



1. Project Data

Project ID P147758	Project Name GN_PRIMARY HEALTH SERVICES IMPROVEMENT		
Country Guinea	Practice Area(Lead) Health, Nutrition & Population		
L/C/TF Number(s) IDA-56570,IDA-D0690	Closing Date (Original) 30-Sep-2020	Total Project Cost (USD) 14,691,019.89	
Bank Approval Date 20-May-2015	Closing Date (Actual) 30-Sep-2020		
	IBRD/IDA (USD)	Grants (USD)	
Original Commitment	15,100,000.00	0.00	
Revised Commitment	15,100,000.00	0.00	
Actual	14,691,019.89	0.00	
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2. Project Objectives and Components

a. Objectives

The project development objective was to improve the utilization of maternal and child health, and nutrition services at the primary level of care in target regions (Financing Agreement, 06/26/2015, p. 5). The objectives statements in the Project Appraisal Document (PAD) and ICR are identical to those in the Financing Agreement.

The project target population was the ten percent most vulnerable women and children in the two poorest regions in Guinea (Faranah and Labe). Together, these regions cover nine out of 34 districts in Guinea: the



Labe region encompasses five districts (Mali, Koubia, Tougue, Lelouma, Labe), and the Faranah region encompasses four districts (Faranah, Dinguiraye, Dabola, Kissidougou).

The project development objectives and indicators did not change throughout the project's life. However, its baselines and targets changed throughout implementation. Because of Guinea's post-Ebola fragile context, the project started implementation without setting baselines and targets. Only in 2019, when the project was restructured, were the baselines and targets formally established. IEG considered carrying out a split rating weighting the project's achievements between two periods: (i) against outcome targets before 2019 and (ii) against outcome targets after 2019. In the absence of formally set baselines and targets in the PAD or prior to 2019, IEG took as baselines the first provisional data established by the team in the Implementation Supervision and Results Reports (ISRs), which occurred in September 2016 at ISR #3. The conclusion was that a split rating was unnecessary, because the project substantially achieved or exceeded both the targets set at ISR #3 and the revised targets established at the 2019 restructuring. See Section 2d (Table 1) for more details on project targets and their evolution over the project's lifetime.

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

19-Dec-2019

c. Will a split evaluation be undertaken?

No

d. Components

Component 1: Commodities and trained human resources for maternal and child health and nutrition (MCHN) services at primary level (Appraisal: US\$6.00 million; Restructuring: US\$ 6.50 million; Actual US\$6.48 million). This component included two subcomponents:

1.1 To strengthen the availability of maternal and child health commodities and supplies at the primary health level by funding operating costs and procurement of essential drugs, supplies, and equipment for health facilities at the post and center level.

1.2 To address human resources shortfalls in target areas by financing the recruitment of unemployed nursing assistants to work at the health center and health post level, and the training of health workers to generate demand and deliver essential services in maternal and child health.

Component 2: Strengthen community-level demand for MCHN services (Appraisal US\$4.00 million; Restructuring: US\$ 2.30 million; Actual US\$2.32 million). This component included two subcomponents:

2.1 To strengthen financial access to essential health services for indigent women and children under five by allowing free access to health services.



2.2 To improve the availability of qualified human resources at the community level by providing standardized maternal and child health training, recruitment, and deployment of community health workers.

Component 3: Strengthen government capacity to plan, implement, monitor, and supervise activities (Appraisal US\$5.00 million; Restructuring: US\$ 6.20 million; Actual US\$6.20 million). This component included three subcomponents:

3.1 To strengthen the capacity to carry out district-level supervision of health centers and posts in target regions. Funding included the development of supportive supervision strategies, training of district health teams, and critical costs linked to carrying out supervision.

3.2 To support the generation of evidence to inform the development of post-Ebola health systems by providing technical assistance to carry out a results-based financing experiment in one district and provide funding for other evidence-based analytical studies in health and nutrition.

3.3 To strengthen the capacity for project implementation and monitoring, address technical gaps, and build capacity for developing interventions and the day-to-day administration of project activities. Also, to obtain quality primary-level MCHN information at all levels in the two target regions.

Baselines and targets at appraisal

At appraisal, the PDO indicator baselines and targets were not set due to the scarcity of data in a post-Ebola context. That is, the PAD lacked baselines and targets for PDO indicators. The agreement with the government at appraisal was to collect this information in the first quarter of the project, but this process took three years and finally led to the 2019 restructuring. During a meeting with IEG, the TTL reported that the team used provisional baselines and targets to guide implementation during the pre-restructuring period (from appraisal until 2019) while the data was being collected. These provisional targets reported by the TTL, shown in Table 1 (column G), have discrepancies with the targets established at ISR #3 (column C).

Table 1. PDO indicator targets throughout the implementation period.

Outcome Indicator	A.	B.	C.	D.	E.	F.	G.	H.
	PAD	ISRs #1,2	ISRs #3,4	ISRs #5,6	ISR #7	ISRs #8-11	Provisional targets used before restructuring*	Restructuring (2019) ICR
Birth deliveries attended by skilled health personnel (number)	N/A	N/A	68,134	43,420	51,161	51,161	51,161	51,161
Children 0–11 months fully vaccinated (percentage)	N/A	N/A	42	65	65	65	65	65



Pregnant women receiving at least 4 antenatal care visits from health provider (percentage)	N/A	N/A	75	55	55	55	60	60
Children under 5 years of age with confirmed malaria who received antimalarial treatment (number)	N/A	N/A	385,407	70,306	73,800	73,800	227,383	73,800
Children (0–1 year) receiving Vitamin A supplementation every 6 months (percentage)	N/A	N/A	90	50	60	60	60	60
Direct project beneficiaries (number)	N/A	930,456	930,456	930,456	930,456	500,000	930,456	500,000

*Data provided during TTL interview.

Baselines and targets at restructuring

During the 2019 restructuring, two PDO targets were reviewed: the target for the number of children under five years of age with confirmed malaria who received antimalarial treatment was reduced from 227,383 to 73,800, and the target for the cumulative number of direct project beneficiaries was reduced from 930,456 to 500,000. Also, one of the intermediate indicator targets was modified: the target for the number of indigents eligible for free health services was reduced from 50,000 to 13,000. The number of indigents who would benefit from the project was initially overestimated, as it was based on the 2012 country poverty assessment that included men and women of all ages (and not just pregnant women and children under five years of age). One intermediate indicator was added to capture better the extent of nutrition services provided by health facilities: the number of children recovering from severe acute malnutrition. The indicator "percent of health facilities and posts assessed monthly (by district team) meeting minimum checklist score" was removed because the activity was cancelled. The indicators "number of deliveries assisted by trained health personnel at the health center" and "number of children under five years old with fever (malaria) in the last two weeks for whom advice or treatment was sought" were revised, replacing percentage with "number of beneficiaries" (this was required as both were core indicators).

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

The PAD (p.viii-ix) reported a total estimated cost of US\$15.10 million, of which the Bank was to finance US\$6 million for Component 1, US\$4 million for Component 2, and US\$5 million for Component 3, with a contingency of US\$0.1 million.



Due to savings in training costs, funds were shifted within the first component at restructuring toward the provision of maternal and child health commodities and supplies. The second component was reduced due to the overestimation of the number of eligible indigents. Funds for the third component were increased to cover new activities such as support for the National Health Account, a Service Availability and Readiness Assessment (SARA) study, and a Demographic and Health Survey (DHS).

Actual costs at project closing were US\$6.48 million for Component 1, US\$2.32 million for Component 2, and US\$ 6.20 million for Component 3, for a total actual Bank cost of US\$15.00 million (ICR, p. 40).

Financing

According to the PAD (p.vii), the project was to be financed by an IDA credit (IDA-56570: US\$ 8.30 million) and an IDA grant (IDA-D0690: US\$ 6.8 million), bringing total financing to US\$ 15.1 million.

Actual Bank financing was US\$ 14.69 million (IDA-56570: US\$ 8.45 million; IDA-D0690 US\$ 6.24 million). The ICR did not include information about borrower contributions to the project (ICR, p. 2). The TTL confirmed that the borrower contribution was traditional financing through budget funding of the health system.

Dates

The project was approved on May 20, 2015, and became effective on December 30, 2015. A mid-term review was undertaken on March 18, 2019. The project was restructured on December 19, 2019, to change the results framework, components, and costs, including reallocation between disbursement categories. The project closed as planned on September 30, 2020.

3. Relevance of Objectives

Rationale

The objectives were relevant to country conditions at appraisal. Guinea was one of the poorest countries in the world and among the worst performers in the region on key health outcomes. The health system in Guinea was severely capacity constrained and underfunded. The 2013 Ebola epidemic took a significant toll on families and communities, leaving large segments of the population even more vulnerable than before. The economy was impacted as poverty escalated, livelihoods suffered, and businesses were disrupted. The Ebola epidemic directly weakened the health system by absorbing much of the resources allocated regularly toward other services. This crisis significantly stretched the management and service delivery capacity of the Ministry of Health (MoH). In addition, the general population was reluctant to access the health system for fear of contamination, mistrust, unaffordability, and lack of essential services. As a consequence, preventable deaths of mothers and children increased.

The objectives were also relevant to government strategy at appraisal and closing. They responded to Guinea's Poverty Reduction Strategy Paper, adopted in 2013, and its National Health Strategy Draft, which prioritized improvements in primary-based health service delivery to the poorest people, especially maternal and child health care. Moreover, the project was aligned with the strategic objectives of the National Health Development Plan (NHDP) 2015, "strengthening the national health system," and the National Plan for the



Recovery and Resilience of the Health System 2015–2017, "strengthening the governance of the national health system." It contributed to a key area of the National Economic and Social Development Plan (NESDP) 2016–2020, aiming at "improve access, supply, and equitable use of quality health services to populations." The project's objectives addressed the supply and demand-side bottlenecks to utilizing MCHN services, providing support to a transition from Ebola response to Ebola recovery to address immediate health service delivery needs for mothers and children in the poorest regions. Also, the project intended to inform broader health systems and services delivery reform strategies, support mobilization of additional funding, and promote future scale-up of the proposed service delivery model.

The objectives also were aligned with the World Bank/Guinea Country Partnership Strategy (CPS) 2014-2017 that sought to improve human development indicators in the country that covered primary education, social protection, and health. The project was intended to support the CPS health targets of strengthening the health sector's capacity to provide services and quality care accessible to the entire population to reduce infant and maternal mortality, malnutrition, and the intensification of the fight against communicable and non-communicable diseases. Those interventions specifically targeted the poor and vulnerable, contributing to the twin goals of the World Bank Group to end extreme poverty and promote shared prosperity of the bottom 40 percent.

At project's closing, the second pillar of the World Bank Country Partnership Framework (CPF) 2018- 2023 related to human capital includes an objective focused on improving health and social protection, especially in rural areas. Its priorities aim at investing in health at the district level and below to complement efforts to decentralize the financing and management of health care; these priorities do not directly echo this project's objectives of improved MCHN service utilization. However, the interventions described in the CPF (strengthen district-level capacity to train, deploy, and supervise health professionals at the local level; strengthen local financing for pharmaceuticals and supplies, including contraceptive supplies and other requirements for maternal health; and improve accountability systems and available data for monitoring and planning efforts) matched with the components and activities included in this project.

Rating

Substantial

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

Improve the utilization of maternal health services at the primary level of care in target regions

Rationale

This objective's theory of change was based on the premise that ensuring the availability of commodities, supplies, and health workers in health facilities would increase the availability of maternal health services at the primary level. The project would also strengthen community-level demand in the target regions by making available community workers and facilitating financial access to the indigent population. Finally, improving



district health authorities' management and supervision capacity would ensure that the newly available medicines and health workers would translate into actual services. These improvements in the supply, demand, and management areas would then contribute to increased utilization of services.

Outputs:

Improve availability of commodities and human resources:

- The percentage of tracer drug stock-outs in health centers was reduced from 60% in 2015 to 14% in 2020, not achieving the target of 10%.
- The cumulative number of new health workers recruited and in service at health centers and posts increased from 0 in 2015 to 450 in 2020, achieving the target of 450.
- The number of health personnel receiving training increased from 0 in 2015 to 450 in 2020, achieving the target of 450 when the project closed.

Improve the demand for MCHN services:

- The number of newly trained community health workers engaged in health promotion and basic service delivery increased from a baseline of 0 in 2015 to 530 in 2020, reaching the target of 530.
- The number of new indigents covered under exemption mechanisms increased from the baseline of 0 in 2015 to 2,761 in 2020. This number was far from reaching either the original target of 50,000 (ISR#3) or the revised target of 13,000 (restructuring 2019). The ICR reported difficulties identifying beneficiaries.
- The number of indigents satisfied with the exemption mechanism increased from a baseline of 0 in 2015 to 77.5% in 2020, exceeding the target of 70%. This information was not in the ICR but was provided later by the TTL.

Strengthen supervision and management:

- The Standardized MNCH District Training Program was developed and implemented.
- The Work Plan budget execution rate increased from a baseline of 0 in 2015 to 98% in 2020, exceeding the target of 85%.
- The percentage of community workers and health workers at the health center that received monthly supportive supervision increased from a baseline of 0 in 2015 to 95% in 2020, exceeding the target of 70%.
- The percentage of health facilities reporting health management data on time increased from a baseline of 0 in 2015 to 100%. All the health facilities provided reports as recommended by the project.

Outcomes:

- The number of deliveries assisted by trained health personnel increased from a baseline of 38,815 in 2015 to 124,188 in 2020, exceeding the original target of 68,134 (ISR#3) and the revised target of 51,161 (restructuring 2019).



- The percentage of pregnant women receiving at least four antenatal care visits from health providers increased from a baseline of 56.6% in 2015 to 64% in 2020, approaching the original target of 75% (ISR#3), and exceeding the revised target of 60% (restructuring 2019).
- The cumulative number of direct project beneficiaries increased from a baseline of 0 in 2015 to 823,601 in 2020, almost reaching the original target of 930,456 (ISR#3) and exceeding the revised target of 500,000 (restructuring 2019). The percentage of female beneficiaries increased from a baseline of 0% to 80%, exceeding the target of 75%.

Although there were shortcomings in achieving intermediate indicators related to coverage of indigents under exemption mechanisms and drug supply stock-outs, there is preponderant evidence indicating that the project substantially improved the utilization of maternal health services at the primary level of care in target regions. Achievement of this objective is therefore rated Substantial.

Rating
Substantial

OBJECTIVE 2

Objective

Improve the utilization of child health services at the primary level of care in target regions

Rationale

The theory of change was based on the principle that increased availability, quality, and access to high-impact health interventions such as diagnosis and treatment of childhood illnesses would increase the use of child health services. In addition, collaboration with other organizations, local leaders, non-governmental organizations, and community workers would improve the demand for services by enhancing the population's trust in the health system and reducing stigma.

Outputs:

- The percentage of health centers offering integrated management of childhood illnesses increased from a baseline of 0 in 2015 to 100% in 2020, exceeding the target of 80%.
- The number of children immunized increased from a baseline of 55,483 in 2016 to 216,818 in 2020, exceeding the target of 73,899.

Outcomes:

- The percentage of fully vaccinated children ages 0–11 months increased from a baseline of 36.5% in 2015 to 69% in 2020, exceeding the original and revised targets of 42% (ISR#3) and 65% (restructuring 2019).
- The number of children under five with confirmed malaria who received antimalarial treatment increased from a baseline of 50,610 in 2016 to 237,763 in 2020, approaching the original target of 385,407 (ISR#3), and exceeding the revised target of 73,800 (restructuring 2019).



Available evidence indicates that the project contributed to substantial increases in the utilization of child health services. Achievement of this objective is therefore rated Substantial.

Rating
Substantial

OBJECTIVE 3

Objective

Improve the utilization of nutrition services at the primary level of care in target regions

Rationale

The theory of change was based on the principle that providing low-income mothers with free access to commodities and training local health workers at the primary level of care would promote better infant and young child feeding practices, better sanitation behaviors, and better infectious disease control. An improvement in trust in the health system and financial support would increase the utilization of nutrition services.

Outputs:

- The number of people who received essential health, nutrition, and population services under the project increased from a baseline of 0 in 2015 to 846,543 in 2020, exceeding the target of 176,221.
- The number of women and children who received basic nutrition services under the project increased from a baseline of 0 in 2015 to 79,292 in 2020, exceeding the target of 51,161.
- The number of children recovering from severe acute malnutrition increased from a baseline of 8,441 in 2019 to 11,110 in 2020, exceeding the target of 10,681.

Outcomes

- The percentage of children (ages 0–1 year) receiving Vitamin A supplementation every six months increased from a baseline of 40.8% in 2015 to 77% in 2020, approaching the original target of 90% (ISR#3), and exceeding the revised target of 60% (restructuring 2019).

Evidence indicates that the project contributed to substantial increases in the utilization of nutrition services. Achievement of this objective is therefore rated Substantial.

Rating
Substantial

OVERALL EFFICACY



Rationale

The project increased the availability of preventive and curative MCHN services at the primary level by making health workers available and providing urgently needed commodities while increasing demand among the target population for these services. With both supply- and demand-side factors addressed, utilization of services increased. The final PDO indicator targets and most intermediate indicator targets were achieved under their original (ISR#3) and revised (restructuring 2019) targets.

On the supply side, the project implemented new effective ways of managing resources. Planned reductions in the percentage of stock-outs of tracer drugs in health centers were not achieved, according to the ICR (p. 30), due to the failure of the drug supply system, particularly the unavailability of medicines and supplies in the national market. However, the project's direct supply of essential drugs and consumables to health facilities, with the technical assistance of the national pharmacy and through the United Nations Children's Fund (UNICEF), considerably reduced stock shortages. The project's interventions improved the functionality of health facilities by eliminating delivery delays and preventing misappropriation. In addition, new health professionals were recruited and trained locally under the project to serve in rural areas. This approach resulted in 100% staff retention at the end of the project, avoiding unjustified absences or the staff wanting to come back to the cities. Finally, children benefited from nutritional support under the project; as a consequence, the undernourishment rate decreased in the target regions more than the national average between 2012 and 2018 (by 1.7 percentage points in Faranah, 1.5 in Labe, and 0.4 in Guinea) (ICR, pp. 14-15).

On the demand side, a critical issue that affected the achievement of targets for demand for services was knowing the number of indigents eligible for free care provided under the project. The TTL explained that it took almost three years to estimate the number of indigents, women, and children under five who would use free health services. The ICR stated that it was challenging to identify indigent populations partly because they refused to be identified as such, and communities also opposed their identification. Communication campaigns were conducted to reduce this stigma.

Also, on the demand side, the project supported the National Program for the Fight Against Malaria through capacity building and equipment provided to community health workers. The provision of drugs, medical equipment, and motorcycles enabled health facilities to respond to the population's needs, boosting the treatment of malaria among children. According to the ICR, this contributed to improving the quality of primary health level services, reducing the population's mistrust in the ability of health facilities to offer appropriate health care, and increasing demand for services. Also, the project increased the number of fully vaccinated children under 11 months at the end of the project by involving local leaders, religious leaders, and non-governmental organizations to sensitize the population to participate in vaccination campaigns.

The health authorities' management and supervision capacity was strengthened at the central and local levels to ensure that support for new commodities and health workers translated into actual services. The project also supported national health surveys such as DHS and SARA to generate evidence and advice to inform decision-making.

Although the PDO-level baselines and targets were not set during the first years of the project life, creating methodological challenges in assessing the efficacy of the project over its entire lifetime, there is evidence that the project made significant contributions, on both the supply and demand side, toward increasing utilization of MCHN services. For this reason, overall Efficacy is rated Substantial.



Overall Efficacy Rating

Substantial

5. Efficiency

The PAD (p. 18) included an economic and financial analysis, with a cost-benefit analysis, in which the discounted total benefits of the project, estimated in productive life-years gained, was US\$ 45.41 million. The estimated net present value (NPV), assuming a constant rate of disbursement, was US\$ 14.15 million, and the benefit-cost ratio (BCR) was 3.21. This result was based on conservative assumptions and likely underestimated the total project benefits.

The ICR team undertook an economic analysis focused on children under five years, using the number of averted disability-adjusted life years as a health outcome in the present value. Only component 1 costs were considered because the indicators used for the analysis were all under this component. However, while the cost-benefit analysis included all the costs of component 1, it did not include the economic benefits of all the activities conducted under this component. A discount rate of 3 percent was used to calculate present values, and analyses were repeated with a discount rate of 1 percent and 5 percent to test the robustness of the results. The NPV was US\$10.2 million with a BCR of 1.74. The internal rate of return was 118 percent, substantially higher than the cost of capital in Guinea, 3 percent (ICR, p. 17).

Some shortcomings affected the efficiency of project implementation. Although there was an agreement with the government to collect the project baselines in the first quarter to set the targets, this process took almost three years. This lack of information affected project monitoring and evaluation as well as implementation. For instance, the original number of indigent beneficiaries targeted the 10 percent poorest in the selected regions, including men. After the 2019 restructuring, when the information was available, this target was reviewed to only incorporate indigent pregnant women and children under five years of age (the total estimated number was 23,243). The targeted number of indigent beneficiaries was reduced to 13,000 because not all of them would necessarily use health services, given demand-side barriers. Due to this adjustment, a project funds balance became available and was reallocated to other activities (ICR, p.19). In addition, the lack of experience of the project implementation unit (PIU) in World Bank procedures led to delays in the start of activities and a budget overrun for capacity building needed to ensure that PIU activities were aligned with Bank procedures.

The project was affected by the COVID-19 pandemic that hit Guinea on March 12, 2020, resulting in considerably slowed-down project activities and a decrease in the use of services at the beginning of the pandemic. The ICR cites mitigation measures the project took to ensure adequate continuity of activities but does not analyze the impact of the pandemic on project implementation and achievement of the project's objectives.

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 <input type="checkbox"/> Not Applicable
ICR Estimate	✓	118.00	43.20 <input type="checkbox"/> Not Applicable

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

6. Outcome

The objectives were aligned with country context and government and Bank strategies at appraisal and closing, though the current country partnership framework does not explicitly address maternal and child health and nutrition services utilization. Relevance of objectives is therefore rated Substantial. Efficacy is rated Substantial because of demonstrated progress in improving utilization of maternal and child health and nutrition services, despite significant shortcomings with M&E early in the project's lifetime that resulted in long delays in establishing baselines and targets. Moderate implementation inefficiencies produced an Efficiency rating of Substantial. Taken together, these ratings point to minor shortcomings in the project's preparation and implementation, leading to an Outcome rating of Satisfactory.

a. Outcome Rating

Satisfactory

7. Risk to Development Outcome

Several important elements of institutional strengthening should contribute to sustaining outcomes in terms of transparency and accountability. PIU capacity building with human, material, and financial resources ensured that procedures were aligned with Bank guidelines. Key government institutions strengthened their capacity to supervise, plan, implement, and monitor activities at the district level and below. Their dialogue systems improved, leading to more robust and effective institutional relationships. The project supported national health surveys to generate evidence to inform decision-making, and improved national actors' capacity to prepare national health accounts. The project also mitigated the risk of lack of transparency in recruitment by hiring and training health professionals locally through transparent processes with positive results and a high retention level. However, an agreement to transfer these workers into the civil service to ensure the project's sustainability has not been fulfilled at the end of the project, risking losing these human resources.

Ebola presents a significant risk for the sustainability of project outcomes, not only because of the capacity constraints the epidemic caused but because technical teams are less willing to visit the more remote and affected parts of Guinea where this project was implemented. During the last outbreak in Guinea (February through June 2021), a total of 23 cases were identified in four sub-prefectures of N'zérékoré Prefecture. Also, the COVID-19 pandemic may negatively impact the sustainability of the project outcomes in many ways.



Economic recession due to the pandemic may impact health expenditure and investments in the health system, and the loss of staff due to the pandemic may affect the availability of qualified human resources.

Political instability has the potential to impact health expenditure and the health sector reform agenda. In September 2021, the government was dissolved through a coup that led to a new government with an interim president.

8. Assessment of Bank Performance

a. Quality-at-Entry

The World Bank team ensured the project's strategic relevance, aligning the PDOs to the country's NHDP and NESDP. The preparation team undertook a technical, financial, and economic analysis and an in-depth assessment of financial and fiduciary challenges at appraisal, and it developed recommendations to measure the project's economic impact. Likewise, the project included adequate assessments of poverty, gender, and safeguards. The Bank team maintained a dynamic dialogue with government counterparts and other donors during preparation. The decentralization of decision-making power to the level of the health facilities and the provision of critical inputs to these facilities increased transparency to decision and implementation processes. It also improved the functionality of health facilities by eliminating delivery delays and preventing misappropriation.

However, there were moderate shortcomings. The project's documents provided adequate M&E arrangements; however, a PDO indicator and intermediate indicator targets needed to be reviewed during implementation. The number of indigents was overestimated, causing an excess of funds that were allocated to other interventions during the 2019 restructuring. The implementation schedule was not realistic relative to the constrained capacities of a post-Ebola context; it took three years to collect the data the project planned for the first quarter. The project documents at appraisal contained a detailed analysis of risks and mitigation measures. However, these measures were insufficient; for instance, the PIU was inadequately prepared to manage a Bank-financed project at the implementation phase, causing delays and necessitating more capacity building than initially planned.

Quality-at-Entry Rating

Moderately Satisfactory

b. Quality of supervision

During the life of the project, the task team leader was based in Guinea. The Bank team closely monitored critical activities of the project through 17 implementation support missions and analysis of relevant data. Project documents such as ISRs, Aide Memoires, and other supervision documents were submitted on time. According to the ICR, the mid-term review, expected in 2018, was postponed until 2019 because the country's low capacity delayed the implementation of planned project activities. This mid-term review helped prepare the analysis identifying the institutional and implementation problems and solutions to inform the 2019 project restructuring. The Bank team was proactive during the implementation of the



project by providing technical assistance and training on financial management, procurement, and audit arrangements to the PIU and government. However, the three-year delay in setting initial baselines and targets presented prolonged challenges in assessing early implementation progress and overall project achievement.

Quality of Supervision Rating

Satisfactory

Overall Bank Performance Rating

Moderately Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

The project team aligned the project's M&E system with the country systems established for the NHDP and NESDP. The PIU was responsible for monitoring the PDO indicators and intermediate outcome indicators during the project's lifetime. Likewise, the National Health Management Information System was to collect monitoring data, with additional support provided by the project to integrate primary-level information. A comprehensive description of the project's results framework and the arrangements for M&E were included in project documents.

There was an agreement with the government that pre-Ebola 2012 baselines would not be used to gauge progress or set targets in the results framework, as the 2012 data represented the pre-Ebola context. New baselines were to be collected during the first quarter of the project by the M&E specialist hired into the PIU, and some project activities were to support the strengthening of the M&E system. This lack of information at appraisal negatively affected project monitoring and evaluation during implementation. Furthermore, the number of indigents likely to use project-supported services was overestimated at appraisal.

b. M&E Implementation

Early in the project implementation period, the PIU was not submitting management reports on time. In addition, the data provided by the National Health Information System to inform the indicators and monitor the results framework of the project was unreliable. M&E performance improved as the PIU undertook regular field supervision missions, increased dialogue with project beneficiaries, and produced more timely reports. The collection of primary data directly from beneficiaries and primary health facilities contributed to improving the quality of M&E. Also, an M&E specialist with experience in the previous project was recruited to support implementation. Due to the capacity constraints mentioned, the team used different provisional values during the first three years of the project's life (see Section 2d) until definitive baselines and targets were set. To do this, the project team worked with the help of a committee that included the National Institute of Statistics and the WB Social Protection team.



In 2019, the results framework assessment during the mid-term review informed the restructuring performed at the end of the same year. Two PDO targets were redefined, and the number of likely indigent users of project-provided health services was recalculated. One intermediate indicator was added to better capture the provision of nutrition services by health facilities. During the restructuring, part of the funds reallocated strengthened the national health survey system to support the M&E system and inform decision-making.

At the project's closing, all the baselines and targets were set, all the project activities related to the M&E system were achieved, and the M&E system was functional to measure and evaluate project progress and achievement.

c. M&E Utilization

M&E findings were used to monitor the status of implementation and outcome indicators. The project team also analyzed results data to ensure quality and credibility. Progress reports included challenges and recommendations to improve implementation. The mid-term review analysis served to inform the 2019 restructuring. Moreover, the project supported national health surveys such as DHS and SARA to generate evidence and advice to inform decision-making (ICR, p.18).

M&E Quality Rating

Substantial

10. Other Issues

a. Safeguards

The project triggered safeguard policy OP 4.01 on Environmental Assessment due to the collection, storage, and disposal of medical waste generated by clinical activities. The project was classified as Environmental Assessment Category B. The National Medical Waste Management Plan, complemented by the Regional Medical Waste Management Plan and the Prefectural Medical Waste Management Plan, supported project safeguards. The three plans provided mitigation measures in purchasing and installing incinerators. Incinerators operated on fuel and solar energy to limit harmful effects on the environment. An environmental safeguards specialist, recruited in 2018, carried out field missions to ensure the proper implementation of medical waste management plans.

According to the TTL, there was compliance with the Bank's safeguard policies. However, although the ICR (p. 23) reported that a grievance redress mechanism was put in place and made accessible to project-affected people through phone lines, the TTL stated that this mechanism existed only in documents and was ineffective.

b. Fiduciary Compliance



Financial Management

The ICR (pp. 23-24) described financial accounting, auditing, and project reporting as adequate and consistent with the Bank’s financial management guidelines. Financial management staffing, accounting, reporting, and control were under the PIU, reporting directly to the Secretary-General of the MoH. According to the ICR, three external audits were carried out, and the recommendations were implemented to improve financial management. There were well-trained financial management and procurement staff at all levels: a financial specialist and an accountant at the central level, a financial officer in the district health team, and community treasurers at the primary health center level. The project’s financial management manuals were adapted from other projects.

Procurement

Overall, the PIU followed World Bank procurement guidelines, updated its procurement plans into the Systematic Tracking of Exchanges in Procurement system, and kept adequate records. The Bank’s procurement team provided hands-on capacity building.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Satisfactory	
Bank Performance	Satisfactory	Moderately Satisfactory	Project design overestimated the country's capacity to collect M&E data. This lack of information affected project implementation and M&E.
Quality of M&E	Substantial	Substantial	
Quality of ICR	---	Modest	

12. Lessons

The ICR (p. 25-26) offered several valuable lessons, including the following adapted by IEG:



- **In low capacity and weak health system contexts, the direct supply of drugs and consumables to health facilities effectively reduces stockouts.** In a post-crisis period, such as Guinea after Ebola, it was essential to use rapid mechanisms to make drugs and inputs available to reduce stockouts at health facilities in the areas affected by the crisis.
- **Involving the ministry in charge of local communities facilitates the implementation of health projects focused on primary health.** This project involved the Ministry of Economy and Finance, the Ministry of Territorial Administration and Decentralization, and the Ministry of Social Action, which enabled sensitization of the population to participate actively in implementing the project. The involvement of these ministries also improved information sharing and dialogue between government agencies.
- **Keeping a project localized in a specific geographic area simplifies its implementation and contributes to success.** This project covered only two administrative regions out of eight in the country, making it easier to focus on the targets and achieve better results.
- **The use of a specialized survey agency ensures adequate identification of target populations.** This project worked with the National Institute of Statistics in collaboration with the World Bank's Social Protection team to identify the populations considered indigent, facilitating readjustment of the number of indigents considered likely to use project-supported health services during the restructuring of the project.

In addition, the IEG review identifies the following lesson:

- **Setting outcome indicators, baselines, and targets at appraisal facilitates the project's monitoring and evaluation and avoids delays in implementation.** In this case, the scarcity of information and capacity constraints led to a lack of reliable data regarding project beneficiaries during the first three years of the project's lifetime, instability in outcome targets, and uncertainty about baselines. Consequently, there were delays in project implementation, a balance of funds to be reallocated, and difficulties in assessing overall project achievement.

13. Assessment Recommended?

Yes

Please Explain

Although the evolution in the performance of the project's M&E system is evident, there is high uncertainty on the baseline data and targets prior to the project's formal restructuring. A deeper assessment is needed to understand how the baselines and targets were set.

14. Comments on Quality of ICR

The ICR provided a comprehensive description of the project's experience. It was results-oriented and carefully linked outputs with observed outcomes under each objective. The evidence presented was well-referenced,



with annexes that included relevant information to support the narrative of project achievements. However, there was limited information about project M&E, with inadequate data about PDO baselines and targets prior to the restructuring or the reason for the change. Also, there were discrepancies with the reported cost of component 1 (ICR, p. 10) and inconsistencies between the ICR's and the project's team information regarding the grievance system. The ICR did not clearly describe the main challenges the project faced and their impact during implementation. While the lessons learned are insightful, not all of them emerged from the project's experience described in the document.

a. Quality of ICR Rating

Modest