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Report Number: ICRR14757

IEG ICR Review

Independent Evaluation Group

1. Project Data:		Date Posted:	05/11/2015	
Country:	Moldova			
Project ID:	P095250		Appraisal	Actual
Project Name:	Health Services & Social Assistance	Project Costs (US$M):	44.36	34.46
L/C Number:		Loan/Credit (US$M):	17.00	27.46
Sector Board:	Health, Nutrition and Population	Cofinancing (US$M):	24.80	0
Cofinanciers:		Board Approval Date:		07/06/2007
		Closing Date:	08/31/2011	08/31/2014
Sector(s):	Health (49%); Central government administration (31%); Other social services (15%); Compulsory health finance (5%)			
Theme(s):	Health system performance (50%); Social risk mitigation (25%); Social safety nets (25%)			

Prepared by:	Reviewed by:	ICR Review Coordinator:	Group:
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2. Project Objectives and Components:

a. Objectives:

The Project Appraisal Document (PAD, p. 5) states that "the overall objective of the project is to promote the Government's program to increase access to quality and efficient health services with the aim of decreasing premature mortality and disability for the local population and improve the targeting of social transfers and services to the poor in line with the MTEF for 2007-09."

According to the Financing Agreement of July 3, 2007 (p. 5), the objective of the project was "to increase access to quality and efficient health services with the aim of decreasing premature mortality and disability for the local population and improve the targeting of social transfers and services to the poor."

The objective stated in the Financing Agreement will be used as basis for this validation.

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

No

c. Components:

The project originally consisted of three components:

Component 1: Health system modernization (appraisal estimate US$ 11.5 million of IDA financing, US$ 9.41 million additional financing; actual US$ 21.26 million, 184.9% of appraisal estimate): This component was to finance technical assistance to develop capacity in areas including health service planning, finance, and monitoring and evaluation (M&E) of policies at the Ministry of Health (MoH) and associated agencies. Also, this component was to focus on developing and implementing a strategy and activities to increase health insurance coverage, reduce informal payments, and introduce a new health care provider payment system based on diagnosis related groups. Activities also aimed to improve the quality of primary care, construct new health centers, optimize hospital capacity and efficiency in Chisinau, and develop a national hospital master plan.

Component 2: Social assistance and welfare (appraisal estimate US$ 5 million of IDA financing, US$ 0.24 million additional financing; actual US$ 5.10 million, 102% of appraisal estimate): This component was to finance a targeted social assistance program to support the poor and improve the efficiency and effectiveness of social assistance and welfare.

Component 3: Institutional support (appraisal estimate US$ 0.5 million, actual US$ 0.55 million, 110% of appraisal estimate): This component was to finance technical assistance to develop administrative capacity in the implementing agencies in areas such as management, M&E, fiduciary management, performance audits, and operational reviews.

A fourth component was added through an additional financing Grant from the Global Food Crisis Response Trust Fund on August 15, 2008:

Component 4: Protecting health and nutritional status (additional financing by IDA US$ 7 million; actual US$ 7 million, 100% of appraisal estimate): This component was to finance expenses related to the procurement of food and nutritional supplements for pregnant and lactating women and children under three years of age and cash transfers to institutions that supported vulnerable groups of the population during the food crisis during the 2008/2009 winter season.

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

Project Costs: According to the PAD (p. 51), the total project was estimated to cost US$ 44.36 million. Actual total cost, including co-financing, was US$ 34.46 million (77.68% of appraisal estimate).

Financing: The project was financed as follows:

- A US$ 17 million IDA credit and US$ 10.2 million of additional financing (December 2011), resulting in a total estimated Bank contribution of US$ 27.2 million, with actual disbursement of US$ 27.46 million (101% of appraisal estimate).
- A US$ 7 million grant from the Global Food Crisis Response Trust Fund (August 2008), which completely disbursed.
- US$ 24.8 million from unidentified bilateral agencies. This direct co-financing did not materialize. The project team explained that other donors contributed to the health sector strategy, which was also developed under this project. However, those donors' contributions were separate from the financing of this project.

Borrower Contribution:

The Borrower was to contribute US$ 2.56 million. This contribution did not materialize.

Dates:

- On August 15, 2008, a grant under the Global Food Price Crisis Response Program in the amount of US$ 7 million was approved. This grant allowed the addition of component 4 to the project.
- On December 8, 2011, the Bank approved the government's request for additional financing in the amount of US$ 10.2 million. The additional funds were to close the financing gap for completing the renovation of primary health care facilities and technical assistance for hospital and primary health care reforms, and to expand the introduction and implementation of information technologies for the social assistance system.
- On May 20, 2011, the project was restructured as follows: i) the Results Framework was revised and key performance indicators were adapted to be more measurable and better aligned with project activities; ii) the project description was adapted to include new activities financed under the additional financing; iii) the closing date was extended from August 31, 2011 to August 31,2013.
- On April 18, 2013, the closing date was extended from August 31, 2013 to August 31, 2014 in order to complete several activities, including: i) technical assistance for the implementation of the new diagnosis-related group payment system for hospitals; ii) construction of two additional health centers; and iii) development and implementation of an additional 15 standardized clinical protocols for family doctors' workplaces.

3. Relevance of Objectives & Design:

a. Relevance of Objectives:

High: Moldova's health indicators were well below the European Union's average. Life expectancy of 68 years was 12 years less than the EU average, infant mortality was two and a half times higher, and maternal mortality was four times higher than in the EU. Results for non-communicable diseases as well as communicable diseases showed similar bad results. Health coverage was not universal, and social assistance was extremely fragmented and inefficient. The project was in line with Moldova's 2004 Poverty Reduction Strategy, which provided a long-term vision for social assistance reforms. The project supported the government's mid-term expenditure program for 2007-09, which aimed to improve the cost-efficiency of the delivery of social services to poor and vulnerable groups. The project also was in line with the Bank's 2004 Country Assistance Strategy, which supported the government's policy to increase access to health services for the poor, and the Bank's current Country Partnership Strategy (FY 14-17), which includes a pillar on improving the quality of and access to health and education services and fiscally sustainable and equitable pension and social assistance systems.

b. Relevance of Design:

Modest: The planned activities were relevant to the achievement of the project's objectives. The planned activities to increase access to quality and efficient health services included strengthening technical capacity in the MoH, developing a strategy to increase insurance coverage, improving the quality of primary health care delivered in rural areas, assessing hospital capacity, and modernizing hospitals. Project design appropriately recognized the need to strengthen primary care before proceeding with hospital rationalization, and it planned extensive consultations with an array of stakeholders to minimize political opposition to hospital reform.

The planned activities to improve the targeting of social transfers and services to the poor included the development of a social assistance data base and training of social workers. These activities were logically and plausibly linked to achievement of the project objectives.

Originally it was planned that the two components (health and social assistance) would be in two different projects. However, since the MoH and the Ministry of Labor, Social Protection and Family (MoLSPF) were merged into one ministry, the two projects were combined into one. This resulted in a complex project design with several components being implemented by different implementing agencies that lacked the necessary technical capacity. A fourth component was added through an additional financing Grant from the Global Food Crisis Response Trust Fund in August 2008, but the objectives were not revised to make the new component relevant to the project's objectives.

4. Achievement of Objectives (Efficacy):

Increase access to quality health services : Substantial

Outputs

- 30% of the National Health Insurance Budget was allocated towards primary care, achieving the target of at least 30%.
- Three rounds of household budget surveys with health modules were conducted and analyzed.
- Five National Health Account reports were produced for each year between 2008 and 2012, surpassing the target of three reports.
- A study to increase health insurance coverage was carried out by the Budget, Finance, and Insurance Department of the MoH.
- A training curriculum/education program for family doctors and nurses was completed and implemented, and all planned training events were completed.
- 122 family doctors' protocols, including 75 new protocols, are in place and operational, surpassing the target of 107 protocols, including 60 new protocols.
- A Human Resource Strategy, including an action plan, was completed for the health sector and is under implementation.
- The National Hospital Master Plan was completed and approved by the government.
- The construction of the Republican Clinical Hospital's new surgical block was completed and is operational.
- An oncology institute feasibility study was conducted, and technical assistance for chemotherapy and radiotherapy services decentralization was provided.
- 77 health facilities were renovated, surpassing the target of 74 health facilities. However, only 38 health centers could be constructed (instead of the planned 65) due to construction costs that were more than 100% higher than had been originally estimated.

Outcomes

- The share of the population covered with mandatory health insurance increased from 76.7% in 2007 to 85% in 2014, surpassing the target of 80%.
- The share of eligible patients tested for arterial blood pressure increased from 81.3% in 2007 to 84.5% in 2014, not achieving the target of at least 95%.
- The share of early pregnancies (within the first 12 weeks) registered at a family doctors' center increased from 77.6% in 2007 to 79.9% in 2014, basically achieving the target of 80%.
- The share of newly diagnosed cases of grade IV malignant tumors decreased from 30% in 2007 to 27.6% in 2014, not achieving the target decrease to below 25%.
- The share of eligible patients tested for cervical cancer increased from 59% in 2007 to 59.9% in 2014, not achieving the target of at least 75%.

Increase access to efficient health services : Substantial

Outputs

- The number of rural health centers directly contracted out by the National Health Insurance Company increased from 17 in 2007 to 208 in 2014, surpassing the target of 100 health centers.
- A new provider payment system based on diagnosis-related groups for hospitals was developed, piloted, and implemented nationwide.
- Hospital master plans and regionalization plans were completed.

Outcomes

- The percentage of vacant family doctors' positions at rural health care facilities decreased from 20% in 2007 to 13.2% in 2014, not achieving the target of 10%.
- The average number of bed-days used during the year increased from 277 days in 2007 to 302 days in 2013, not achieving the target of 310 days. Achievement for the first six months of 2014, however, was 156 days, which is the equivalent of 312 days over the course of the entire year, exceeding the target of 310 days.

Improve targeting of social transfers : Substantial

Outputs

- A Social Assistance Automated Information System was developed to effectively and securely transfer cash benefits, achieving the target. Its cash transfers module evaluates and cross-checks income levels of applicants to ensure eligibility for benefits.
- The number of households benefiting from Ajutor Social, a targeted cash transfer program, increased from 151 households in 2008 to 57,000 households in 2014.
- All social workers were equipped with new information technology equipment.
- A functional review of the MoLSPF was completed.

Outcomes

- Since 2008, when the Ajuctor Social was implemented, approximately 147,000 households received cash benefits at least once.
- According to official data of the National Bureau for Statistics, the share of the population vulnerable to extreme poverty decreased from 3.2% in 2008 to 0.3% in 2013, and over 132,000 persons were moved out of poverty during this time period. The ICR (p. 40) acknowledges that these results are due to overall economic recovery in the country, but also attributes them in part to "the positive impact made on poor families through accurate allocation of resources to those in real need."

Improve targeting of services to the poor : Negligible

Outputs

- A Social Assistance Automated Information System was developed to effectively and securely transfer

social service benefits, achieving the target. Its social service module covers services and case management for children, persons with disabilities, victims of violence, and other beneficiary groups.

Outcomes

- No outcomes were reported under this objective.

Decrease premature mortality and disability for the local population :
Even though the following outcomes are not completely attributable to this project, Moldova experienced positive trends in health outcomes between 2009 and 2012:

- Life expectancy increased from 69.4 years to 72 years.
- The standardized death rate for cardiovascular diseases decreased from 155.2 to 140.5 per 100,000 persons within the age group of 0 to 64 years.
- The standardized death rate for cancers decreased from 98.3 in 2009 to 94.3 in 2012 per 100,000 persons within the age group of 0 to 64 years.

The following outcomes were reported under the Food Crisis Response Trust Fund. However, they did not contribute to the achievement of the project's objectives:

- On average 7,621 women received nutrient supplements before their infant reached eight weeks of age in each of three rounds of food distribution, surpassing the target of 5,941 women.
- On average 11,580 children less than two years old received nutrient supplements in each of three rounds of food distribution, surpassing the target of 8,434 children.
- 1,645 beneficiaries received adequate food and nutrition through the cash transfer program.

5. Efficiency:

Modest

The PAD (p. 83) conducts a cost-benefit analysis. The analysis distinguishes between direct benefits and indirect benefits of the project. Direct benefits include reduced hospital stays, elimination of unnecessary discharges, fewer consultations from specialty care, and saved travel time and costs. Indirect benefits include reduced mortality rates and associated potential years of life saved. Costs included the project costs and recurrent expenditures such as maintenance and depreciation of medical equipment. The analysis applied a discount rate of 10%. Based on these assumptions, the internal rate of return was estimated at 31% for the primary health care restructuring and 22% for the primary healthcare and hospital restructuring combined. The Net Present Value was estimated at US$ 22.1 million of total benefits and US$ 8.6 million of net benefits.

The ICR does not conduct an economic analysis due to lack of data. Instead, the ICR provides a qualitative analysis of whether the project presented the least-cost solution to attain desired benefits. The ICR states (p. 33) that the economic efficiency of the project was impacted by significantly higher than originally estimated costs (more than 100% higher) for the construction of health centers, due to increases in labor and building materials prices, as well as failure initially to consider the costs associated with ensuring that buildings were earthquake-proof. As a result, instead of 65 health centers as originally planned, only 38 could be constructed. The ICR concludes that due to the cost overruns, the benefits are at the lower end of the spectrum.

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

	Rate Available?	Point Value	Coverage/Scope*
Appraisal	Yes	31%	30.4%
ICR estimate	No		

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

6. Outcome:

Relevance of objectives is rated high due to strong linkages between the project's objectives and

Bank/government strategy. Relevance of design is rated modest due to the project's complexity and the inclusion of activities that did not contribute to achievement of the objectives. The project substantially increased access to health services through improved insurance coverage, and it substantially increased efficiency in health services through increased provision of primary care and hospital reform. The objective to improve targeting of social transfers was also substantially achieved, with the program reaching over 57,000 households and consequent reductions in poverty. No outcomes were reported for improvements in targeting of other services to the poor, and therefore achievement of that objective is rated negligible. Efficiency is rated modest due to the negative impact of substantially higher costs for the construction of health centers and lack of data to do an economic analysis ex post. Taken together, these ratings are indicative of moderate shortcomings in the project's preparation and implementation, and therefore an Outcome rating of Moderately Satisfactory.

a. Outcome Rating: Moderately Satisfactory

7. Rationale for Risk to Development Outcome Rating:

The government continues to be committed to reforming the health sector and to social welfare assistance. The project will be followed by a new Bank project that focuses on the reduction of key risks for non-communicable diseases and efficiency improvements in health services. Risk to development outcome is rated moderate, however, given that challenges such as weak government capacity, high turnover of staff, and political tensions associated with health sector reform will persist and need to be addressed by the government.

a. Risk to Development Outcome Rating: Moderate

8. Assessment of Bank Performance:

a. Quality at entry:

The project design was based on extensive analytical work and lessons learned from the implementation of previous Bank projects in the region. The Bank team collaborated with development partners to identify specific reform steps to be addressed by this project and projects implemented by development partners.

In March 2007, a Quality Enhancement Review was conducted by the Bank. This review suggested linking the health and social assistance components by adding a poverty-related health indicator to the Results Framework, and improving the M&E of the health component by measuring utilization of primary health care services by the poor and morbidity from chronic diseases. Also, the review encouraged the government to decide if social workers would be allowed to enter information on targeting into the data base for social assistance. The Bank team took all of these suggestions, except the addition of a poverty-related health services utilization indicator, into account when preparing the project.

The Bank identified relevant risk factors during project preparation (PAD, p. 12), including the donor planning cycle not being well synchronized and the possible lack of public support for certain aspects of reform. The Bank mitigated these risks by planning for extensive consultations with central and local counterparts and other donors.

Project design had several shortcomings. It was overly complex, and it overestimated the implementing capacity of the two ministries. Also, the Results Framework had several significant weaknesses (see Section 10a).

Quality-at-Entry Rating: Moderately Satisfactory

b. Quality of supervision:

The Bank collaborated and coordinated well with the government and other development partners. The team conducted regular supervision missions and satisfactorily supervised procurement and financial management. However, supervision also had some weaknesses. The project experienced a high turnover of Bank Task Team Leaders, and the extent of project reporting varied and was often insufficient. According to the ICR (p. 22), between January 2012 and project closing in August 2014 there was no progress reporting on the second component in any of the aides-memoire, and during the last 10 months of project implementation, no aide memoire was prepared. This might be indicative of weak supervision.

In August 2008, the project received a grant of US$ 7 million through the Global Food Price Crisis Response Program, which allowed the addition of component 4 to the project. However, even though the component is not linked to the project's objectives, the Bank did not revise the objectives accordingly.

Focus on development impact was initially limited, given the lack of a functioning M&E system. However, throughout the project, the Bank made a significant effort to improve M&E, revising the Results Framework several times, but shortcomings continued to persist until closing.

Quality of Supervision Rating : Moderately Satisfactory

Overall Bank Performance Rating : Moderately Satisfactory

9. Assessment of Borrower Performance:

a. Government Performance:

The government actively participated in the preparation of the project and was committed to achieving the development objectives throughout implementation. In 2004, the government approved a Poverty Reduction Strategy for social assistance reforms that set the stage for this project. Also, the government established a joint inter-ministerial steering committee and set up strategic management teams within each ministry, responsible for the daily project management and coordination.

The expected financial contribution to the project by the government of US$ 2.56 million did not materialize. The ICR does not comment on the reason for this. According to the Task Team Leader, who took the project over in June 2010, government contributions were not mentioned in any of the aides memoire or other documentation.

Government Performance Rating Moderately Satisfactory

b. Implementing Agency Performance:

The project was implemented by the MoH and the MoLSPF.

MOH - Moderately Satisfactory

The Ministry of Health was committed to achieving the project's objectives and was responsive in addressing implementation challenges. Also, the MoH coordinated effectively with other entities such as the district authorities, health facilities, hospitals, and the medical university. However, the MoH experienced a high turnover of staff and lacked technical capacity. Also, the appointment of several new ministers and deputy ministers led to delays in the decision making process and to slow progress in the implementation of key reforms such as the hospital, primary care, and payment system reforms and the human resource strategy.

MoLSPF - Satisfactory

The MoLSPF was also committed to achieving the project's objectives. During the initial phase of the project, a program working group and a steering committee were established and effectively provided strategic guidance throughout implementation. The working group reported to the steering committee and collaborated across ministries and with consultants and development partners.

There were no significant issues related to financial management and procurement. M&E activities were carried out by both ministries and experienced significant challenges (see Section 10b).

Implementing Agency Performance Rating : Moderately Satisfactory

Overall Borrower Performance Rating : Moderately Satisfactory

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

a. M&E Design:

The design of M&E was weak. Even though the objectives were clearly specified, they were not sufficiently reflected in the selected indicators. The Results Framework in the PAD (pp. 32-33) included six PDO indicators and 12 intermediate outcome indicators. Several indicators were weakly linked to project activities, difficult to measure, had overly ambitious targets, and lacked baselines. A M&E plan was developed with counterparts. However, M&E lacked sufficient ownership, and methods for data collection and analysis were weak.

b. M&E Implementation:

The Results Framework was revised several times during project implementation.

In December 2011, five PDO indicators were dropped, one PDO indicator was revised, and six new PDO indicators were added. Also, 10 intermediate outcome indicators were revised, 11 new intermediate outcome indicators were added, two intermediate outcome indicators were merged, and only two intermediate outcome indicators were continued as originally planned.

In April 2013, two PDO indicators were dropped, three PDO indicators were added, and one intermediate outcome indicator was moved to be a PDO indicator. At project closure, the Results Framework included nine PDO indicators and 19 intermediate outcome indicators, some of which were only measured during the last 16 months of project implementation.

In July 2008, under the additional financing through the Food Crisis Response Trust Fund, three indicators were added to measure progress towards meeting nutritional needs of pregnant women, nutritional needs of children less than two years old, and beneficiaries of the cash transfer program. However, the objectives were not revised; therefore, the new component and related activities were not relevant to achievement of the project's objectives.

The ICR states (p. 10) that, due to intensive efforts to enhance the Results Framework, monitoring and reporting improved throughout project implementation to a satisfactory level. However, the ICR does not comment on the reliability and quality of data, and whether the system designed and implemented is sustainable.

c. M&E Utilization:

The ICR (p. 10) states that M&E was used by both ministries for short- and long-term planning in the health sector. However, given the challenges with measuring several indicators, it is questionable to what extent M&E data were available.

M&E design is rated negligible due to significant shortcomings in the Results Framework. However, during the restructurings a strong emphasis was put on M&E and the Results Framework was modified twice, resulting in an overall Modest rating.

M&E Quality Rating: Modest

11. Other Issues

a. Safeguards:

The project was classified as category B and triggered safeguard policy OP/BP 4.01 (Environmental Assessment). An Environmental Management Plan was developed, which included activities to reduce the environmental impact of the construction and renovation of primary health care centers and the surgical block. Furthermore, two documents, "The National Action Plan for Health Care Waste Management" and "Regulation Regarding Medical Waste Management," were published. During project supervision, no shortcomings in the

implementation of the Environmental Management Plan were identified. Also, the project did not have any significant or irreversible negative environmental impacts (ICR, p. 11)

b. Fiduciary Compliance:

Financial Management

The Budget, Finance and Insurance Department at the MoH and the Economic, Financial, and Accounting Department at the MoLSPF were responsible for the financial and contractual management of the project. In both ministries, all financial management functions were rated Satisfactory until January 2014, when financial management was downgraded to Moderately Satisfactory because the implementation of the accounting software had not been completed. External audit reports were conducted in a timely manner and were rated as unqualified.

Procurement

A procurement plan for the project was prepared and updated when necessary. Procurement was rated Satisfactory during most of project implementation. At times it was downgraded to Moderately Satisfactory. The ICR does not comment on why and how procurement issues were addressed by the Bank and the implementing agencies.

c. Unintended Impacts (positive or negative):

None reported.

d. Other:

12. Ratings:	ICR	IEG Review	Reason for Disagreement/Comments
Outcome:	Moderately Satisfactory	Moderately Satisfactory	
Risk to Development Outcome:	Moderate	Moderate	
Bank Performance:	Moderately Satisfactory	Moderately Satisfactory	
Borrower Performance:	Moderately Satisfactory	Moderately Satisfactory	
Quality of ICR:		Satisfactory	

NOTES:
- 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 ICR (p. 26) identifies several lessons, including:

1. A well designed Results Framework that includes measurable indicators with reliable baselines and realistic targets is critical for tracking progress towards the development objectives. In this project, the initial design did not allow for rigorous tracking and needed to be revised twice, with the final revision taking place only 16 months before project closing. This had a negative impact on the reliability and credibility of project results.
2. Collaborating with different development partners is important for taking advantage of synergies and

avoiding duplication of activities. In this project, the construction of the surgical block for the Republican Clinical Hospital was complemented by the European Union's Neighborhood Farm, and the equipment was provided by the Government of Japan. Also, the World Health Organization conducted several studies, including a study on extending health insurance coverage, which contributed to project implementation.

A lesson added by IEG:

1. This project demonstrated that strengthening primary care, conducting a political economy analysis, and extensive consultation with stakeholders prior to implementing hospital rationalization is critical for smoothing the political path for hospital reform.

14. Assessment Recommended? ● Yes ○ No

Why?

To analyze and learn lessons from this project's relatively successful progress with hospital rationalization, particularly in comparison with other countries in the region.

15. Comments on Quality of ICR:

The ICR provides a good overview of project preparation and implementation. It includes a detailed analysis of the various revisions of the Results Framework. However, the ICR presents sometimes inconsistent information, such as the date of the second restructuring and the extent of commitment to the project by the MoH. It could have gone into more detail in critical areas such as the performance of the implementing agencies, financial management and procurement. The ICR also does not provide any economic analysis. The ICR is rated Satisfactory.

a.Quality of ICR Rating: Satisfactory