Project Completion Report

PCR

Project Name: Reorganization and Rationalization Program of the National Health System

Country: Haiti

Sector/Sub-sector: SA-SER

Original Project Team: Chrétien Louis François, Sophie Makonnen, Chapuis Émilie, Antigua Bovio, Rosa Mariela, Etienne Salnave Maryse, Edwige Joseph Baron, Gaarder Marie, Ehrlich Marko, Gonzales-Poze Paulina, Joseph Patrice.

Project number: 1009/SF-HA

Loan (s) Number CT(s): HA0045

QRR Date: June 18, 2013

Final Approval Date of PCR: June 24, 2013

Team Responsible for the Preparation of the PCR: Jean André (consultant), Meri Helleranta (SPH/CHA) and Vladimir Mathieu (CDH/CHA).

Acronyms and Abbreviations

IDB:	Inter-American Development Bank
MSPP:	Ministry of Public Health and Population
NGO:	Non-Governmental Organizations
UCS:	Community Health Unit

Table of Contents

I. BASIC INFORMATION ABOUT THE PROJECT 1

II. THE PROJECT 1

A. PROJECT CONTEXT 1
B. PROJECT DESCRIPTION 2
C. QUALITY-AT-ENTRY REVIEW (NOT APPLICABLE) 3

III. RESULTS 4

B. EXTERNALITIES 4

I. Basic Information about the Project

BASIC INFORMATION (AMOUNTS IN $US)	
PROJECT No.: 1009/SF-HA	Reorganization and Rationalization Program of the National Health System
Borrower: Ministry of Public Health and Population	**Approval Date by the Board of Directors:** August 12, 1998
Executive Body (EB): Management and Coordination Unit	**Coming Into Force Date of the Loan Contract:** January 8, 2001
	Eligibility Date of the First Disbursement: November 13, 2003
Loan (s): $22,500,000.00	
Sector: Health	**Duration of the Implementation (in months)**
	*** since the Approval:** 177
Loan tool: FSO	*** since the entry into force of the Loan Contract:** 148
	Disbursement Periods
	Date Originally Scheduled for the Final Disbursement: May 8, 2004
	Effective Date of the Final Disbursement: May 30, 2013
	Cumulated Extension: 108
	Amount of the loan (s)
	*** Initial Amount:** $22.500.000
	*** Current Amount:** $22.500.000
	*** Pari Passu (if applicable):** 100%
Investments Targeting Poverty (PTI): Yes **Social Equity:** Yes **Environmental Classification:** C	**1) Disbursements** *** Amount to date:** 22,500,000.00 (100 %)
	Total cost of the Project (Initial Estimate): $25, 000,000
	Alert Status
	Is the project currently classified as being in "alert status" by the Alert System on Projects in Difficulty (PAIS): No

Summary of the Classification of the Project's Performance	
O	[ ] Highly Likely (HL) [X] Likely (L) [ ] Low Probability (LP) [ ] Unlikely (U)
PE	[ ] Very Satisfactory (VS) [X] Satisfactory (S) [ ] Unsatisfactory (U) [ ] Very Unsatisfactory (VU)
U	[ ] Highly Likely (HL) [ ] Likely (L) [X] Low Probability (LP) [ ] Unlikely (U)

II. The Project

a. Project Context

2.1 The project spans over 15 years of Haitian history (1998-2013) which entails years of political and social instability as well as important democratic advances. At the time when the project was approved on October 5, 1998, a constitutional government had returned only four years earlier which preceded four years of military rule. The Government together with the international community had started to make systematic

advances to respond to the pervasive social degradation and to create a context for peaceful civic participation and rebuild the economy.

2.2 At the time of project approval, the social and economic situation remained bleak and was characterized by the acute, nearly universal social exclusion, with unemployment close to 75 %. With a life-expectance of mere 55 years (compared to the regional average of 70), the Haitian population was dying prematurely on cause of preventable disease, and infectious diseases stood as the main causes of death. Despite of the dire need, government's ability to finance and deliver public health services remained extremely limited. It was estimated in 1998 that public and private health spending jointly in Haiti would amount to 27 US$ per capital (compared to 202 US$ in Latin America and the Caribbean) of which only 4 US$ came from government budget. Furthermore, during the 1980s the political instability caused large numbers of experienced technicians and administrators to leave public administration and in 1998 the public sector had only begun in the past three years to reestablish functioning dispensaries, health centers and hospitals.

2.3 In order to address many of the institutional failures the project aimed to set a model for a systemic change that would capitalize on the existing service delivery capacity by creating a structure of Community Health Units (UCS). This meant that also private providers, such as Non-Governmental Organizations (NGO) would enter into a service delivery network coordinated by the Ministry of Health (MSPP). In essence, NGOs would be contracted to deliver a defined package of services while using a common management and information system based on the technical requirements of the MSPP. Hence the project aimed to assist in the definition and consolidation of public and private service delivery though strengthening the stewardship of the MSPP in many critical areas such as regulatory oversight, management of service contracts, surveillance and other essential public health functions. As most donors in the sector continued to strictly work via the NGO network, this project which was to be executed by the MSPP was of pivotal importance to the ministry giving them an opportunity to set the stage for a new era in managed service delivery.

b. Project Description

i. Development Objectives

2.4 The original objective of the Program was to support the Government's efforts to improve the health status of the Haitian population by enhancing the quality, efficiency and equity of health services provided by public and private institutions in the national health system. Hence the project was to: (i) improve the quality of and access to both public and private health services in a way that is, over the long term, financially and institutionally sustainable; (ii) increase the efficiency of services at the national level; and (iii) develop innovative models for financing and delivery of basic health services, that are replicable at the national level.

2.5 Only 4 months after the project had been approved, political turmoil resulted in a situation in which the president ruled by decree until the next elections took place in 2000. These incidents and their aftermath on parliamentary rule, resulted in significant delays for the government to full-fill conditions prior. Hence as a consequence, the

project only reached eligibility in Nov 13, 2003, four months after the Board of Directors of the IDB had approved a reformulation of the project in order to better respond to the developments since 19981. Importantly however, the Development Objective had remained relevant and thus this remained unchanged.

2.6 The Program as originally conceived was a two-phase, 50 million US$, six-year execution project. Yet, the reformulation transformed the project into a single-phase investment loan with an execution period of 4 year, in part as the original project it lacked the kind of measurable triggers that had sense then become standard for such operations.

ii. Components

2.7 The project was originally organized in five components:

(i) Development of the Communal Health Units Model (14,7 million US$)
(ii) Institutional Strengthening of the Departmental Directorates (3,9 million US$)
(iii) Institutional Strengthening of the Central Directorates (2,5 million US$)
(iv) Viability and Permanence of the Reorganized System (1,3 million US$)
(v) Evaluation and Administration (1,4 million US$)

During the reformulation however components 2 and 3 were merged as well as 4 and 5, resulting in the below three components that were eventually executed.

2.8 **Component 1: Development of the Community Health Councils (UCS) model**

This component aimed to reinforce the technical and organizational capacities of the UCS and implement a pilot project on maternal and child health in selected health councils. In particularly the component would (i) Develop an action plan for the UCS; (ii) Establish and operationalize an administrative council for the UCS; (iii) Strengthen institutional management capacity to improve the quality of the services delivered and (iv) Finance the delivery of basic maternal and child health services.

2.9 **Component 2: Institutional strengthening of the MSPP at the central and departmental levels**

This component financed i) Institutional strengthening of the regulatory and legal framework at the central level and ii) Institutional strengthening of public health functions such as disease prevention, surveillance and control of communicable diseases at the departmental level.

2.10 **Component 3: Sustainability and permanence of the reorganized system**

This component aimed to develop basic monitoring and evaluation instruments in order to adjust public health policies overtime. These tools would include an analytical database, a system for National Health Accounts and a viable plan for financial sustainability of the health system.

c. Quality-At-Entry Review (not applicable)

2.11 **N/A**

[1] Eligibility and reformulation memo IDBDOCS-#271376

III. Results

a. Outcomes

ACHIEVEMENT OF DEVELOPMENT OBJECTIVES (DO)	
Development Objective(s) (Purpose)	**Key Outcome Indicators**
1. The quality of and access to basic health services in private and public health facilities has improved and the efficiency of service delivery at the national level has improved. 1.1 Reproductive age women and children under five years of age have received a basic package of health services according to the norms. *Classification: P*	
Baseline Intermediate End of Project 1.1 0 (11/2003) 150,000 (4/2008) 350,000 (7/2009)	**2) Outcomes Achieved** End of Project 1.1 140,000 (12/2008)
i) **Reformulation.** ii) [X] N/A	
iii) **PPMR Retrofitting**. iv) [X] N/A	
Summary Development Objective(s) Classification (DO):	
[ ] Highly Probable (HP) [P] Probable (P) [ ] Low Probability (LP) [ ] Improbable (I)	
Briefly justify DO classification, based on degree to which planned targets were met, explaining the differences between planned and achieved outcomes as well as any other relevant factors. Include references to evidence that can support these results. The project had underestimated the time it would take for the contractual arrangements to become operational and hence to reach the target of providing the basic package for 350,000 persons. The most important factors for the delays were the following; (i) All contracted health facilities (public and private) were requested to adjust their current operational model to a standardized format and this process which entailed material development and training was very time consuming; and (ii) The six organizations that were hired to build the capacity of the Community Health Units were less effective than expected, possible due to the limited size of their contracts, which did not allow for sufficient personnel to be hired.	
Country Strategy. Given the results described above, briefly discuss how the project contributed to the Bank's strategy in the country. The investment in the project are fully align with the Haiti Country Paper (11/1996) underlying the importance on investing in human capital. It notes that the "allocations of Fund for Special Operations resources will emphasize initiatives to improve living conditions, health and nutrition, and education and technical training to improve labor skills. This will require a leadership role by the Bank in working with the authorities to define and implement a comprehensive social sector agenda".	

b. Externalities

3.1 The project supported the work of several technical committees which produced key documents that the MSPP has sense used as guidance in rationalizing health service delivery. These include the (i) *Forum for Realignment of the Health Sector Reform*, which was used as a reference to develop the new National Health Policy and Executive Plan of the MSPP 2011-2021. The project also financed the production of the (ii) *Public Health Code* to provide a legal framework to the health sector, which the MSPP has adopted with minor modifications. In addition to these, many other documents have also served as key reference for the MSPP, e.g. the agreements used for the service contracts with the providers are used as reference now (1/2013) that the MSPP is in the process of establishing a separate unit for Contractual Arrangements. The ministry has also used the *accreditation and certification manuals* produced by the project and shared them with the Hospitals' Association as standards for institutions to refer to in case of malpractice. Finally, the *Organizational Manuals for Primary Care, Community Reference Hospitals, and Departmental Hospitals* created by the project have been adopted by the MSPP.

c. Outputs

IMPLEMENTATION PROGRESS (IP)

Components (Outputs):

1. Component 1: Development of the Community Health Unit (UCS) model

Total cost of Component 1: $14,875,388
Counterpart: $2,125,480
IDB: $12,751,103
IDB Disbursement: 86%

Classification: S

Key Output Indicators:

1.1 Community Health Units rehabilitated and equipped according to MSPP standards.
1.2 Service delivery institutions certified in the targeted 6 Community Health Units according to the norms to assure serviced delivery in the pilot zones.

Planned Outputs			Outputs Achieved
Baseline	Intermediate	End of Project	End of Project
1.1: 0 (11/2003)	N/A	11 (7/2009)	1.1: 11 (12/2008)
1.2: 0 (11/2003)	50 (11/2007)	100 (7/2009)	1.2: 50 (12/2008)

Briefly explain differences between planned and actual outputs (if applicable).

1.2: The initial estimated cost of the rehabilitations greatly underestimated the real cost of the works and in the light of the new cost estimates the number of rehabilitated councils was reduced to 50. However, close to 150 health facilities were assessed for potential future rehabilitation. The project results in terms of the rehabilitations lagged behind for the first half of the project due to several procedural steps related to procurement. For example, adapting the standard Bidding Documents (DAO) of the Bank for the project's specification took 12 months. Later on additional delays incurred due to (i) frequent postponements of the tender evaluations due to the occasional absence of a MSPP representative(s) in the committee, (ii) the non-compliance of contractual deadlines by suppliers in depositing financial guarantees and (iii) the non-compliance of service delivery organizations with contractual deadlines.

With respect to the accreditation of health the institutions, it became apparent that the task was more complex than initially perceived and that a dedicated consultant needed to be hired to develop the accreditation procedures and standards for the health institutions. Subsequently the validation of these documents took place in a series of departmental meetings with sanitary department officials in all of the 4 departments where the pilot Community Health Units were located. The actual accreditation was preceded by official visits of the departmental officers and training session before the actual evaluation visit took place. It was however concluded that the institutional capacity building was not sufficient to bring all targeted institutions to the accreditation level and efforts were made to lower threshold in order to make the process more realistic. In the end however the process of applying the lower standards was disrupted and many originally selected delivery organizations were left without formal accreditation. As a result, not a single UCS had all of its service delivery institutions certified.

Reformulation.
[X] N/A

Restructuring. Indicate if this component was restructured (date of approval by Manager). Briefly discuss the consequences of these changes.
[X] N/A

2. Component 2: Institutional Strengthening of MSPP at the central and departmental levels

Total cost of Component 2: $7,479,187
Counterpart: $174,520
IDB: $7,304,667
IDB Disbursement: 98%

Classification: S

Key Output Indicators:

2.1 Professionals and technicians of central and departmental levels trained and certified in public health functions.

2.2 Operational plans for promotion, prevention and control of diseases developed and put into execution.

2.3 Children (6 months to 9 years) reached with a national vaccination campaign for measles, polio, vitamin A and de-worming.

Planned Outputs			Outputs Achieved
Baseline	Intermediate	End of Project	End of Project
2.1: 0 (11/2003)	20 (11/2007)	50 (7/2009)	2.1: 50 (12/2008)
2.2: 0 (11/2003)	2 (11/2007)	5 (7/2009)	2.2: 5 (12/2008)
2.3: 0 (06/2012)	N/A	1,8 million (12/2012)	2.3: 2,0 million (6/2012)

Briefly explain differences between planned and actual outputs.

2.1: The following training session we conducted (the number of MSPP executives attended is presented in parenthesis): Leadership and strategic planning (72), Hospital management (50), Human Resource Management (50), Activities' management (27), Time management (22), and Basic epidemiology (86).

2.2: MSPP's Central and departmental directorates were reinforced with the development of operational and organizational plans in order for them to perform at least three key public health functions as defined by PAHO/WHO, namely: (i) diseases prevention (ii) epidemiological monitoring/surveillance (iii) monitoring/evaluation. With regards to the departmental plans for promotion, prevention and diseases control, these should be an extension of the National Plan. Yet, while this national plan was developed, they have not been fully operationalized at the departmental level.

2.3: In terms of the figures presented for the vaccination coverage, it must be noted that the targeted audience for each intervention during the vaccination campaign is age specific. In total the campaign reached 2,5 million persons with measles vaccine, 2,7 million with polio vaccine, 1,2 million with vitamin A and 2 million with albendazole/de-worming. Due to the high coverage received during the campaign, WHO declared Haiti free of polio and measles in June 2013.

Reformulation.
The component was reformulated 6/30/2003 during which the activities of original components 4 and 5 were merged in to this component, combining the activities aiming at the institutional strengthening of both departmental and central directorates under a single component[2]

Restructuring.
The Project Monitoring Report was restructured on 9/20/2011 when a new output indicator (vaccination coverage) was added in order to demonstrate the results of a *new* activity. On 12/2009 when all planned all activities under the project had been finalized, the project was left with a balance of 830,503 US$ and the intention was to cancel these funds. Yet, in the light of the significant health sector demands in the aftermath of the earthquake of 12/01/2010, a decision was made to add another vaccination activity under the component 2 in order to avoid cancelling the funds[3].

3. Component 3: Sustainability and permanence of the reorganized system

Total cost: $1,797 974
Counterpart: $276,500
IDB: $1,521,474
IDB Disbursement: 85%

Classification: S

Key Output Indicators:

3.1 Conduct studies on national health accounts and feasibility of extending the coverage of service provision.

3.2 Conduct a study on maternal mortality.

3.3 Institutionalize the program's monitoring and evaluation system at MSPP.

[2] Reformulation memo IDBDOCS-#271376
[3] Extension memo IDBDOCS-#36419970

Planned Outputs			Outputs Achieved
Baseline	Annual/Intermediate	End of Project	End of Project
3.1: 0 (11/2003)	1 (11/2006)	1 (6/2009)	3.1: 0 (12/2008)
3.2: 0 (11/2003)	N/A	1 (6/2009)	3.2: 0 (12/2008)
3.3: 0 (11/2003)	N/A	1 (6/2009)	3.3: 1 (12/2008)

Briefly explain differences between planned and actual outputs (if applicable).

1.1 Two studies were completed under this sub-component: Assessment of the National Health Accounts 2005-2006 and the feasibility study to extend the Minimum Package of Services were both completed in 2008.

1.2 Due to the initial execution delays after project eligibility, the project could not financially contribute to the Mortality, Morbidity and Utilization of Services Survey (EMMUS IV 2005-6) as the budget for this had already been assigned from other projects. However the Project's Monitoring and Evaluation System was used to develop a system for community surveillance on maternal mortality and this document has been used as the basis for the for the development of the National Framework for Sanitation Information System (CONASIS[4]).

1.3 The project's Monitoring and Evaluation System was set up in June 2008 at the time when the pilot project in 6 Community Health Units had already begun. Yet, even then the system was operational, it was criticized that it was not able to effectively provide timely information to project management to guide decision making due to the poor quality of the data. It was further criticized that the system was merely a list of indicators rather than an integrated evaluation framework that would have also provided qualitative data and that some indicators lacked realism altogether in the Haitian context. Based on the shortcoming of the system as a whole, it is hence understandable that it was never adopted by the MSPP as an institutional metrics.

Restructuring.
The component was reformulated 6/30/2003 during which the activities of original components 4 and 5 were merged in to this component, combining the activities on viability and permanence of the reorganized system with those of evaluation and administration under a single component[5].

Reformulation.
[X] N/A

Summary of the Classification for the Project Execution

[ ] Highly Satisfactory (HS)	[] Satisfactory (S)	[X] Unsatisfactory (IS)	[ ] Very Unsatisfactory (TI)

[4] Conseil National de System Information Sanitaire (CONASIS)
[5] Reformulation memo IDBDOCS-#271376

d. Project Costs

Total Cost of the Project - Expected (US$000)	Total Cost of the Project - Current (US$000)	% Difference
22, 500,000 USD	22, 500,000 USD	0,00%

TOTAL COST OF THE PROJECT (US$)*	Estimated cost	Actual cost	% Difference from estimated
1. Development of UCS Model	**12,725,000.00**	**12,751,103.20**	**0**
1.1 Organizational Strengthening			
1.1.1 Strenghtening technical and organizational capacities at UCS	350,000.00	411,277.28	
1.1.2 Implementation of Org Strength Plan of Action	5,300,000.00	5,410,480.88	
1.2 Pilot for delivery of basic Maternal and Chile Health Services			
1.2.1 Implementation of stage 1	1,075,000.00	2,965,500.28	
1.2.2 Implementation of stage 2	6,000,000.00	3,963,844.76	
2. Institutional Strengthening MPHP	**6,220,000.00**	**7,304,667.76**	**17**
2.1 Institutional Strengthening at the central level			
2.1.1 Improvement of regulatory framework	882,000.00	678,087.01	
2.1.2 Project support and sector coordiantion	950,000.00	3,036,833.52	
2.2 Institutional Strengthening at the departmental level			
2.2.1 Improvement of disease control	3,400,000.00	844,251.29	
2.2.2 Health promotion and community participation	1,000,000.00	2,745,495.94	
3. Viability and permanence of the reorganized system	**2,330,000.00**	**1,521,474.56**	**-35**
3.1 Concurrent Monitoring and evaluation of Pilot in 1.2	950,000.00	648,242.80	
3.2 Maternal Mortality Survey	350,000.00	689.92	
3.3 Studies	750,000.00	301,921.30	
3.4 Overall Project monitoring and evaluation	280,000.00	570,620.54	
4. Financial audit[+]	**400,000.00**	**243,784.00**	**-39**
5. Financial Expenditures[+]	**825,000.00**	**678,970.48**	**-18**
5.1 FIV	225,000.00	225,000.00	
5.2 Interest	600,000.00	453,970.48	
5.3 Credit fee	-	-	
TOTAL	**22,500,000.00**	**22,500,000.00**	**0**
* Source WLMS hence exludes counterpart contribution.			
[+] Belong to component 3			

IV. Project Implementation

a. Analysis of Critical Factors

4.1 The operation incorporated important progressive elements to the way in which donors had worked in the past with the MSPP. The execution mechanism which placed all of the core decision making power in execution within the MSPP was

ambitious yet this set-up generated the kind of buy-in from the government that would be have been hard to achieve otherwise. This likely contributed to the fact that the project was able to stay functional and continue supporting the departmental service delivery through the turbulent years of political change. Yet at the same time, the project was fully dependent on MSPP ability to stay fully engaged and respond in a timely manner as the Minister was assigned to co-sign each expense. Between 2004-2009 the project worked directly with four different ministers who would all have a district take on execution priorities.

4.2 Importantly the project can be considered as a frontrunner in aligning the MSPP towards service delivery contracts with NGOs and creating similar contractual arrangements with MSPP's own public facilities, hence in essence setting performance incentives and accountability standards for public facilities. The 50 facilities that were certified to deliver a standardized health care package set an important example on private providers' responsibility on reporting to the MSPP and revealed the potential for effective use of resources should all health service providers follow suit. A significant challenge however in implementing this novel schema was the lack of qualified human resources at the institutional level to support the implementation of activities, and the organizations to support the Community Health Units were not as effective as planned.

4.3 In general the coordination with other development partners and private service providers was another important challenge that the project faced, because of the hundreds of private health care providers and related actors who lack formal coordination mechanisms and do not report to the MSPP on their service delivery. In general, considering for the many challenges in the given environment the initial planning for the execution period proved to be overly optimistic.

b. Borrower / Executing Agency Performance

4.4 While the MSPP was the official execution agency, in practice an external entity, the Management and Coordination Unit was in charge of the execution with oversight from the Minister. All of the employees of this unit were externally hired consultants paid by the project (yet most ex-functionaries of the MSPP) and this, on its own was a source of criticism towards the project, as it was viewed as only 'semi'-integrated to the MSPP's functions in reality. This unit executed the project activities in a complicated and constantly changing environment. To an extent they were expected to initiate a *change from within* inflicting a vision for accountability in service delivery yet many internal departments showed little interest to incorporate such vision into their operations. While reaching a compromise with the MSPP for each step of the way was indeed time consuming, the unit is applauded for the persistent collaboration. The capacity within the MSPP that was built throughout the years

in the process of creating joint annual operating plans, acquisition plans and bidding documents remains as an important externality of the project.

CLASSIFICATION OF THE BORROWER/EXECUTING UNIT'S PERFORMANCE
[ ] Highly Satisfactory (HP) [X] Satisfactory (S) [ ] Unsatisfactory (I) [ ] Very Unsatisfactory (TI)

c. Bank Performance

4.5 The Bank is acknowledged for the facilitation of project execution at each step of the way and for the decision to go through restructuring of the project in order to update the project design from 1998. It is however noted that the execution schedule was too ambitious and among other factors this did not allow sufficient time to build alliances during execution and to advocate for project outcomes which would have helped to institutionalize the results. The Bank is however commended on setting-up a Steering Committee for the project which was not initially foreseen. This consisted of specialists from the IDB, officials from the Ministry of Finance, Ministry of Planning and External Cooperation and the Principal Coordinator for the project. The monthly meetings were an added mechanism for technical and administrative monitoring of the project, which helped to identify execution bottlenecks as well as find solutions to the problems, for which the multi-sectorial support was key.

CLASSIFICATION OF THE BANK'S PERFORMANCE
[ ] Highly Satisfactory (HP) [X] Satisfactory (S) [ ] Unsatisfactory (I) [ ] Very Unsatisfactory (TI)

V. Sustainability

a. Analysis of Critical Factors

5.1 A critical factor that is expected to impact the sustainability of the project results is that the frequent leadership changes at the Ministry as well as the general management culture did not allow for the project to be fully owned by the different technical directions of the MSPP. Hence stronger institutional support for the project would have helped to address the general resistance to change. With regards to timing, it was also unfortunate that towards the end of the project execution, the minister changed once more and no advocacy was done on the part of the government for the activities supported by the project to continue to be financed.

b. Potential Risks

5.2 As no other source of funding has been identified to continue supporting the service delivery, it can be expected that within months, many providers will be unable to continue providing free or reduced cost care. It is also possible that

retention of qualified staff especially in the rural areas will be challenging after the sense dynamism created e.g. by series of trainings by the project is no longer an added motivational factor. In the worse scenario, he health centers that became fully operational under the project risk returning to their pre-project state, characterized by low attendance, and insufficient staff and supplies.

c. Institutional Capacity

5.3 The institutional capacity of the Community Health Units was indeed extremely very weak at the beginning of the project and while the project has been able to strengthen many of the critical skills, particularly in planning and monitoring, the capacity remains unsatisfactory for the most. In part the continuous challenges arose from the general unfamiliarity with *results based financing* and the lack of available experts that would have supported this approach at all concerned levels. The value of the many normative documents however, as well as the management and monitoring/evaluation tools that were produced with the support of the project, should not be underestimated.

CLASSIFICATION OF THE SUSTAINABILITY :			
[ ] Highly Probable (HP)	[ ] Probable (P)	[X} Weak Probability (FP)	[ ] Unlikely/Improbable (I)

VI. Monitoring and Evaluation

a. Information on Results

6.1 The project's results were obtained from multiple sources such as evaluation reports, observational visits, and monitoring data. Unfortunately however due the many delays that had incurred during execution, at the time when the data for the final evaluation was collected, some Community Health Units only initiated project activities few months earlier and hence this evaluation does not fully capture the full impact of the project. Because of this reality however rather than focusing on the achieved progress, the final evaluation of the project[6] elaborated on the quality of the data produced by the monitoring system, deeming it unsatisfactory on many accounts.

b. Future Monitoring and Ex-Post Evaluation

6.2 The project supported the development of important monitoring tools which unfortunately become available too late to be put in practice during the execution period. These tools however are available for the MSPP and others for future use.

[6] Final evaluation of HA0045 in 2009 IDBDOCS-#19066119.

VII. Lessons Learned

7.1 The lessons learned from the project can be classified into six categories related to; (i) Alignment with sectorial vision; (ii) Project execution; (iii) Contracting for service delivery (iv) Management of human resources; (v) Health care financing and (vi) Social mobilization.

(i) Alignment with sectorial vision: The experience with this project demonstrated clearly that for sustained results, the principles of the project must fully align with the Ministry's vision. In exchange, the Ministry should provide the project privileged stewardship in order to avoid unnecessary competition and parallel efforts by other players in the sector. Most importantly however, the government and donors should commit to defined public policies and long term sectorial plans which should be sustained through leadership changes in the ministries and the government.

(ii) Project execution model: In order to improve integration of project activities with those of the Ministry, for future projects, it is recommended to find approaches that involve more effectively the relevant directorates of the Ministry in managing projects. The Execution Unit for this project was external to the Ministry and this was a source of constant friction. Better integrated arrangements would also help sustain the project results over the medium-term.

(iii) Contracting for service delivery: The experience with the project proved that the Community Health Unit model, which focuses on strengthening primary health care facilities and linking them with Community Referral Hospitals, provides a workable solution to disease management in a country with limited resources. Coordinating all service delivery in a given geographic zone could further improve both resource allocation and quality of care. Another project output worth mentioning is that the final evaluation showed no added benefit in contracting private NGOs as oppose to public facilities. In fact public facilities performed a tad better than did NGOs when benefitting from the project's counseling and capacity building. Future operations could hence build on this experience in the public sector where the attained results are likely to be better sustained then in the NGO sector where intermittent project financing is the norm.

(iv) Management of human resources: Retention of qualified staff is such an important element in sustaining results that future projects should think of innovative ways to assure that MSPP can absorb the newly trained staff after the project. Unfortunately, most of the contracts for new staff that were supported by funds from this project were not sustained by the MSPP. An effective retention plan should also address the remuneration, working conditions and the possibility of providing accommodation particularly in remote areas to motivate health personnel to commit to these positions.

(v) Health care financing: While the project has improved access to health services, for many the availability and cost of medicines still remained an obstacle to care even during the project demonstrating the extreme economic scarcity of many households. Thus, to ensure universal access to health care, a broader social

security system would be needed to address some of the basic needs of the population.

(vi) Social mobilization: The project was able to demonstrate the power of social mobilization in the communities and how at the core, social mobilization holds the key to strengthening the accountability of MSPP's senior officials towards the public. Future programs should invest more in these aspects and encourage the communities to participate, and demand to be consulted regularly by the MSPP officials as well as receive access to service data and client satisfaction surveys. The vaccination brigades are an excellent example of how empowered communities can have a critical role in reaching health targets.

Anexos

1. Report of the Exit Workshop
2. Borrower Evaluation

HA0045 Reorganization and Rationalization Program of the National Health System

CLOSING SEMINAR

The results of the Final Evaluation of the project were presented in September of 2009 in Hotel Montana, Petion-Ville, in a workshop chaired by the Minister of Health Dr. Alix Larsen together with Chief of Cabinet Dr. Ariel Henry from the MSPP. All technical personnel of MSPP and health sector partners were invited and the approximately 60 people attended the event including all departmental directors of the targeted 4 departments (West, North-West, South and Artibonite); MSPP Directorates (UADS, DSF, DOSS, UPE); NGOs including Management Sciences for Health and Save the Children; and international organizations including PAHO/WHO, UNICEF, USAID and UNFPA. The project execution team was dismantled in December 2009 when all planned activities had been finished with a remaining budget of 830,503 US$. Because of the earthquake on 1/12/2010 the planned closing seminar where the PCR report would have been presented in January of 2010 was not organized. However, as the results of the Final Evaluation of September 2009 concluded all of the key findings and related observations also elaborated in the PCR, it was concluded that the seminar of September 2009 can be considered sufficient in order to full fill the role of an official closing seminar as well.

In light of the significant health sector demands in the aftermath of the earthquake of 12/01/2010, a decision was done on 9/20/2011 not to cancel the funds and rather to add another vaccination activity under the component 2 in order to avoid cancelling the funds. Due to this decision however, the project made its final disbursement towards an activity on 4/16/2012 for the vaccination campaign and the results of this activity were added to the PCR report drafted earlier. However, this meant that once all of the results of the project were available and the PCR produced, close to three years had passed sense the main activities had been dismantled and organizing yet another closing seminar lacked timeliness.

Execute summary of the Final Evaluation presented at the seminar:

I| SOMMAIF : EXÉCUTIF

Le Programme d Réorganisation et de Rationalisation du Secteur de Santé (PRRSS) haïtien, financé à hautet de 25 M par un prêt de la Banque Interaméricaine de Développement (BID) et une co tribution de l'État haïtien, portait sur le renforcement des capacités techniques et or nisationnelles de onze Unités Communales de Santé (UCS) situées dans huit départemer ; sanitaires et un projet pilote pour la prestation de services de santé maternelle et inf ntile dans six de ces UCS, sur des activités de renforcement institutionnel auprès du Minist re de la Santé Publique et de la Population (MSPP) aux niveaux central et départemental, s r le développement d'un système de suivi et d'évaluation du projet pilote ci-haut mentionr de même que la réalisation de certaines études (comptes nationaux de santé, enquête s la mortalité maternelle, etc.). Étant donné les retards accumulés dans la mise en œuvre ı projet, l'évaluation à mi-parcours fut éliminée et on ne conserva que l'évaluation final qui fait l'objet du présent rapport.

Quatre questior d'évaluation ont permis été posées : 1) Quelle était la théorie de l'intervention? 2) Quel fut le niveau de mise en œuvre de l'intervention? 3) Quels ont été les effets de l'interv ntion? 4) Comment doit-on étendre l'intervention à l'avenir? L'évaluation s'est déroulée er re avril et septembre 2009 et a fait appel aux approches suivantes : une analyse docume aire à partir des sources mises à la disposition de l'équipe d'évaluation par les responsa es du projet, des entrevues semi-structurées avec un grand nombre d' informateurs clé: ı tous les niveaux du système de santé, un sondage de satisfaction auprès d'un échantillon e patients dans les UCS concernées, un sondage sur le climat de travail et la motivation au ès d'un échantillon du personnel des institutions de santé et des bureaux d'UCS et des ob rvations structurées auprès d'un échantillon d'établissements de santé dans les UCS visé ; par le projet.

La théorie d l'intervention

En l'absence d' ı cadre logique, le modèle de l'intervention fut extrait des autres documents disp ıibles et de l'analyse des indicateurs de performance qui avaient été proposés dans le projet pilote de renforcement et de prestation des services dans les UCS. Une Unité de G tion et de Coordination (UGC) créée au sein du MSPP pour les fins du projet devait gé r l'attribution des marchés et des ressources financières selon les règles de la BID et coo onner l'ensemble de la mise en œuvre. Des Organisations Contractuelles Principales (OCP se voyaient confier l'appui technique aux Bureaux de coordination des UCS (B-UCS) : q ıtre UCS étaient appuyées par des ONG privées et deux UCS étaient appuyées par ur organisme public rattaché au MSPP, la Direction Départementale de la Santé (DDS) du S d. Le projet devait bonifier les ressources humaines dans les B-UCS et les institutions de s ıté (IS) visées à travers le recrutement, le paiement de suppléments salariaux et la fc nation. Le projet devait aussi réhabiliter les infrastructures et fournir les matériels, équip ıents et intrants nécessaires à la prestation des services selon les normes du MSPP et assu r la gratuité des services aux groupes cibles (femmes en âge de procréer et enfants de mc ıs de cinq ans). Les B-UCS fonctionnels et appuyés par les OCP devaient à

leur tour appuye les IS entre autres par la supervision du personnel et le support à la planification. Des utils de gestion et des processus de traitement de l'information, fournis respectivement r une Firme d'Assistance Technique (FAT) et une Firme de Suivi et d'Évaluation (FSE devaient contribuer à la performance du système. Ce qui précède devait augmenter l'acce ibilité géographique et financière, la qualité et l'utilisation des services par les groupes bles, entraînant une amélioration de la couverture, de l'efficacité, de l'efficience et de a satisfaction des clientèles. L'analyse de l'implantation et l'analyse des effets reprennent hacun de ces éléments afin de déterminer dans quelle mesure ils ont été atteints et pourq i.

Analyse de l' nplantation

L'analyse de l'imp ntation a porté sur la gestion du projet et sur sa mise en œuvre dans les structures du sys me de santé visées par le projet. En ce qui concerne la gestion du projet, l'équipe de l'UGC dut œuvrer dans un contexte difficile et, sans sa grande persévérance, il est douteux que l projet ait pu être mené à terme.
Des retards imp rtants furent constatés à tous les niveaux dus entre autres à la multiplication de marchés (environ 270 en quatre ans), à la lourdeur des procédures (qui furent malgré to assouplies par la BID), à une planification initiale trop optimiste, à un manque de collal ration de la part des autres structures du MSPP qui ne put être réduit par les hautes instan s du ministère, au manque de ressources nationales compétentes pour certains marchés à la faiblesse de certains contractants, à une compréhension variable des termes de référ ce, à la faiblesse de la coordination entre certaines firmes ayant des mandats semblal es, à la sous-estimation du temps nécessaire pour l'accomplissement de certains mandats etc.

La faiblesse de la estion financière à tous les niveaux de la pyramide sanitaire et la grande difficulté d'accè à l'information financière ont entraîné des retards de paiement, en particulier dans l s cas où les pièces justificatives ne pouvaient être obtenues. Afin de ne pas interrompre s services, on alla jusqu'à décaisser en l'absence de pièces justificatives. Les outils et syst mes de gestion financière et de gestion de projet du l'UGC présentaient aussi certaines fa lesses.

Des structures d gestion prévues initialement se sont révélées non fonctionnelles telles que les comités le suivi et d'acquisitions. La volonté de faire participer les directions centrales, entre utres à l'élaboration et au suivi des marchés, et l'implication directe du ministre dans de aspects opérationnels plutôt que stratégiques contribuèrent aussi aux retards, amplifié par deux changements de ministre. La résistance des directions centrales s'expliquerait en artie par le fait que le programme était perçu comme un « projet » parmi d'autres (un proj de la BID) plutôt que comme une initiative propre au MSPP.

Toutes ces difficu és seront prises en compte dans l'élaboration du projet d'extension et, à ce titre, les leçon tirées du PRRSS auront été d'une grande utilité.

En ce qui concer e la mise en œuvre du projet dans le système de santé, elle fut affectée par tous les reta s mentionnés précédemment, ce qui laissa peu de temps pour implanter les changement: On peut considérer qu'au moment de l'évaluation « finale » le projet commençait à p ne à prendre son envol. Il est regrettable que l'expérience n'ait pu être prolongée d'un ı ou deux, ce qui aurait permis de mieux apprécier le bien-fondé du modèle.

La contractualisa on avec des OCP avait été choisie *a priori* comme mécanisme d'appui aux UCS pour compı ser la faiblesse du MSPP. L'évaluation ne révèle aucun avantage de la contractualisatio avec des ONG privées (expérimentée dans quatre UCS) par rapport au support des str tures de l'État (expérimenté avec la DDS du Sud). Au contraire, les résultats, bien e ténus, semblent favoriser le modèle public. Les effets y sont plus importants (voir lus loin), le personnel y est plus satisfait de ses conditions de travail (en particulier de la ualité de la supervision et de l'autonomie de gestion) et les entrevues révèlent que les NG privées ne sont pas considérées comme légitimes par les acteurs du système de sant L'UGC avait accordé un appui direct à la DDS du Sud pour lui permettre d'accomplir son nandat et nous croyons que cet appui explique en grande partie les résultats observe . Cette approche sera conservée dans le projet d'extension. En l'absence d'une démonstr ion claire de la supériorité du modèle privé sur le modèle public et considérant les ûts supplémentaires et le déficit de légitimité du système privé, nous recommandons ıbandon du modèle privé dans le projet d'extension. Nous croyons par ailleurs que la t es faible disponibilité d'ONG ayant les compétences et les ressources suffisantes pour ouer le rôle d'OCP aurait de toute façon empêché l'extension de cette approche à l'ens nble du territoire.

En ce qui concer les ressources humaines, nous avons identifié une insatisfaction face à la rémunération, à a sécurité d'emploi et aux perspectives d'avenir mais une assez bonne satisfaction face ux autres aspects des conditions de travail. Le manque de ressources humaines persist encore tel qu'en témoigne l'absence de spécialités de base dans certains hôpitaux commu autaires de référence (HCR). Il n'a pas été possible d'apprécier le niveau de compétence (personnel.

Beaucoup de fo mation a été dispensée au cours du projet mais nous n'avons pas suffisamment d' formation pour apprécier sa qualité et son impact. Il semblait toutefois manquer une d narche systématique d'analyse des tâches et des compétences et les approches péda giques étaient le plus souvent assez traditionnelles. Il y avait aussi un manque de coor nation entre la mise en œuvre, la disponibilité des outils de gestion et la formation. Ceci a té pris en compte dans la proposition d'extension.

En ce qui conc ne la réhabilitation des infrastructures et la fourniture des matériels, équipements et trants, les fonds disponibles ont permis d'effectuer environ la moitié des travaux de réhal itation qui avaient été identifiés. Le projet prévoyait que les IS seraient mises à niveau p ur répondre aux normes du MSPP mais cette idée fut abandonnée, faute de quoi la prest ion des services n'aurait pas pu démarrer. À la fin du projet, la capacité installée s'était néliorée mais elle restait encore largement insuffisante dans l'ensemble

des UCS. L'enqui e ménage réalisée par la FSE révèle que l'équipement et les installations déficientes reste encore des obstacles importants à l'utilisation des services.

La fourniture de médicaments a été mise en place de façon variable entre les UCS et des ruptures de stoc s se produisent encore. La gratuité a été elle aussi implantée de façon variable selon le UCS et même selon les IS dans chaque UCS. La mauvaise qualité des données du sys me de suivi du projet empêche toute comparaison avec la situation antérieure mais enquête ménage révèle que la disponibilité et les coûts des médicaments restent des obsta les importants à l'utilisation des services de santé dans les zones ciblées. Le projet a perm de développer plusieurs outils de gestion dont la plupart sont arrivés tard au cours de l'imp ntation et n'ont pas encore été mis en œuvre. Il reste cependant que ces outils représent nt un potentiel considérable qui pourra être exploité dans la phase d'extension.

Le traitement d l'information, incluant sa collecte, son analyse et son utilisation pour l'évaluation et la rise de décision, est l'un des aspects les plus faibles du projet. Malgré les efforts déployés ar la FSE et par la responsable de la composante 3, la validité et la fiabilité de l'information ont extrêmement problématiques à tous les niveaux. La FSE a proposé un système de suivi t d'évaluation et un système de suivi de la mortalité maternelle mais leur implantation et s rtout leur accès à des données valides ne sont pas réalisés. Ces difficultés sont prises en ompte dans le projet d'extension. Le PRRSS a appuyé une initiative intéressante d'in gration de l'information sanitaire au niveau national, le CONASIS, et ceci devra être maint nu.

Finalement, la f nctionnalité des B-UCS est limitée à tous les niveaux et ils devront continuer à être pportés dans le projet d'extension.

Analyse des ffets du programme

À la lumière de c qui précède, il n'est pas étonnant de constater que les effets attendus du PRRSS ne se soi t pas manifestés de façon importante. Pour reprendre l'expression d'un consultant au pr et, on observe tout au plus un « frémissement » de certains indicateurs. Les données de gestion issues des rapports trimestriels des B-UCS étant de mauvaise qualité, nous n'a ons retenu que les données des enquêtes ménages pré et post qui sont elles-mêmes ass douteuses : en particulier, il nous semble que les échantillons ne soient pas comparable et certaines données sont pour le moins bizarres : par exemple, les ménages ont mo s d'enfants en 2009 qu'en 2008...

Les résultats pos ifs constatés incluent une légère amélioration de l'accessibilité financière et géographique ans certaines UCS. Les UCS du Sud enregistrent des progrès au niveau du taux de consulta ons prénatales et de vaccination antitétanique chez les femmes en âge de procréer. Le tau: de vaccination « totale » des enfants de 0-11 mois a augmenté dans cinq UCS sur six. Dan certaines UCS, on observe une augmentation de l'utilisation de méthodes contraceptives a opriées, de la possession de moustiquaires imprégnés et de traitement

approprié des é sodes de diarrhée. Mais tous ces indicateurs restent en-dessous des valeurs ciblées a début du projet. Les résultats sont en général meilleurs dans les UCS du Sud gérées selon e modèle public.

La faiblesse des effets observés est tout à fait normale dans la mesure où, lors de l'évaluation, l'im antation du projet était à peine amorcée dans la plupart des UCS et que les enquêtes poj lationnelles ne sont pas des instruments de mesure appropriés dans de telles circonstan s. Il est dommage que les données du SSE, plus proximales, n'aient pas été de meilleure ualité.

Le projet d'e tension

Malgré les limit mentionnées précédemment, le PRRSS a été extrêmement utile pour identifier les prc haines étapes à accomplir pour arriver éventuellement à doter le pays d'un système de santé primaire adéquat et les constats de l'évaluation ont été pris en compte systéma quement pour élaborer le projet d'extension.

Ce dernier inclu trois composantes complémentaires. La composante « Prestation des services » vise, c nme la composante 1 du PRRSS, l'amélioration de la santé des femmes en âge de procréer des enfants de moins de 5 ans dans les UCS concernées. Pour ce faire, elle agira sur l'a roissement de l'utilisation des services et de la qualité de ceux-ci, sur la disponibilité con ue des intrants et sur l'accroissement des pratiques favorables à la santé chez les groupes bles. Les groupes cibles sont les mêmes que ceux du PRRSS et qui ont été retenus parce qu s sont prioritaires et vulnérables et pour limiter les coûts.

La composante Gestion » vise l'amélioration de l'efficience du système de santé par l'amélioration d la planification, du suivi/évaluation, de la gestion des opérations et du management à ous les niveaux du système de santé. Comme dans la composante prestation, chac n de ces domaines sera amélioré à travers un accroissement de l'instrumentatio et de la compétence des acteurs concernés. Au niveau du management, la motivation du p rsonnel sera accrue par la mise en place d'incitatifs dont l'une des modalités pourra être la contractualisation.

La composante « Diffusion » est celle qui facilitera la réplication du modèle dans le pays et son amélioratior ontinue. Lorsque la prestation des services et la gestion auront atteint un niveau acceptab dans certaines DDS-UCS, un milieu de formation, d'accompagnement et de développem t des pratiques sera identifié et renforcé. Cette composante vise l'utilisation de D -UCS milieux de formation par les gestionnaires des futures zones ciblées, la qualité de l'er adrement et de la formation qui y seront offerts et l'amélioration globale des pratiques d gestion et de dispensation des services de santé. Cette composante permettra aussi évaluer le modèle et de le mettre à jour pour qu'il continue à répondre aux besoins de la opulation.

La gestion du p jet sera complètement intégrée aux structures du MSPP et elle pourra bénéficier de re: ources humaines et d'outils de travail adéquats, en particulier en gestion

de projet et er gestion financière. Un conseiller permanent au ministre assurera la continuité de la ision et le coordonnateur général du projet sera situé à la direction générale dont i renforcera le leadership. Des équipes d'implantation composées de ressources du M P et d'experts du projet seront constituées dans les directions centrales concernées et vi idront appuyer les structures ciblées (DDS, UCS, IS et communautés) par l'accompagneme : direct dans l'action. Le projet vise la cohérence à travers deux mécanismes : l'i égration horizontale qui permettra de renforcer simultanément des compétences int -reliées (ex. planification et évaluation), et l'intégration verticale qui vise la cohérence ent les différents niveaux du système de santé (central, départemental, UCS, etc.). La gestion l'information sera transversale aux autres fonctions et elle sera placée à la direction gén ale et en lien avec le CONASIS de façon à permettre une intégration effective des sou es d'information. Afin de favoriser la cohérence entre les bailleurs, il est proposé de faire articiper plusieurs de ceux-ci au financement du projet.

Plusieurs risques stratégiques, politiques, financiers, opérationnels et environnementaux sont associés à c projet. Le risque principal est le manque de consensus quant au modèle de soins primaire à retenir au niveau national et quant à la priorisation des soins primaires dans le système santé. Ceci devra être résolu avant de pouvoir aller de l'avant.

Inter-American Development Bank
Project Completion Report - PCR
Borrower Evaluation

Project Name: Program for Organization and Rationalization of the Health Sector (HA0045)	
Executing Agency: Ministry of Public Health and Population (MSPP), Haiti	
Borrower: Inter-American Development Bank	
Date of Borrower Evaluation: April 1, 2013	Date of Exit Workshop: Sep 15, 2009

Borrower Project Performance Ratings

Probability on Achieving its Development Objective(s):

[ ] Highly Probable (HP) [X] Probable (P) [ ] Low Probability (LP) [ ] Improbable (I)

Project Implementation:

[ ] Highly Satisfactory (HS) [X] Satisfactory (S) [ ] Unsatisfactory (US) [ ] Very Unsatisfactory (VU)

Sustainability of Project Results:

[ ] Highly Probable (HP) [ ] Probable(P) [X] Low Probability (LP) [ ] Improbable (I)

Comments: The original project design was approved in December 1998, yet the project objectives remained relevant throughout the execution period. Very significant changes in government have since taken place yet sufficient flexibility within the project and close dialogue with the MSPP at all times allowed the project to remain relevant.

Borrower Performance During Project Preparation

Please rate your own performance during Project Execution:

[ ] Highly Satisfactory (HS) [X] Satisfactory(S) [ ] Unsatisfactory (US) [ ] Very Unsatisfactory VU)

Comments:

The MSPP provided key inputs to project design and elements such as (i) Resource allocation on the basis of demand and absorption capacity, (ii) Plan for transfer of responsibility as capacity grows and (iii) Recognition of Prior Expenditure were incorporated to the original design.

Borrower Performance During Project Execution

Please rate your own performance during Project Preparation:

[ ] Highly Satisfactory (HS) [X] Satisfactory(S) [ ] Unsatisfactory (US) [ ] Very Unsatisfactory (VU)

Comments:
MSPP remained fully engaged throughout despite of the concurrent political changes. The evaluation results demonstrate the capacity of the MSPP to supervise and build delivery capacity in the departments when the means to cover for the expenses are present. The project was well integrated to the MSPP services in the departments and was able to provide important technical reinforcement to the MSPP staff at the departmental direction level as well as in the outreach clinics.

Bank Performance During Project Preparation

Please rate the Bank's performance during project preparation. Factors to be considered include the extent to which the Bank facilitated a participatory project design, proposed adequate technical solutions to the problems identified, and responded to the needs of the Borrower (timeliness, selection of instrument type).

[ ] Highly Satisfactory (HS) [X] Satisfactory(S) [ ] Unsatisfactory (US) [ ] Very Unsatisfactory (VU)

Comments:

To demonstrate the interest that the Bank had towards achieving sustainable results, the project was restructured 2003 to better respond to government needs since 1998. The changes done to the components were considered necessary and while the time frame remained ambitious, the reduced list of conditions prior, helped the project to reach eligibility.

Bank Performance During Project Supervision

Please rate the Bank's overall performance during project supervision. Factors to be considered include technical assistance (including informal and formal training) to Executing Agency, timeliness of Bank response and the Bank's flexibility to respond to emergency situations during project implementation.

[ ] Highly Satisfactory (HS) [X] Satisfactory(S) [ ] Unsatisfactory (US) [ ] Very Unsatisfactory (VU)

Comments:

The Bank provided uninterrupted support towards the implementation of the project throughout the execution period. The project can be considered a flagship project for the MSPP, through which the model "contracting for services" was piloted. While the MSPP signed-off on expenses conjointly with the execution unit, a fully integrated execution unit would have allowed more alignment with the various technical directorates and hence contributed to the sustainability of the results. The cross-sectoral Steering Committee for the project consisting of specialists from the IDB, officials from the Ministry of Health, Ministry of Finance, Ministry of Planning and External Cooperation should be mentioned as an element that strengthen the government ownership of the project and that provided a good platform to address cross-cutting public sector issues.

Additional Suggestions for Improving Bank Performance

Additional comments/suggestions for improving Bank performance in the future:

It is recommended that future operations align its objectives fully with those of the MSPP and that execution of the project would be carried-out through the existing structures of the MSPP. This would hence mean that an execution unit would be fully integrated to the MSPP and that all staff within this unit would be made MSPP staff assigned to the project. It would be important to avoid a “stand-alone” project design and hence a model of pooled financing which would minimize project specific reporting requirements, and generate significant savings in administrative costs of managing external financing would be recommended.