implementation capacity. Achievement of objectives is rated Modest for development of effectiveness and efficiency in the RHCNs in the area of secondary care. The RHCNs' contribution to diagnosis, prevention, and treatment of major health conditions was Negligible. Efficiency was also Negligible given multiple delays and few achieved outcomes. Overall, although the project assisted with conceptualizing regional health care networks and putting in place their legal and institutional basis, no meaningful, measurable outcomes were observed. These ratings are indicative of major shortcomings in the project's preparation and implementation, resulting in an Outcome rating of Unsatisfactory.

a. Outcome Rating  
Unsatisfactory

## 7. Rationale for Risk to Development Outcome Rating

Minimal outcomes were achieved. In keeping with IEG/OCPS harmonized guidelines, this section assesses the risk that this little outcome will be knocked off by a shock (rather than maintained). That risk is rated as Substantial. Support for health care network development in Brazil is being funded entirely by the government, producing important financial risks due to the current economic downturn and resulting fiscal constraints. The project's contribution to MOH guidelines regarding the regionalization process for delivery of health care is likely to be sustained, but according to the ICR (p. 28), institutional capacity development under the project was minimal, and therefore effective implementation of those guidelines is uncertain.

a. Risk to Development Outcome Rating  
Substantial

## 8. Assessment of Bank Performance

a. Quality-at-Entry

The project drew a number of lessons from prior experience with health reform in Brazil, including the need to limit the number of subprojects to avoid resource dispersion, the importance of substantial technical assistance to participating states, the need for a pre-investment phase of capacity building, the prioritization of managerial and organizational change over investment in hardware, the importance of specific links



between investment financing and the achievement of performance targets, and the appropriateness of using independent groups/commissions to review subproject proposals and assess subproject performance (PAD, pp. 19-20). The project's design drew on four analytic studies prepared by the Bank in response to the government's request for support in improving the efficiency and quality of public services, and its focus emerged logically from other Bank-financed work in the health sector. Risk assessment acknowledged several significant risks: overly complex network design, political interference in subprojects, weak performance of subprojects, over-emphasis on hardware investments, lack of experience with Bank-financed projects, and weak technical and fiduciary capacity. After mitigation measures were considered, the only risk still considered substantial was that of political interference with the planning and implementation of subprojects that might produce pressure to finance investments outside the project's scope.

Although the project was prepared at a two-phase APL, the government approved only the first phase; the ICR (p. 10) states that it would have been prudent for the Bank team to have adjusted the project for implementation in one phase only. Overall, the approach during preparation was "overly positive" (ICR, p. 11), underrating several key risks and not taking into account lessons from prior projects about the need to put in place adequate M&E systems during preparation. Project design was quite complex, with capacity-building that would enable the federal MOH team planned to occur simultaneously with the selection and roll-out of regional-level subprojects that would depend on that capacity having already been built at the federal level. The planned five years was a short time period to expect this to happen. Overall, the project was not ready for implementation upon approval by the Board: the Operational Manual had not been finalized, critical staffing at the MOH was not in place, M&E arrangements (including baseline data) were not complete, and criteria for selection of subproject proposals had not been elaborated and adopted. Finally, the Bank's Task Team Leader changed in the final stages of preparation and was no longer based at the Country Office.

Quality-at-Entry Rating  
Moderately Unsatisfactory

b. Quality of supervision

The Bank team worked closely and continuously with the MOH to accelerate implementation and keep the project's activities in line with government priorities and guidelines. Nonetheless, the project's legal framework, definition of criteria for selecting participating states, contracting of consultants to work on subproject preparation, and communication with state-level health secretariats about the project were completed over two years after approval. There were extensive delays in submitting and approving a request for a Level 2 restructuring, and the project's objectives were never brought in line with changing government priorities. Monitoring and reporting on formal project indicators did not take place, and Implementation Status Reports did not reflect ongoing challenges. Implementation support for the first several years of the project was provided by a Headquarters-based Task Team Leader, resulting in inadequate "hands-on" support (ICR, p. 35); this situation was rectified with a handover to a country-based Task Manager for the project's final stages.

Quality of Supervision Rating  
Unsatisfactory

Overall Bank Performance Rating  
Unsatisfactory

## 9. Assessment of Borrower Performance

a. Government Performance

The government was not committed to the project throughout most of the preparation and implementation periods. Project preparation took a relatively long time (over three years) because of changes in the government's technical team. Preparation was carried out by the Executive Secretariat of the MOH supported by three external consultants; this limited buy-in by the various MOH technical departments that had roles in implementation. Effectiveness was also delayed (more than one year after approval by the Board) because of a lengthy process ratification by the Senate (impacting all projects in the country) and because of MOH reconsideration of implementation arrangements (eventually the original arrangements were adopted). Upon a change in federal government administration in January 2011, priorities shifted in the health sector to primary care, reducing the relevance of the project's focus at the secondary level. The MOH issued new guidelines on regionalization in December 2010 that shifted counterpart funding from regular transfers to participating states and municipalities for higher-complexity services -- the focus of the project's objectives -- instead to transfers to thematic health care networks focusing on maternal/infant health and emergency care. As the project progressed, the MOH worked closely with the states to improve the implementation of subprojects, but eventually it agreed to finalize the subprojects without a Level 1 restructuring to reorient the project.



Government Performance Rating  
Moderately Unsatisfactory

b. Implementing Agency Performance

The majority of project activities, under the first components, were implemented by the states, with the second component implemented by the MOH Executive Secretariat. The states varied considerably in their capacity to formulate and implement subprojects, and the Executive Secretariat displayed little commitment to the project. A formal Project Execution Unit was established only two years after approval. Although this Unit attempted to improve project performance during its final stages, it could not overcome initial delays (including the completion of some important bidding procedures) and the mismatch between project and government priorities.

Implementing Agency Performance Rating  
Moderately Unsatisfactory

Overall Borrower Performance Rating  
Moderately Unsatisfactory

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

a. M&E Design

The PAD (p. 9) acknowledged the intrinsic difficulty of measuring the impact of health care networks and care coordination practices. Most of the key project indicators were therefore process indicators that were proxies for more robust outcome indicators, but were not geared toward measuring true progress toward achievement of the development objectives. It was also acknowledged that most existing data collection was oriented toward programs, facilities, and broad population-based data; regional and patient-level information related to care coordination and case management across multiple providers did not exist. The project therefore proposed to put in place processes such as standardized clinical pathways, risk classification systems, and continuous patient monitoring, as well as information systems and institutional structures to capture the impact of RHCNs on service quality, effectiveness, and efficiency and, ultimately, health status. Process indicators were specified for the overall system of RHCNs, for each specific RHCN, and for capacity development at the federal MOH. Specifically, the M&E system was to collect, analyze, and act upon six sets of data: project performance indicators included in federal-state agreements, performance indicators not included in those agreements, MOH institutional capacity indicators, fiduciary indicators, environmental indicators, and baseline and ex-post survey data for impact evaluation.

This was a highly complex results framework. Participating states were to be financed in relation to implementation and results at specified intervals. Support was to be provided to the MOH for technical assistance to the RHCNs to monitor performance, including the collection of baseline data.

b. M&E Implementation

Few of the indicators in the formal results framework were ever monitored or reported in Implementation Status Reports, as the required monitoring and reporting systems were never put in place at the subnational or federal level. Baseline data were compiled only in June 2014. At the June 2015 restructuring, the results framework was revised to align with government indicators, to acknowledge the project's limitations in influencing the quality and efficiency of the RHCNs, and to reflect the government's decision to prioritize thematic health care networks focused on maternal/child health and emergency care.

c. M&E Utilization

With little to no data collected and reported, there was no opportunity for the project's M&E to impact implementation or policy development.



M&E Quality Rating  
Negligible

## 11. Other Issues

### a. Safeguards

The project was environmental category "B" and triggered three safeguard policies: Environmental Assessment (OP/BP 4.01), Physical Cultural Resources (OP/BP 4.11), and Indigenous Peoples (OP/BP 4.10). An Environmental Assessment was prepared to identify potential environmental impacts. It proposed activities to enhance environmental management, particularly under the RHCN subprojects. All RHCNs were required to incorporate the establishing or strengthening of an organized sanitary and transport system for medical waste that serves all municipalities and units within their regions. A project Environmental Framework (EF) was also established to guide the selection, screening, construction, and monitoring of health networks and units. In order to address the Physical Cultural Resources safeguard, the EF included "chance find" rules and procedures, as well as screening procedures to identify any known cultural resources requiring special attention during renovation activities. An Indigenous Peoples Planning Framework was incorporated, through which states whose subproject catchment areas included indigenous communities would develop Indigenous Peoples Plans.

At the time of the mid-term review in May 2012, a review of compliance with safeguard policies was carried out, but given the lack of subproject implementation at that time, there was only a review of plans. The project team later confirmed that there was full compliance with the Bank's safeguard policies.

### b. Fiduciary Compliance

Financial management presented no major issues during implementation, although internal controls at the state level were weak. Corrective actions included the use of state- and federal-level systems and the information technology system developed for another Bank-financed project. However, there were extensive procurement delays, as state and municipal capacity to handle procurement varied widely. The ICR (p. 19) states that little (if any) training on Bank procurement guidelines was carried out. Ultimately, because of operational delays during implementation, several states were unable to complete contracts included in their procurement plans. The project team later confirmed that there was full compliance with the Bank's fiduciary policies.

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

None reported.

### d. Other

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## 12. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Unsatisfactory	Unsatisfactory	---
Risk to Development Outcome	Substantial	Substantial	---
Bank Performance	Moderately Unsatisfactory	Unsatisfactory	The project's objectives were not brought in line with changing government priorities, monitoring



			and reporting on formal project indicators did not take place, and Implementation Status Reports did not reflect ongoing challenges.
Borrower Performance	Moderately Unsatisfactory	Moderately Unsatisfactory	---
Quality of ICR		Substantial	---

**Note**

When insufficient information is provided by the Bank for IEG to arrive at a clear rating, IEG will downgrade the relevant ratings as warranted beginning July 1, 2006.

The "Reason for Disagreement/Comments" column could cross-reference other sections of the ICR Review, as appropriate.

### 13. Lessons

The following lessons are derived from the ICR (pp. 33-35):

Government policy shifts can render existing projects less relevant, or even irrelevant. In this case, a project whose buy-in was tenuous from the beginning suffered fatal blows when government priorities changed. Continuous dialogue and attention is necessary so that the need for restructuring is identified early and accurately.

Sequencing is important. When enhanced institutional capacity is essential to project implementation, it must be adequately planned and provided. In the case of this project, MOH required capacity development in order to support the subnational levels in design and implementation of subprojects, but the required phasing of activities was not put in place.

Candor in Implementation Progress Reports is a prerequisite for mid-course adjustment. In this case, lack of candor in ratings for progress toward development objectives and implementation support translated into lack of urgency regarding corrective action and restructuring.

### 14. Assessment Recommended?

No

### 15. Comments on Quality of ICR

The ICR is analytical, concise, and candid in its reporting of the challenges with the project's preparation and implementation. Its provides a thorough assessment of attribution of observed outcomes to the project's interventions. Lessons are insightful and well derived from project experience. However, the ICR is repetitive at points, and there are numerous mismatches in outcome data between the Data Sheet and main text.

- a. Quality of ICR Rating  
Substantial