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IMPLEMENTATION COMPLETION REPORT
(CPL-38520; SCL-3852A)

ON A

LOAN

IN THE AMOUNT OF US$ 13.7 MILLION

TO THE

PHILIPPINES

FOR A

PH-WOMEN'S HEALTH & SAFE MOTHERHOOD

02/21/2003

Human Development Sector Unit
East Asia and Pacific Region

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CURRENCY EQUIVALENTS

(Exchange Rate Effective February 21, 2003)

Currency Unit = Philippines Pesos (PHP)
PHP1.00 = US$ 0.018
US$ 1.00 = PHP54.24

FISCAL YEAR
January 1 December 31

ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
AusAID	Australian Agency for International Development
BME	Benefit Monitoring and Evaluation
DOH	Department of Health
EC	European Community
EU	European Union
FP	Family Planning
GOP	Government of the Philippines
GTZ	German Technical Cooperation
HIV	Human Immunodeficiency Virus
HSRA	Health Sector Reform Agenda
IEC	Information, Education and Communication
ILHZ	Inter-Local Health Zone
KfW	Kreditanstalt fur Wiederaufbau of Germany
LCA	Life Cycle Approach
LGU	Local Government Unit
LMIS	Logistics Management and Information System
NG	National Government
NGO	Non-Governmental Organization
NHIP	National Health Insurange Program
OR	Operations Research
PCU	Project Coordination Unit
PHDP	Philippines Health Development Project
PHIC	Philippine Health Insurance Corporation
PMO	Project Monitoring Office
RH	Reproductive Health
RTI	Reproductive Tract Infection
SAR	Staff Appraisal Report
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
UNFPA	United Nations Population Fund
UPMD	Unified Project Management Division
USAID	United States Agency for International Development
WH	Women's Health
WHDP	Women's Health and Development Program
WHTP	Women's Health Training Project

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PHILIPPINES
PH-WOMENS HEALTH & SAFE MOTHERHOOD

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Project ID: P004567	*Project Name:* PH-WOMENS HEALTH & SAFE MOTHERHOOD
Team Leader: Teresa Ho	*TL Unit:* EASHD
ICR Type. Core ICR	*Report Date: February 20, 2003*

1. Project Data

Name:	PH-WOMENS HEALTH & SAFE MOTHERHOOD	*L/C/TF Number:*	CPL-38520; SCL-3852A
Country/Department:	PHILIPPINES	*Region:*	East Asia and Pacific Region
Sector/subsector:	Health (100%)		

KEY DATES

			Original	*Revised/Actual*
PCD: 03/09/1992		*Effective:*		07/27/1995
Appraisal: 06/01/1994		*MTR:*	12/30/1998	12/11/1998
Approval: 03/09/1995		*Closing:*	12/31/2002	06/30/2002

Borrower/Implementing Agency: GOVT OF THE PHILS/DOH
Other Partners: ADB, AUSAID, EU, KfW

STAFF	Current	At Appraisal
Vice President:	Jemal-ud-din Kassum	Gautam S. Kaji
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2. Principal Performance Ratings

(HS=Highly Satisfactory, S=Satisfactory, U=Unsatisfactory, HL=Highly Likely, L=Likely, UN=Unlikely, HUN=Highly Unlikely, HU=Highly Unsatisfactory, H=High, SU=Substantial, M=Modest, N=Negligible)

Outcome: S
Sustainability: L
Institutional Development Impact: SU
Bank Performance: S
Borrower Performance: U

	QAG (if available)	ICR
Quality at Entry:		
Project at Risk at Any Time:	Yes	

3. Assessment of Development Objective and Design, and of Quality at Entry

3.1 Original Objective:
The project's objective was to improve the health status of women, with particular focus on women of reproductive age, and thereby support the Government's long term goals of reducing fertility, female morbidity and maternal mortality. Its specific objectives were to:
a) improve the quality and range of women's health and safe motherhood services;
b) strengthen the capacity of local governments to manage the provision of these services, and of the Department of Health (DOH) to provide policy,
technical, financial and logistical support;
c) enhance the effectiveness and sustainability of health interventions, through the participation of local communities and NGOs in the project; and
d) expand the knowledge base on which to draw policy and technical guidance for the women's health program.

The project objectives were clear and broadly appropriate. As indicated in the SAR, the project embodied the Philippine Government's response to the Program of Action of the 1994 International Conference on Population and Development in Cairo. This project was the first in support of a newly created Women's Health Program, seen then as the 'flagship' program of the Department of Health (DOH). Bringing five donors under one project umbrella helped to ensure that a single program concept was endorsed—an important benefit, which was probably worth the extra management burden of multiple donor procedures.

Although the first objective, which covered the core of the project's activities and outcomes, might have benefited from more explicit statement of how exactly the quality and range of services were to be improved, these details were evident in the project description and content. Objective (b) gave the needed attention to the evolving roles of local governments and central DOH in a then-recently devolved health system – LGUs were to manage and provide services, DOH to provide support. Objective (c) rightly stressed the roles of local communities and beneficiaries themselves. Objective (d) would ensure that the science behind the new Women's Health Program was up-to-date.

Quantitative service outcome and impact objectives were developed at appraisal for the ADB-financed areas of the project, but not for the WB-financed areas. Quantifying impact objectives at appraisal was not realistic, given the lack of baseline data at the time. It might have been appropriate to put in place a system for developing disaggregated, locally appropriate outcome objectives with participating local governments, but this did not happen, making it difficult to measure performance during implementation and evaluation.

The project's multiple objectives made it complex and therefore difficult to implement. Furthermore, the project's scale and cost were ambitious, given the uncertainties posed by the recent devolution. But the positive experience with implementing the earlier Bank-financed Philippines Health Development Project (PHDP) suggested that such complexity could have been managed, with the appropriate institutional arrangements (see section on Project Management below).

3.2 Revised Objective:
No change

3.3 Original Components:
1. *Service Delivery* (US$85.73m of which US$8.20m from IBRD), including civil works and equipment to upgrade health facilities; piloting of an approach for integrating services and targeting them on high risk women (the 'life cycle' approach); and provision of drugs and supplies for key women's health services,

including maternal care, family planning, reproductive tract infections (RTIs), sexually transmitted diseases (STDs) and cervical cancer. The strategies and interventions chosen were appropriate. They were high priorities from an epidemiological point of view, and the range of services was limited enough to be implementable. It would, however, have been simpler and probably more effective to have planned just one or two service packages, rather than several permutations in different provinces, mainly determined by which provinces were supported by which donor.

2. *Institutional Development* (US$36.53m of which US$8.80m from IBRD), including information, education and communication (IEC), training, developing the DOH logistics system for distributing essential drugs, and project management. This component was broadly appropriate, but it failed to provide for strengthening the health management capacity of local governments, even though this was included in the appraisal report as a project objective and benefit.

3. *Community Partnerships* (USS$13.0m of which US$0.0m from IBRD), aiming to bring the DOH, local governments, and local NGOs/peoples' organizations together to increase health awareness, empower women, and raise finance to implement mini health improvement projects. This concept was appropriate.

4. *Policy and Operations Research* (US$1.18m of which US$1.00m from IBRD). This component funded project evaluation, and operations research (OR) to feed into policy. The OR focused on testing new technical approaches for service delivery.

3.4 Revised Components:

Although there was no formal restructuring of the IBRD portion of the project at anytime during project implementation, the project concept evolved in a number of ways and for a number of reasons. Among the reasons for change were: (i) as donors came on board, they made changes to the project design presented in the SAR, following their own respective evaluations; (ii) the roles of LGUs in implementation of women's health programs became increasingly evident as devolution itself took shape; (iii) implementation delays in the first half of project life made it necessary to reduce output targets for certain project activities; and (iv) new activities to promote the project's objectives were identified as implementation proceeded. Among the main changes were:

- The target number of health workers to be trained was scaled down in an effort to ensure the quality of the training activities, given that Competency Based Training was an untested approach within DOH. This decision was made at the onset of the AusAID-funded Women's Health Training Project (WHTP) in 1996. A similar adjustment was made in 1998 at the start of training activities for the 36 WB-funded provinces. Original targets that called for universal training coverage among health workers were drastically reduced to cover only areas where other project inputs were provided. Later, because of difficulties experienced in running the distance education modules for Barangay Health Workers (there was insufficient communication infrastructure at the village level to support distance learning), the approach was shifted to the training of Rural Health Midwives, reducing target numbers significantly.
- The Logistics sub-component was adjusted twice. The first change was made in 1998 to shift responsibility for drug logistics from central DOH to regional DOH offices. A second, major change was made in 1999, in which drug distribution by the public sector was replaced by a system to contract private sector suppliers to deliver drugs directly to health facilities; funds budgeted for upgrading government warehousing were therefore no longer needed.
- In recognition of the role of LGUs in supporting women's health programs, the ADB-funded IEC component was revised at mid-term to add advocacy activities addressed to Local Government Executives (in addition to IEC activities directly focused on project beneficiaries). Coverage of the component was expanded nationwide from the original 40 ADB-supported provinces.

- Due to general delays in implementation, the project was rated as unsatisfactory by the WB in May, 1998. The components were revised at the time of the November 1998 project mid-term review, since spending was no more than 13% of the initial loan amount by that time. Output targets for civil works, equipment and training were reduced (minor changes for civil works, major reductions for equipment and training), and there was a partial cancellation of the ADB and WB loans (although target reductions were only one of several reasons for cancellation -- see section E). A number of new activities were also added at mid-term (RTI/STD prevalence study, procurement of additional cervical cancer reagents, expansion of coverage of LMIS).
- In the last year of the project, anticipated uncommitted funds from the IBRD loan were reallocated to the establishment of ten Reproductive Health Clinics in areas of high STI prevalence (large numbers of commercial sex workers), justified on the basis of project research findings of very high STI prevalence countrywide and the fear that this could lead to a sudden flare-up of HIV infection.

Except for reductions in output targets due to implementation delays, the above adjustments can be considered to be appropriate strategic adjustments in response to a changing implementation environment.

3.5 Quality at Entry:
Quality at entry is rated satisfactory. The project was consistent with the Government's policies and the WB's Country Assistance Strategy objectives, and was in most respects well designed. Co-financing arrangements for the project were complex but were clearly defined at the time of appraisal. Donor commitments worked out as planned and were maintained throughout the project life.

The project was prepared with participation of local governments who, after devolution, would be key implementors, and although adjustments needed to be made in the design of specific components as the roles of LGUs and DOH were further clarified over time, the recognition of LGUs' roles during appraisal at a time when the real impact of devolution was still uncertain indicated conscious effort to address the problem. Risks related to devolution were highlighted in the SAR and mitigating measures undertaken (including signing of Project Implementation Agreements between DOH and individual LGUs at the start of the project, requiring LGUs to pay salaries, utilities, travel costs, and other specific project costs). The one shortcoming of LGU-DOH arrangements was the failure to indicate explicitly in the PIAs co-financing shares of LGUs, let alone specifically requiring increasing LGU shares over project life to increase the chances of project sustainability.

Though not Bank requirements at the time the project was prepared, implementation by today's WB standards would have required the following, which were not present at the time of this project's entry:
- civil works and equipment requirement surveys completed by effectiveness
- key indicators defined, and monitoring and reporting processes and formats ready
- detailed design for project evaluation, or plan for strengthening evaluation capacity.

4. Achievement of Objective and Outputs

4.1 Outcome/achievement of objective:
Rating the achievement of this project is difficult, because (a) most activities were implemented well but some output targets were reduced due to implementation delays in the first half of project life; and (b) performance was much better in the second half of the project than the first. On the positive side, the project contributed to increasing the quality and range of women's health services (objective (a)) through upgrading health facilities, through technical training, and through a modest expansion of relatively new interventions for RTI and STD detection and treatment. The project was successful in achieving several of its institutional development objectives, especially in developing (i) a competency-based approach to

women's health training, (ii) a service quality assurance system, which is now being extended to other DOH programs; and (iii) a new drug distribution system, initial tests of which are promising (objective b)). The community partnership component appears to be increasing the effectiveness and sustainability of health interventions (objective c), albeit on a small scale. Some though not all of the planned operational research was carried out, and has expanded the knowledge base on which to draw policy and technical guidance (objective d). The RTI/STI prevalence study and establishment of ten Reproductive Health Centers in high STI-prevalence areas were added achievements not anticipated at appraisal, but responsive to the growing threat of HIV/AIDS.

The project met the revised targets agreed at mid term, following which implementation performance was satisfactory. However, rated against the achievement planned at appraisal, rather than later revisions, many project inputs were significantly delayed, or on a lesser scale than planned. For example, drugs and supplies reached the field in significant quantities only in the fourth year of the project, due to serious procurement delays. Project training reached only a quarter of midwives, compared to the universal coverage planned at appraisal; while the appraisal target was over-ambitious, the achievement could have been greater. The IEC program was so late that it was still scaling up as the project ended.

On balance, judging by the standards (targets) prevailing at the time of the ICR, the project's overall output is rated as satisfactory, although only marginally so if rated either against the original plan, or what could realistically have been done with better management.

4.2 Outputs by components:
Component 1: Service Delivery.

This component is rated as satisfactory, though it is considered to be only marginally satisfactory because of the delays in implementation and the consequent reduction in some output targets at mid-term. The repair, extension, equipping and supplying of health facilities were financed by the WB, ADB and KFW. Overall, there was a 2-3 year delay in implementation of this component. The designs by the project's architectural consultants (who had to be replaced) did not comply with DOH standards. Remedial works had to be undertaken, to ensure that facilities were appropriate for their purpose and met building codes. Civil works delays in turn delayed the provision of equipment. Procurement of drugs was delayed due to slow project procurement overall, and because of a temporary suspension of drug procurement DOH-wide in 1998 following revelations of large-scale procurement anomalies under an ADB-funded component of the project. At mid-term, a decision was taken to reduce targets for civil works, equipment and training and loan funds were cancelled correspondingly for both IBRD and ADB loans. Ultimately, with overall project implementation improved after mid-term, these adjusted output targets were completed as planned, and provision of drugs and supplies for key women's health services, including maternal care, family planning, reproductive tract infections (RTIs), sexually transmitted diseases (STDs) and cervical cancer all took place. In addition, the project's quality standards for RHU infrastructure, equipment and staffing were adopted as the country-wide standard for Sentrong Sigla (health facility quality assurance) around which an award system has been developed.

The Life Cycle Approach pilot was carried out under the ADB loan, then re-piloted in a different setting to more clearly draw out lessons on effectiveness. Initial reviews of the re-pilot have been positive in terms of heightened community participation in ensuring improved health outcomes and overall responsibility for the LCA systems established under the project was turned over to the community in December 2002. The syndromic approach to treatment of RTIs proved an effective alternative to specific treatment of RTIs in areas where laboratory facilities are not available to identify the specific infection.

Data from the Benefit Monitoring and Evaluation (BME) study shows mixed results with respect to changes in awareness and satisfaction betwen the first and second surveys (conducted in 2000 and 2001 respectively). Awareness and satisfaction for prenatal care remained unchanged (at around 98-99%). Awareness of delivery care services increased substantially (from 69 to 82%) but satisfaction declined from 79 to 80%. Awareness of postpartum services also declined from 98 to 90%, although satisfaction with these services increased substantively from 65 to 89% (see Annex 1, Outcome/Impact Indicators). Note the short period between surveys which may explain partly the erratic results. Service data in project barangays showed increases in utilization between 1996 and 2001 for all key services -- prenatal visits, postpartum care, iron, Vitamin A and iodine supplementation, use of family planning methods -- except for voluntary female sterilization, which showed a disturbing decline during the period. Rates of increase ranged from 14% for postpartum visits to 302% for iodine supplementation. Female sterilization declined by 51% during that period (pls see Annex 1, Output Indicators).

The clearest lesson resulting from evaluation of this component is the importance of ensuring that procurement procedures are well advanced by effectiveness or earlier. In addition, although project design is not in question, as it was consistent with the state of the women's health program needs and know-how at the time of preparation, a number of lessons have been learned. These are listed in the "lessons learned" section below.

Component 2: Institutional Development. Performance varied by activity, as follows.

IEC. Affected by the general slow pace of implementation during the first half of the project, IEC activities picked up during the second half, including the added dimension of activities aimed to raise awareness among LGU executives and promote women-friendly legislation at the local level. Other strategic changes made at midterm were also implemented by project completion. The ICR mission was not staffed to evaluate this ADB-financed sub-component in detail and a fuller evaluation awaits the results of the ADB's completion report.

Training. AusAID and the Bank financed this sub-component in different areas of the country. Implementation of Bank-financed training activities was slower than AusAID-financed ones, since Bank funds were managed through the mainstream DOH and LGU systems, while the AusAID grant was managed by a foreign consultant team and directly disbursed to locally hired trainors. AusAID evaluated the training activities it financed very positively. Though slightly delayed at start-up, the project completed on time and met or exceeded its target number of trainees, except in the categories of Rural Health Physicians, Ob-Gynecologist, and Medical Technologists, where insufficient numbers of trainees could be identified (short by 6%, 12% and 30% respectively). Bank-funded training activities also met or exceeded target numbers. There was clear evidence that trainees had increased knowledge, competence and confidence. Training in gender sensitivity was consistently mentioned as the most useful component of training, likely contributing significantly to improved client satisfaction. Project training activities also succeeded in developing considerable institutional capacity, for example through improving the training needs assessment process, and introducing competency-based training and a new training MIS.

The component was not without difficulties, including hesitation on the part of local governments to release staff for training, or to help as trainers; and, apparently by far the most important, a moratorium in 1999 on all DOH training outside of government training facilities. Local governments, on the other hand, suffered from counterpart funding constraints. In addition, procurement and training were poorly synchronized because of the delays in the former, although the AusAID end-project evaluation states: "While this has had an effect on some skills which they were trained in, evaluation studies reveal this has had a minimal impact". The trade-off between timely implementation and capacity-building is also evident

in the contrast between AusAID and World Bank areas post-project: in the former, where consultants carried out training, contributing to timely completion, there is less continuity in training activities after the project than in the latter areas where, though implemented more slowly through mainstream staff, training activities are continuing to some extent even after project closing.

Overall, the training sub-component contributed substantially to institutional development and to increasing skills levels in women's health service delivery. Given the large unmet training needs for the program, however, new strategies will be needed in the future to greatly accelerate the pace of training. These should include strategies for sustainable financing of staff training.

Logistics. The changes of logistics strategy around mid term delayed implementation, but the revised system is now being piloted in several regions, and seems promising. The sub-component is therefore rated as satisfactorily implemented. It is unfortunate that DOH management decided to not fully integrate the drugs and contraceptives logistics systems through the project – apparently under pressure from USAID who felt that integration would endanger the existing contraceptives distribution system established with their support. With current plans to phase out USAID funding of contraceptives in the country, a thorough review of contraceptive distribution (and financing) systems would be appropriate at this time, and integration of drugs and logistics system should be considered.

Project Management. This was highly unsatisfactory during the first half of the project, as evidenced by

- the lack of systems for a) annual planning and targeting and b) physical and financial reporting, which could have provided an early warning of slow progress and under-spending
- insufficient management action and technical support from the DOH Women's Health Program, due to lack of clarity about roles and responsibilities
- slowness by top management to intervene following the poor performance of much of the technical assistance contracted to help the PMO with civil works management, procurement, monitoring and evaluation
- serious procurement and disbursement delays, due to understaffing, unfamiliarity with donor procedures, and systemic problems in the procurement and financial management systems.

Most of the above problems stemmed from causes beyond the control of the PMO staff. The first two were the consequence of incomplete project preparation; the third was the responsibility of top management; and the fourth resulted in large part from a decision by DOH management not to use the services of the PHDP Project Coordination Unit (PCU), which had a successful track record, to manage WHSMP procurement and disbursements as had been discussed during preparation.

Project management improved to satisfactory in the second half of the project, with

- more top management attention (following changes in DOH management)
- the development of a conceptual framework for the Women's Health Program, and the issuance of administrative orders clarifying working relationships between the PMO and the technical program units
- the cancellation of the original technical assistance contract for the PMO, and the hiring of better performing consultants
- considerably improved processing times for procurement and disbursements
- the formation in 2000 of a DOH Unified Project Management Division (UPMD), which is systematizing management procedures for all foreign-assisted projects.

Despite these positive developments, some project management problems remain to be resolved:

- the staff of the Woman's Health Program is too small for it to be able to carry out the functions of

strategic planning, technical support, and program monitoring and management, which are its responsibility, rather than that of the UPMD

- some procurement posts need to be upgraded in seniority, and procurement and financial management should be handled by permanent staff who are professionals in these fields
- staff in the DOH technical programs need training in the procurement process, in the assessment of new technologies, and in specification-writing
- Bids and Awards Committee members need training in technical evaluation.

Component 3: Community Partnerships

Agreement on the design of this EU-financed component was reached only in 1997, and implementation will continue until December, 2003. The component has therefore not been rated. However, it is clear that much has already been achieved in developing and field testing systematic processes for partnership development and community empowerment, and there are indications that these will be sustainable. The component is expected to fully disburse by its revised closing date, by when it is expected to be operating in 250 villages.

Community and local government empowerment are essential to the success of health programs after devolution. There is therefore a strong case for extending some form of community partnership activity to all municipalities, not just a few of the most distant and disadvantaged. What is needed prior to a policy decision on whether to upscale is more evidence, as quantitative as possible, about outcomes; and a careful analysis of the costs and cost-effectiveness of this activity in areas where there are NGO partners, and where there are none.

Component 4: Policy and Operations Research

This component has two parts. The first is the project evaluation, which was Government-funded. This activity is rated as unsatisfactory, because of the delayed start-up and, particularly because of the poor quality of the analysis. Results of the baseline survey carried out as part of the Benefit Monitoring and Evaluation (BME) Study were not available until after mid-term. A number of shortcomings were noted in the application of certain statistical methods as well as in the analysis of available data, raising questions about some conclusions reached by the researchers that link observed outcomes to project interventions. The BME exercise is potentially helpful to policy but needs further work to validate conclusions on the project's performance in terms of targeting poor and underserved, awareness and availment of and satisfaction with women's health services under the project, and the costs of interventions versus derived benefits. However, the data collected appears to be of sufficiently good quality, and further analysis, with improved analytical methods, could yield more reliable results. The DOH has been encouraged to pursue analysis of this data.

Factors contributing to poor evaluation performance appear to be lack of a plan at the time of project appraisal for how evaluation would be done; and weak evaluation capacity in DOH. It is tempting to conclude that this activity might have been more successful had it been Bank-funded and therefore more closely supervised by the Bank team. However, the poor record of project evaluation performance in Bank health projects overall, where evaluation components are more typically Bank-funded, does not permit drawing this conclusion.

The operations research component, which was Bank-funded is rated successful. Planned operations research on active contact tracing for STDs, on alternative iron supplementation regimes and on the

incidence of breast cancer were not carried out; but planned studies on social marketing of iodized salt, on alternative interventions to reduce violence against women, and on alternative approaches to cervical cancer screening were. The study on cervical cancer was very successful. It demonstrated the cost-effectiveness of an alternative lower-cost approach to Pap smear – acetic acid wash screening – and resulted in a March, 2001 decision by DOH management to adopt the new screening technique for areas where laboratory facilities for doing Pap smears are not accessible.

4.3 Net Present Value/Economic rate of return:
These were not calculated. But the interventions included in the project (such as maternal tetanus immunization, maternal health care, family planning and micro-nutrient supplementation) are ones which the Bank's global analytical work has shown to have high cost-benefit ratios. A new and more cost-effective approach for cervical cancer screening was developed under the project. Cost-effectiveness analysis remains to be done for the following strategies: maternity waiting homes, lying-in clinics, community partnerships, and interventions for violence against women.

4.4 Financial rate of return:
Not Applicable

4.5 Institutional development impact:
The project provided the vehicle for establishment of the DOH's Women's Health and Development Program (WHDP), following commitments made at the Cairo Conference. The WHDP, formally established as a Unit under the Family Health Cluster of the DOH during the DOH re-engineering of 2000, is responsible for DOH's activities in family planning, safe motherhood, RTI, nutrition and control of violence against women. The project also provided a vehicle for establishment of close working relations among major donors actively supporting various components of the WHDP and ensured that common approaches were used wherever possible. In addition to these program-wide contributions, a range of institutional development contributions were achieved under specific project components, as described in the component-specific discussions (above). The most significant among these were in establishment of quality standards for health facilities; introduction of training approaches and methodologies; introduction of an LGU-based logistics system; development of approaches to building community partnerships for women's health; and establishment/development of cost effective clinical practices for RTI treatment and cervical cancer screening and prevention. The project's institutional development impact fell short in areas involving LGUs and their roles in managing and financing Women's Health Programs, largely because of the slow progress in defining LGUs' amd NG's respective roles under the devolved health system overall. These latter shortcomings notwithstanding, the project's institutional development impact is considered to be substantive overall.

5. Major Factors Affecting Implementation and Outcome

5.1 Factors outside the control of government or implementing agency:
Outside the control of government and implementing agency:

- Confusing and rapidly evolving sector management framework following devolution of the health system imposed by legislative action. As is typical of radically decentralized system, the sector took many years to stabilize following devolution, and is still evolving one decade after the start of devolution.
- There were three elections at the national level during the project life, and three local elections meant that incoming governors and mayors had to be oriented.
- Multiple donor procurement and disbursement procedures complicated project management, and contributed to procurement and disbursement delays.

Close donor coordination on the project, including joint supervision missions, helped mitigate these complications.

5.2 Factors generally subject to government control:

- There were seven DOH Secretaries during the project. Because of the political appointee system, each change meant changes in some of the DOH
managers and staff dealing with the project. The different priorities of successive Secretaries also meant varying commitment and attention to women's
health.
- One other factor concerns the difficult political environment given the conflict between the position of the Catholic Church and the objectives of the
project with respect to improved Family Planning. With 80% of the population being Catholic, and with the Catholic Church actively advocating against
artificial FP methods, government support for the program has been (and continues to be) erratic, subject to the vagaries of politics. In this sense, the
project was a high risk operation to some extent, still it was important to work on the reproductive health and women's health issues to try and influence
the substance and content of the RH and WH programs while also helping move FP forward.

5.3 Factors generally subject to implementing agency control:

- DOH management paid insufficient attention to the project during its first half. Non-performing technical assistance consultants were replaced only
three years into the project, and a Unified Project Management Division was created only after five years.
- Weaknesses in DOH procurement and financial management processes

5.4 Costs and financing:

The project is estimated to cost up to US$83.57 million (if we assume full disbursement of the EC Grant which is still ongoing) as against the $136.4 million estimated at appraisal, an under-run of US$52 million, or 39%. With US$11.58 million disbursed as of October 31, 2002, the under-run on the original WB loan amount of US$18 million was almost as big as that on the project as a whole, at 36%. This disbursement level is 85% of the reduced US$13.7 million WB loan, after cancellation. Estimated GOP expenditure is US$3.13 million as against projected GOP expenditures of US$26.6 million, a saving of US$23.5 million on the part of Government.

Of the total project under-run, about US$27 million can be accounted for by savings due to a) decisions by DOH management to buy less than the planned amount of obstetric kits (about US$8 million) and iron supplements for pregnant women (about US$4 million); b) depreciation of the Peso (about US$10 million); and c) redesign of the logistics strategy (about US$5 million). The remaining under-spending can be attributed to reduced targets due to slow project implementation. In response to the savings from these various causes, US$4.3 million was cancelled at mid term from the WB loan of US$18 million, and US$21.2 million from the ADB loan of US$54 million.

6. Sustainability

6.1 Rationale for sustainability rating:

Institutional capacity improvements in quality assurance, logistics management and training management are likely to be sustained, as are the application of the syndromic approach for RTI control and acetic acid wash for cervical cancer screening and prevention. Because they are lower-cost than previously prevailing approaches, and depend less on access to laboratory facilities, these latter two activities also contribute to long-term access and financial sustainability of the RTI and cervical cancer programs. The project also

appears to have had a demonstration effect. Though not formally documented, there are numerous anecdotal cases of non-project LGUs "copying" project activities in neighboring project areas.

Financial sustainability of project activities is less certain. Given the current and anticipated fiscal situation, National Government (NG) budgets, including DOH's, are likely to remain under tight control. LGU budgets are also likely to be cut back, given their almost exclusive dependence on their Internal Revenue Allotments from the NG. While better planning of LGU co-financing for project activities, including imposing a declining loan allocation for recurrent inputs, might have improved chances of financial sustainability by shifting at least part of the responsibility for this high priority program to the LGU, there is no guarantee that the LGUs will be in any better position than the DOH to finance it. One promising source of new funding is the National Health Insurance Program run by the Philippine Health Insurance Corporation (PHIC) which, after years of concentrating benefits on inpatient services, has now expanded its outpatient benefit package to include capitation coverage for Indigent Program members through Rural Health Units and has plans to introduce coverage for prenatal care, facility-based normal deliveries (up to the 2nd birth), IUD insertion, acetic acid wash for cervical cancer screening, STI treatment using the syndromic approach and some support for HIV patients (yet to be determined). Note that coverage for the syndromic approach for STI treatment and for the acetic acid wash cancer screening method are being justified on the basis of experience under this project. DOH is also helping LGUs plan their funding more carefully under the framework of the Health Sector Reform Agenda (HSRA), launched in 1999. Like any far-reaching reform program, though, the HSRA is expected to be a long-term undertaking, requiring 10-15 years before results can be felt.

Continued assistance from the donor community will therefore be required to ensure sustainability of the project's outcomes. Of the 5 donor agencies that co-financed this project, at least 3 (WB, ADB and KfW) have decided to continue with a follow-on project. USAID, UNFPA and GTZ are also continuing ongoing support and starting new initiatives. In addition, WB, ADB, GTZ and EU have started or will start preparing projects to support the HSRA. With respective responsibilities of NG/DOH and LGUs getting clearer with time, it is evident that DOH can no longer carry sole responsibility for national priority programs like women's health, and that LGUs must take the lead on delivery of these programs, with continuing priority support from the DOH. Preparation of the two new WB projects is therefore focusing closely on allocation of responsibility for management (between NG and LGUs) and financing (among NG, PHIC and LGUs) of health services in general and women's health services in particular in the devolved health system. Both projects will also explore ways in which existing private sector capacity for provision of care can be used to speed up expansion of services, using public sector financing.

Because of the likely sustainability of institutional improvement capacities and the promising financing framework under PHIC and the HSRA, project sustainability is judged to be likely. Nevertheless, substantial risk remains due to NG and LGU budget constraints, making continued donor support still necessary.

6.2 Transition arrangement to regular operations:
Although there will be a gap between project closing and start-up of the follow-on project (FY04), DOH and PHIC are continuing during this period with implementation of system-wide reforms under the HSRA. Implementation of the HSRA, started with USAID support and now being picked up by other donors, will improve the overall environment for implementation of the women's health program. The DOH is also initiating efforts (with support from the WB) to pool donor resources for preparation of the proposed follow-on projects for women's health, with focus on remaining gaps in the program following the first round of operations, including:

- Clarifying respective roles of NG/DOH, PHIC and LGU for management and financing of women's health services, including shifting the lead for women's health programs to LGUs.
- Developing templates for LGU-level planning of integrated women's health services, targeting women at specific stages in their life cycle and/or women with special needs: adolescents, women in unions, women in commercial sex, pregnant women. Integrated delivery of the full menu of family planning methods is especially critical
- Undertaking a comprehensive review of women's health training programs to find ways to reduce costs, accelerate implementation and ensure sustained financing, given the large numbers of health workers still requiring training
- Seeking ways to facilitate procurement and logistics of women's health commodities and supplies, including merging logistics systems for contraceptives and essential drugs, pooling procurement at appropriate levels regardless of source of funding (NG or LGU) to gain economies of scale; clarifying funding sources and financial management arrangements.
- Seeking ways to strengthen staffing of the DOH Women's Health Program given general staff shortages in DOH and the NG-wide freeze on hiring
- Developing an effective evaluation system for the program.

7. Bank and Borrower Performance

Bank

7.1 Lending:

The WB led the multi-donor project preparation missions, and was successful in building donor commitment to a unified women's health program, a very significant achievement. The technical aspects of the project were generally well prepared, and were notable for stretching the bounds of the women's health program by promoting sterilization as a family planning method, exploring interventions to reduce violence against women, promoting the syndromic approach to management of RTIs, and testing acetic acid wash as an alternative to Pap smears. As noted above, however, project management arrangements were insufficiently prepared by current standards.

It is debatable whether more might have been done at the time of appraisal to push for greater LGU involvement in management and financing of the program under the devolved health system. With hindsight, and given experience in other countries where decentralization/devolution of health services has been shown to lead to many years of uncertainty and confusion, it may be unfair to judge preparation a failure because more was not done four years after a devolution that had been imposed on the executive branch of government by the legislature, when the former was clearly unprepared for it. To the Bank team's credit, the uncertainties related to devolution were highlighted as a project risk and mitigating actions (involvement of LGU executives during preparation, signing of Project Implementation Agreements) were undertaken.

Preparation is on balance rated as satisfactory. However, because of the shortcomings in project management arrangements, preparation is considered to be only marginally satisfactory.

7.2 Supervision:

This was generally satisfactory. Joint-donor missions were regular, and procurement supervision improved when this was handed over to resident mission staff mid-way through the project. Regular participation of a financial management specialist in missions during the last two years of the project also made a difference. Mission aide-memoires identified the major problems and appropriate courses of action. The WB and other donors seem to have been flexible in their approach to the project revisions at mid term, and the agreed reallocations were appropriate. Given the large number of donors involved, and the practice of

conducting regular joint missions and collaborative preparation of aide memoires, donor coordination can be rated as highly satisfactory.

7.3 Overall Bank performance:
On balance, Bank performance is rated as satisfactory.

Borrower
7.4 Preparation:
For the same reasons as in the case of the Bank – building a framework for a unified women's health program to which major donors were able to subscribe, pushing the technical boundaries of the women's health program, and highlighting the risks related to devolution while taking the first steps to involve LGUs in national public health programs -- performance is rated as satisfactory.

7.5 Government implementation performance:
Sufficient counterpart funds for the project were made available by the central Government. Some local governments balked at providing counterpart funds for training activities and others experienced delays in providing counterpart funds for other project activities, but in general LGUs provided the necessary counterpart funds (or inputs in kind) for the project.

7.6 Implementing Agency:
As detailed in section D, project management was highly unsatisfactory in the first half of the project, resulting in very substantial implementation delays. More could have been achieved in the project overall if the project management skills of the PHDP PCU had been drawn on as planned during preparation, if the project had had more attention from DOH management at the start and if the contract of the poorly-performing management consultants had been terminated sooner. Borrower performance improved very significantly during the second half of the project. Consequently, the revised targets set at the mid term review were largely met. Compliance with covenants was satisfactory.

7.7 Overall Borrower performance:
Because of the unsatisfactory performance during the first half of the project related directly to omissions at the level of DOH senior management, and the consequent loss in time and overall project achievements, overall Borrower performance is rated as unsatisfactory

8. Lessons Learned

The project experience reaffirms three critical lessons that have been learned across many Bank projects:

- the need to improve project readiness by effectiveness;
- the importance of adequate implementation capacity and management oversight in the implementing agency; and
- the need to clarify respective responsibilities of National and Local Governments from as early as preparation when implementing a project in a devolved/decentralized health system.

On the first point, joint adoption by the GOP and the World Bank of the Project Readiness Filter since the time this project was prepared will ensure that any new project is appropriately prepared by the time of effectiveness. On the second point, establishment in 2000 of the Unified Project Management Division in DOH to provide permanent in-house project management and implementation skills, as well as clarification of the respective responsibilities of the UPMD and the Department's technical/program units, has helped improve project management capacity in DOH. Still, staff shortages in both the UPMD and the technical

units due to general budget constraints represent a serious threat to any future projects. On the third point, the Health Sector Reform Agenda (and preparation of the Bank's Health Sector Reform Project) is paving the way for more orderly joint implementation of future programs and projects in the health sector. Since HSRA implementation is slow and complex, special attention to devolution-related issues will still be required for preparation of any future projects in the sector.

Other lessons specific to the field of WHSM and requiring attention in the proposed Second Women's Health Project include:

A. Recognize that WHSM programs and policy frameworks require complex operations which have had mixed results worldwide over the past three decades. Projects in this area therefore require careful technical preparation and designs that are sensitive to the local context. In the case of the Philippines, a number of policy areas require further exploration of options and development of good guidelines for their application. These include:

• the technical strategy for iron supplementation
• where deliveries should take place, and exactly what interventions are needed to improve management of the referral system for obstetric
emergencies, to help reduce maternal mortality; whether Maternity Waiting Homes and Lying-In Centers are cost-effective interventions
• how STI services are to be integrated with other women's health services

B. Promote integration and avoid waste caused by duplication
• the planning, financing, management and delivery of different services related to women's health need to be integrated for greater efficiency and
effectiveness. This integration should take place at the key operational level for women's health services, which is at the health district or Inter-Local Health Zone (ILHZ) as referred to in the HSRA (comprising the first level referral hospital and outpatient facilities in its catchment area). Integration of services should revolve around service packages tailored to specific target groups such as adolescents, women in unions, women in commercial sex and pregnant women, as attempted under the LCA component.
• program inputs should be delivered as a complete package, with proper timeliness (convergence) -- for each catchment area or ILHZ. Fragmented
delivery of program inputs (e.g., training and civil works/equipment inputs going to different sets of project sites or arriving at different times) is to be
avoided.
• the essential drug and contraceptive logistics systems should be unified.

C. Intensify interventions in Family Planning to reduce the lag in family planning services and *organize services to deliver the full menu of FP methods* to ensure that clients have full choice based on complete information. Priority needs to be given to catching up with the backlog in basic training (only 40% of doctors, nurses and midwives in rural health facilities have had basic family planning training), giving family planning appropriate IEC support, and ensuring that contraceptives remain available and affordable.

D. Intensify interventions in RTI/STI control, given the operational success of the syndromic approach, the findings of high STI prevalence under project research, and the potential link between STI prevalence and HIV infection.

E. Plan and implement financing arrangements at the outset, to improve financial sustainability,

including LGUs and the NHIP as sources of finance, in addition to the NG.

F. *Undertake a comprehensive review of training programs in women's health* with the goals of (i) accelerating the rate of uptake to be able to keep up with needs; (ii) reducing costs (e.g., by reducing duplication and shortening course duration); (iii) rationalizing program content (tailoring courses to specific skills needs of specific health workers, integrating content); (iv) seeking sustainable sources of financing (including LGUs as employers of health workers); (v) expanding capacity for training provision, introducing a program of accreditation for training providers and developing mechanisms for competitive contracting of training courses.

9. Partner Comments

(a) Borrower/implementing agency:
NA

(b) Cofinanciers:
NA

(c) Other partners (NGOs/private sector):
NA

10. Additional Information

Annex 1. Key Performance Indicators/Log Frame Matrix

Outcome / Impact Indicators:

Indicator/Matrix	Projected in last PSR	Actual/Latest Estimate
Maternal mortality rate per 100,000 births	209 (1993)	172 (1998)
Infant mortality rate per 1,000 births	34 (1993)	35 (1998)
Iron deficiency anaemia among: (a) pregnant , (b) lactating	(a) 43 6 (1993) (b) 43 (1993)	(a) 60.7 (1998) (b) 45.7 (1998)
Iodine deficiency (with goiter) (a) pregnant; (b) lactating	(a) 23 (1993) (b) 18 (1993)	(a) no new data (b) no new data
Vitamin A deficiency(nightblindness)· (a) pregnant and (b) lactating	(a) 16.4 (1993) (b) 16.3 (1993)	(a) 7.1 (1998) (b) 3 9 (1998)
Family Planning. Total fertility rate	4.1 (1993)	3.7 (1998)
% of women who are aware of pre-natal services	99.93 (BME1)	98.69 (BME2)
% of women who are satisfied with pre-natal services	98.12 (BME1)	98.4 (BME2)
% of women who are aware of delivery care services	69.34 (BME1)	82.41 (BME2)
% of women who are satisfied with delivery care services	79 44 (BME1)	60.24 (BME2)
% of women who are aware of postpartum care services	97.72 (BME1)	90.14 (BME2)
% of women who are satisfied with postpartum services	65.5 (BME1)	89.12 (BME2)

BME1 survey was conducted in 2000; BME2 survey was conducted in 2001; all BME data refer to Implementation Areas

Output Indicators:

Indicator/Matrix	Projected in last PSR[1]	Actual/Latest Estimate
1. Pregnant women with at least 3 pre-natal visits (per 1000 livebirths)	756	969
2. Pregnant women given complete iron dosage (per 1000 livebirths)	657	920
3. Postpartum women with at least 1 visit (per 1000 livebirths)	834	952
4 Lactating women given complete vitamin A (per 1000 livebirths)	720	887
5. Lactating women given iron dosage (per 1000 livebirths)	225	844
6 Women 15-49 years old given iodized oil capsule (per 1000)	282	851
7 Current users of FP methods (per 1000 women of reprod age)	471	680
8 % of women of reprod age who availed of Bilateral Tubal Ligation (BME1 vs BME2)	2.44 (BHS) 4.86 (RHU) 5.56 (Dist Hosp) 6.72 (Prov. Hosp.)	1.2 (BHS) 1.85 (RHU) 1.63 (Dist Hosp) 1.63 (Prov. Hosp.)

[1] End of project

For items 1-7, data are based on Field Health Service Information Data in Barangay/Village Health Stations in Intervention Areas in 1996 (column 2) and 2001 (column 3) -- from Benefit Monitoring and Evaluation (BME) Study II; Item 8 is based on BME1(2000) and BME2(2001) Data.

Annex 2. Project Costs and Financing

Project Cost by Component (in US$ million equivalent)

Component	Appraisal Estimate US$ million	Actual/Latest Estimate US$ million	Percentage of Appraisal
Service Delivery	74.96	42.17	54.35
Institutional Development	32.68	26.07	82.37
Community Partnerships (USS$13.0m of which US$0.0 from IBRD)	11.80	6.85	58.05
Policy and Operations Research	0.96	2.33	233.33
Total Baseline Cost	120.40	77.42	
Physical Contingencies	4.98		
Price Contingencies	11.07		
Total Project Costs	136.45	77.42	
Total Financing Required	136.45	77.42	

The table above refers to total project financing, including from GOP and other donors. Except for EC which still has activities underway, all costs are as of the various donor-funded components, and hence, final costs.

Project Costs by Procurement Arrangements (Appraisal Estimate) (US$ million equivalent)

Expenditure Category	Procurement Method ICB	NCB	Other[2]	N.B.F.	Total Cost
1. Works	0.00 (0.00)	3.62 (2.54)	0.00 (0.00)	0.00 (0.00)	3.62 (2.54)
2. Goods	5.15 (4.99)	2.48 (2.42)	2.61 (2.54)	0.00 (0.00)	10.24 (9.95)
3. Services	0.00 (0.00)	5.92 (5.51)	0.00 (0.00)	0.00 (0.00)	5.92 (5.51)
4. Miscellaneous	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
Total	5.15 (4.99)	12.02 (10.47)	2.61 (2.54)	0.00 (0.00)	19.78 (18.00)

Above table refers only to procurement under the IBRD loan.

Project Costs by Procurement Arrangements (Actual/Latest Estimate) (US$ million equivalent)

Expenditure Category	Procurement Method[1] ICB	NCB	Other[2]	N.B.F.	Total Cost
1. Works	0.00 (0.00)	1.74 (1.57)	0.00 (0.00)	0.00 (0.00)	1.74 (1.57)
2. Goods	0.49 (0.49)	0.69 (0.69)	3.51 (3.51)	0.00 (0.00)	4.69 (4.69)
3. Services	0.00 (0.00)	0.00 (0.00)	7.25 (5.32)	0.00 (0.00)	7.25 (5.32)
4. Miscellaneous	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
Total	0.49 (0.49)	2.43 (2.26)	10.76 (8.83)	0.00 (0.00)	13.68 (11.58)

Above table refers only to IBRD loan-financed procurement.

[1/] Figures in parenthesis are the amounts to be financed by the Bank Loan. All costs include contingencies.

[2/] Includes civil works and goods to be procured through national shopping, consulting services, services of contracted staff of the project management office, training, technical assistance services, and incremental operating costs related to (i) managing the project, and (ii) re-lending project funds to local government units.

Project Financing by Component (in US$ million equivalent)

Component	Appraisal Estimate			Actual/Latest Estimate			Percentage of Appraisal		
	Bank	Govt.	CoF.	Bank	Govt.	CoF.	Bank	Govt.	CoF.
Service Delivery	8.20	16.77	60.76	3.66	2.04	36.47	44.6	12.2	60.0
Institutional Development	8.80	9.71	18.02	5.93	0.75	19.39	67.4	7.7	107.6
Community Partnerships	0.00	0.00	13.00	0.00	0.00	6.85	0.0	0.0	52.7
Policy and Operations Research	1.00	0.18	0.00	1.99	0.34	0.00	199.0	188.9	0.0

Note that US$3.7m, or 20.6% of the Bank loan, was cancelled in 1999. Gov't costs are based on approximated exchange rates at the time of the transaction.

Annex 3. Economic Costs and Benefits

An economic rate of return was not calculated for the project at the time of appraisal, nor at closure.

Annex 4. Bank Inputs

(a) Missions:

Stage of Project Cycle	No. of Persons and Specialty (e.g. 2 Economists, 1 FMS, etc.)		Performance Rating	
Month/Year	Count	Specialty	Implementation Progress	Development Objective
Identification/Preparation				
n.a.	*n.a.*	n.a.		
Appraisal/Negotiation				
n.a.	*n.a.*	n.a.		
Supervision				
06/28/1995	*2*	TASK MANAGER (1); MISSION LEADER (1)	HS	HS
02/26/1996	*3*	LOGISTICS CONSULTANT (1); TASK MANAGER (1); SR. HEALTH SPECIALIST (1)	S	S
10/04/1996	*3*	OPERATIONS OFFICER (1); HEALTH SPECIALIST (1); PUBLIC HEALTH SPEC. (1)	S	S
03/12/1997	*2*	CONSULTANT (1); Task Manager (1)	S	S
12/09/1997	*3*	MISSION LEADER (1); PROCUREMENT (1); REPRODUCTIVE HEALTH (1)	S	S
05/28/1998	*3*	TASK MANAGER (1); CONSULTANT (1); PROCUREMENT SPECIALIST (1)	U	U
08/13/1999	*4*	TASK MANAGER (1); OPERATIONS OFFICER (1); CIVIL WORKS CONSULTANT (1); FINANCIAL CONSULTANT (1)	U	U
08/13/1999	*5*	SR. HEALTH SPECIALIST (1); SECTOR MANAGER, HNP (1); OPERATIONS ANALYST (1); PRINCIPAL HEALTH SPEC (1); PROCUREMENT OFFICER (1)	S	S
03/21/2000	*14*	TASK TEAM LEADER (1); PROCUREMENT SPECIALIST (1); OPERATIONS OFFICER (1); FM SPECIALIST (1); ADB TASK MANAGER (1); PROJ. MGR., KFW (1); CONSULTANT, KFW (2); FIRST SECRETARY, AUSAD (1); SR. PROG OFF., AUSAID	S	S

			(1); COUNSELLOR, EU (1); EU (1); PROJ. MGR., EU (1); ADB (1)		
	10/11/2000	*8*	TEAM LEADER (1); PROCUREMENT SPECIALIST (1); OPERATIONS OFFICER (1); FM SPECIALIST (1); ADB TASK MANAGER (1); ADB PROJECT ASSISTANT (1); PROGRAMME OFFICER, (1); CONSULTANT, KFW (1)	S	S
	04/30/2001	*8*	TASK MANAGER (1); OPERATIONS OFFICER (1); PROCUREMENT OFFICER (1); FM CONSULTANT (1); TEAM ASSISTANT (1); ASSOCIATE PROJ ANALYST (1); CONSULTANT (2)	S	S
	10/15/2001	*12*	TASK MANAGER (1); OPERATIONS OFFICER (1); PROC. OFFICER (1); FM SPECIALIST (1); TEAM ASSISTANT (2); ADB TASK MANAGER (1); COUNSELLOR (1); PROJ. OFFICER (1); SR. PROJ. MANAGER (1); SR. PUBLIC HEALTH SPEC (1); KFW CONSULTANT (1)	S	S
	04/24/2001	*6*	TASK TEAM LEADER (1); OPERATIONS OFFICER (1); PROCUREMENT SPECIALIST (1); TEAM ASSISTANT (1); FM SPECIALIST (1); PROJECT OFFICER (EU) (1)	S	S
ICR					
	09/27/2002	*8*	TASK TEAM LEADER (1); PUBLIC HEALTH SPECIALIST/CO-TEAM LEADER (1); FP/RH SPECIALIST (1); HIV/AIDS SPECIALIST (1); PROCUREMENT SPECIALIST (1); FM SPECIALIST (1); OPERATIONS OFFICER (1); EVALUATION SPECIALIST (1)		

(b) Staff:

Stage of Project Cycle	Actual/Latest Estimate	
	No. Staff weeks	US$ ('000)
Identification/Preparation	n.a.	
Appraisal/Negotiation	n.a.	605.8 *
Supervision	n.a.	439.4 **
ICR	n.a.	
Total		1,045.2

* includes identification/preparation

** includes ICR

Annex 5. Ratings for Achievement of Objectives/Outputs of Components

(H=High, SU=Substantial, M=Modest, N=Negligible, NA=Not Applicable)

	Rating				
	H	SU	M	N	NA
☒ *Macro policies*	○	○	○	○	●
☒ *Sector Policies*	○	○	●	○	○
☒ *Physical*	○	●	○	○	○
☒ *Financial*	○	○	●	○	○
☒ *Institutional Development*	○	●	○	○	○
☐ *Environmental*	○	○	○	○	○
Social					
☒ *Poverty Reduction*	○	○	●	○	○
☒ *Gender*	○	●	○	○	○
☐ *Other (Please specify)*	○	○	○	○	●
☒ *Private sector development*	○	○	○	○	●
☒ *Public sector management*	○	○	●	○	○
☐ *Other (Please specify)*	○	○	○	○	○

Annex 6. Ratings of Bank and Borrower Performance

(HS=Highly Satisfactory, S=Satisfactory, U=Unsatisfactory, HU=Highly Unsatisfactory)

6.1 Bank performance	*Rating*
☒ *Lending*	○ *HS* ○ *S* ○ *U* ○ *HU*
☒ *Supervision*	○ *HS* ○ *S* ○ *U* ○ *HU*
☒ *Overall*	○ *HS* ○ *S* ○ *U* ○ *HU*

6.2 Borrower performance	*Rating*
☒ *Preparation*	○ *HS* ○ *S* ○ *U* ○ *HU*
☒ *Government implementation performance*	○ *HS* ○ *S* ○ *U* ○ *HU*
☒ *Implementation agency performance*	○ *HS* ○ *S* ○ *U* ○ *HU*
☒ *Overall*	○ *HS* ○ *S* ○ *U* ○ *HU*

Annex 7. List of Supporting Documents

IMAGES

Report No.: 25422
Type: ICR