



Validation Report

Reference Number: PCV: PAK 2008-33
Project Number: 27037
Loan Number: 1671(SF)
August 2008

Pakistan: Women's Health Project

Asian Development Bank
Operations Evaluation Department

ABBREVIATIONS

ADB	–	Asian Development Bank
DOH	–	Department of Health
EA	–	executing agency
FHV	–	female health visitor
FHW	–	female health worker
FP	–	family planning
IEC	–	information, education, and communication
MCH	–	maternal and child health
MOH	–	Ministry of Health
M&E	–	monitoring and evaluation
NGO	–	nongovernment organization
NHMIS	–	National Health Management Information System
OED	–	Operations Evaluation Department
PCR	–	project completion report
PCU	–	project coordination unit
PIU	–	project implementation unit
PPTA	–	project preparatory technical assistance
TA	–	technical assistance

NOTE

In this report, “\$” refers to US dollars.

Key Words

adb, asian development bank, pakistan women’s health, pcr validation, project completion report

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OED PCR Validation Report Form

A. Basic Project Data		PCR Validation Date:	May 2008	
Project and Loan Number:	27037/1671-PAK(SF)		Appraisal	Actual
Project Name:	Women's Health Project	Total Project Costs (\$M):	75.0	48.8
Country:	Pakistan	Loan (\$M):	47.0	39.3
Sector:	Health, Nutrition, and Social Protection	Total Cofinancing (\$M):	13.0	0.0
ADB Financing (\$M):	ADF: 47.0	Borrower (\$M):	15.0	9.5
Cofinanciers: ¹	(i) Organization of Petroleum Exporting Countries (OPEC) Fund (ii) United Nations Children's Fund (UNICEF)			
Approval Date:	16 Mar 1999	Effectiveness Date:	20 Apr 2000	23 Jun 2000
Signing Date:	21 Jan 2000	Closing Date:	31 Dec 2005	31 Oct 2007
Project Officers:	Name: Vincent de Wit Barbara Lochmann Vincent de Wit Sohail Sober Khan Kazim Niaz Samia Mufti Abbas Munir Ahmed Abro	Location (HQ or RM): HQ HQ HQ PRM PRM PRM PRM	From 1998 2000 2002 2003 2005 2006 2006 2006	To 2000 2002 2003 2005 2006 2006 2007
Evaluator:	P. Schoeffel, Consultant	Director:	R. B. Adhikari, OED1	
Quality Control Reviewer/Peer Reviewer:	K. Hardjanti, Principal Evaluation Specialist, OED1			

ADB = Asian Development Bank, ADF = Asian Development Fund, HQ = headquarters, OED = Operations Evaluation Department, PAK = Pakistan, PCR = project completion report, PRM = Pakistan Resident Mission, SF = special fund.

B. Project Description (Summarized from RRP)²

- (i) **Rationale.** The health status of women in Pakistan is poor compared with other countries in Asia. Some 30,000 women die each year due to complications of pregnancy, and 10 times as many develop life-long, pregnancy-related disability. Many girls die prematurely from common infections and malnutrition that could be easily prevented and treated. The untimely death or disability of a woman is itself tragic, but also adversely affects the health of her children, household productivity, and the national economy. About 25% of children are born with low birth weight due to maternal problems. Ten percent of children do not reach their first birthday. Fertility is high, with an average of six children per woman, resulting in a high population growth of about 3% per annum; if sustained, this will exacerbate poverty and environmental deterioration.

¹ At appraisal, the OPEC Fund and UNICEF were expected to finance \$10 million and \$3 million, respectively, of the entire project cost. However, UNICEF expressed its inability to provide the originally agreed amount, although it continued to provide technical support in kind. The OPEC Fund was not used by the Government due to its high interest rate, and the availability of savings generated from the changes in the SDR-dollar-rupee parity.

² ADB. 1999. *Report and Recommendation of the President to the Board of Directors on a Proposed Loan to the Islamic Republic of Pakistan for the Women's Health Project*. Manila (Loan No. 1671-PAK [SF], approved on 16 March 1999, for \$47 million).

The difference in mortality rates between females and males is explained by women's unique reproductive role and special needs, lack of quality health services for women, and social constraints on women. Four key issues need to be addressed to improve the health status of women and girls: (a) lack of awareness of women's health needs, (b) neglect of women's health needs, (c) lack of quality reproductive health care, and (d) weak management and institutional support of maternal and child health and family planning services. Factors underlying these issues are the lower education and social status of women, the traditional seclusion of women, limited institutional capacity, and governance constraints. Addressing these problems requires a specific focus on the service aspects of women's health as well as its educational, social, and managerial dimensions.

The Government foresees that it must continue to play a major role in the provision of health services to poor rural women and girls, while at the same time mobilizing nongovernment organizations (NGOs) and the private sector in this field. In its Ninth Five-Year Plan, the Government accords high priority to women's development, including women's health. The Women's Health Project came under the umbrella of the Government's Social Action Program, addressed programmatic as well as organizational priorities identified by the Government, and formed part of its core investment program.

- (ii) **Objectives.** The Project targeted 20 districts in four provinces (eight in Punjab, and four districts each in Sindh, North-West Frontier Province, and Balochistan), and was expected to reduce maternal and infant mortality and fertility. The Project was to be implemented over 6 years. The Project was to focus on reproductive health care and control of common infections with special emphasis on health and nutrition education, skilled delivery care, emergency obstetric care, family planning, and sexually transmitted diseases. The Project aimed to improve the health of women, girls, and infants. Its objectives were to
 - (a) expand basic women's health interventions to underserved populations;
 - (b) develop women-friendly district health systems providing quality health care for and acceptable to women, from community to first-referral level; and
 - (c) strengthen capacity (institutional and human resources-related) to improve women's health in the long term.
- (iii) **Components.** The Project had three components corresponding to its three objectives:
 - (a) Extend basic interventions for underserved populations in the 20 selected districts by expanding basic health care and family planning through female health workers, conducting safe delivery campaigns, and promoting women's health through the mass media.
 - (b) Develop 20 women-friendly district health systems by strengthening district health management, developing women's health and referral services, and mobilizing social support for women's health. The selection of districts by the provincial health departments is based on regional representation, and reflects the entire range of development levels in the country.
 - (c) Support project coordination, capacity building, advocacy, monitoring, evaluation, research, policy development, and human resource development.
- (iv) **Outputs.** The outputs referred to in the RRP are:

Component 1: Expand Basic Women's Health Interventions to Underserved Populations

- (a) Expand community-based health care and family planning:
 1. contract 8,000 village women to become female health workers (FHWs), with an opportunity to become private village midwives after 2 years of work as a FHW;
 2. support their training, supply, supervision and monitoring by the FHW program;
 3. train 500 program staff as trainers, supervisors, or program managers; and
 4. supply basic drugs, micronutrients, and other commodities in the form of a standard kit that will be contracted out to the private sector.

- (b) Conduct safe delivery campaigns:
 1. provide tetanus toxoid immunization for women of reproductive age;
 2. mobilize support for women's health and reduce social hurdles for women to access health services;
 3. educate women about the danger signs of maternal complications and the importance of timely referral;
 4. educate women about nutrition in pregnancy and provide them with a sample of micronutrients;
 5. educate women about safe and hygienic delivery; and
 6. support the campaigns with training, logistics, cold chain equipment and supplies, micronutrients, and delivery kits.
- (c) Promote women's health through mass media:
 1. support mass media advertising in the local language, skits and drama, and preparation of education materials for FHWs; and
 2. plan and contract out design, testing, and dissemination, and evaluation of health education activities.

Component 2: Develop 20 Women-Friendly District Health Systems

- (a) Strengthen district health management:
 1. contract NGOs to assist with project implementation and provide complementary health and support services for women to mobilize social support for women's health; and
 2. provide 3 months of management training and retraining for NGOs at the provincial health development centers.
- (b) Develop women's health services and referral:
 1. support the expansion of community-based health care with health and nutrition promotion, immunization, tuberculosis identification and follow-up;
 2. train 2,000 experienced FHWs at the district schools of nursing to become domiciliary midwives to provide prenatal, delivery, and postnatal care and family planning;
 3. train female health visitors (FHVVs) at the primary care level to become trainers and supervisors of FHWs and midwives;
 4. improve health care for women and girls with protocols, training, equipment, and supplies;
 5. rehabilitate or upgrade selected maternal and child health, and family planning (MCH/FP) facilities;
 6. improve staff accommodation and transportation for female staff;
 7. improve reporting, transportation, and stabilization of obstetric and other emergencies with telecommunication equipment and training;
 8. improve access to obstetric emergency care at the first-referral level by upgrading one or two first-referral hospitals
 9. provide staff, equipment, and supplies; and
 10. provide protocols and training.
- (c) Mobilize social support for women's health (contracted out to an NGO):
 1. advocate for women's health needs and services among local leaders;
 2. train public and private health care providers to sensitize them to women's health needs, rights, and services, and to train them in initial assistance for victims of abuse;
 3. assist selected communities to develop community-based health organizations to support women's health;
 4. train staff and school teachers to promote women's health, nutrition, and family planning needs and rights;
 5. provide safe houses for victims of abuse in six districts in Punjab and Sindh; and
 6. educate groups of people at high risk of HIV/AIDS.

Component 3: Institutional and Human Resource Development

- (a) Support project coordination, capacity building, and advocacy:
 1. support project coordination units (PCUs) to build up the capacity of the Ministry of Health (MOH) and public health departments; and
 2. support the National Women's Health Forum in workshops, media coverage, and publications.

- (b) Monitor and evaluate benefits and develop policies:
 1. monitor implementation of the national programs through existing program monitoring systems;
 2. assess program impact through the Pakistan Integrated Household Survey (financed under the second Social Action Program project);
 3. strengthen the regular health management information system in the 20 targeted districts, expanded to include hospitals;
 4. spot check health facilities for monitoring of staff and quality of services with third party validation through the auditor general office;
 5. conduct surveys in the 20 districts and up to five control districts; and
 6. support policy research and field studies by local institutions to identify constraints in women's health care and develop policies.

- (c) Develop human resources:
 1. support four new public health schools for FHV's;
 2. support hostels for midwifery students in the targeted districts;
 3. expand the health services academy to increase training capacity for public health managers of MCH/FP services;
 4. develop the nursing council to improve female staff planning, development, regulation, and quality control;
 5. provide 44 international scholarships in women's health management; and
 6. provide 276 domestic fellowships in MCH/FP management, community nursing, operating theater nursing, FHV training, and diploma-level obstetric surgery and anesthesiology.

C. Evaluation of Design and Implementation (PCR assessment and Validation)

- (i) **Relevance of design and formulation.** OED agrees with the PCR assessment that the Project was "relevant" (section D). The Project generally provided a feasible strategy for reducing maternal mortality but the design failed to take into account the (a) insufficient number of health managers and middle-level health professionals (and particularly females in these positions) at provincial and district levels; (b) lack of incentives for appointing and retaining medical specialists, PCU managers and other key positions (and particularly females in these posts) needed in provincial PCUs; (c) limited effectiveness of existing monitoring and evaluation (M&E) systems; (d) availability of competent NGOs at provincial level, particularly in Punjab and Balochistan provinces; and (e) the willingness of provincial and district Public Health Department agencies to work with NGOs. The most significant obstacle, as the PCR notes in detail in its analysis of the project design, was that the Project was designed in 1997, before major changes in health governance occurred under the Government's devolution plan of 2002. This transferred health management responsibilities from provincial to district level, where capacity was limited and facilities were in very poor condition.

At the time of project formulation and design there were two health ministries, one for population and one for health, and coordination was generally poor. The Director of the Ministry of Population recommended to the consultation mission that the Project be a sector project, and this deserved further consideration. Family planning is integral to safe motherhood and women's health but the modality selected to promote it through FHWs in the project design appears only partially adequate, given lack of power of most rural women. The PCR comments that national contraceptive utilization is only 30%. The issue of a family planning strategy was noted at the Asian Development Bank

(ADB) Board meeting that approved the Project, where it was noted that the Project could have incorporated family planning strategies targeting men, which have been successful in other Asian countries. The PCR prepared by the EA in April 2007 described the project design as generally “misconceived,” despite the fact that many of the outputs occurred more or less as stated in the RRP.

- (ii) **Project Outputs.** (Outputs and costs by component as envisioned during appraisal as compared to actual costs and achievement of outputs; reasons for any deviation.)

Component	Appraisal Estimate (\$ million)	Actual (\$ million)
Civil Works	8.7	11.4
Equipment, Furniture, and Vehicles	11.8	15.0
Supplies	10.9	5.8
Training	8.5	0.8
Fellowships	2.6	0.3
Information, Education, and Communication	2.9	2.1
Social Mobilization and NGO Support	4.6	7.1
Consulting Services	2.5	0.4
Management and Institutional Development	2.4	0.7
Monitoring, Evaluation, and Studies	1.7	0.7
Operational Costs	3.3	3.7
Subtotal	59.9	48.0
Taxes and Duties		
Contingencies		
Physical	5.1	0.0
Price	3.9	0.0
Subtotal	9.0	0.0
Interest and Charges During Construction	2.0	0.8
Total Project Cost	75.0	48.8

The PCR provides a detailed account of outputs and expenditure. It seems likely that due to the weaknesses in the PCU capacity at federal and district level, procurement for the “hard” components of the Project (equipment, furniture, vehicles, and civil works) were found easier to implement than the “soft” components (for training, fellowships, information, education, and communication (IEC), consulting services, management and institutional development, and M&E). The PCR notes that the Government banned overseas training without any explanation. The cost of supplies may have been lower than anticipated due to in-kind contributions made by other donor agencies for some supplies, such as vaccines, and in-kind support to IEC and training. The Government declined to fully utilize resources available for consulting services, apparently because of the unsatisfactory quality of consultants.

- (iii) **Project Cost, Disbursements, Borrower Contribution, and Conformance to Schedule (as relevant to project performance).** As originally envisaged, the ADB loan was to be used for health service activities and the OPEC Fund loan for infrastructure, vehicles and related consulting services. ADB financed almost 81% of the project cost of \$48.8 million, as the Government decided not to utilize the OPEC Fund loan due to the relatively higher interest rate. UNICEF was unable to provide a financial contribution, but provided some in-kind contributions. The Project was originally scheduled to start in July 1999 and end in June 2005, and the loan to close on 31 December 2005. However, at the Government's request, the loan closing date was extended by 1 year (to 31 December 2006), to compensate for the almost 2-year startup delay. The loan took effect on 23 June 2000, more than a year after it was approved, due to the inability of the Executing Agencies (EAs) to establish the federal and North-West Frontier Province PCUs. Therefore, few activities were started and completed on time. The Project encountered considerable and repeated delays in civil works, the procurement of medical equipment and supplies, the recruitment of FHWs, the implementation of IEC activities, safe-delivery campaigns, and the recruitment of NGOs. Despite the 1-year extension in the loan closing date, the PCUs could not complete all the project activities. In

many cases, the activities were completed before the loan closing date but the contractual obligations took more time than expected to complete. Thus, to accommodate the submission and processing of eligible withdrawal applications, the loan account had to be kept open well beyond the scheduled date of 31 March 2007, and was closed on 31 October 2007. Loan savings were cancelled on three occasions: SDR1,735,677 was cancelled in 2005; SDR3,970,359 was cancelled in May 2007; and SDR743,090 was cancelled in October 2007. The extensions were to allow ongoing activities to be completed.

Disbursements were initially very low (12%) for the first half (3 years) of the Project, due to implementation delays. The PCUs lacked understanding of ADB procurement procedures until ADB provided training in 2002. From 2000 to 2007, disbursements to the MOH occurred over a period of 81 months; to Department of Health (DOH) Punjab, over 77 months; to DOH Sindh, over 85 months; DOH North-West Frontier Province, over 80 months; and to DOH Balochistan, over 71 months from 2001 to 2007. The Project was extended by 1 year but activities still could not be completed.

- (iv) **Implementation Arrangements, Conditions and Covenants, related Technical Assistance, Procurement and Consultant Performance.** There was a 2-year delay in establishing and adequately staffing the PCUs. Subsequently, there were frequent changes in key PCU staff, including project directors. At the provincial level, two PCUs had engineers on their staff to plan and supervise civil works, while the other two PCUs relied on engineers from other provincial government agencies, which significantly delayed implementation and compromised quality. The PCUs were generally staffed by health professionals, and clearly lacked the technical expertise and experience to judge the capacity of the Communication and Works Department to meet project requirements, or to manage the performance of the civil works contractors.

Delays in the completion of civil works were due mainly to weak project management and lack of close supervision by the Building Department and Communication and Works Department. Had the civil works consultant been recruited as proposed at appraisal, the overall coordination and quality of civil works could have been far more satisfactory. The PCUs made top-down procurement decisions without consultation; as a result, in many cases the medical equipment procured by the PCUs was superfluous and unused. The Government complied with the covenants except for (a) the contracting of an NGO (no NGO was available in Balochistan); (b) the covenant related to surveys and M&E (which was only partly complied with); and (c) the covenant related to project steering committees (which was also partly complied with, because only a few meetings were actually held).

The Project was formulated through project preparatory technical assistance (PPTA) for the Women's Health Project.³ However, this PPTA was not evaluated in the PCR. The performance of both international and national consultants, all of whom were individual consultants, fell short of expectations, according to the PCR. Most of their outputs lacked the required quality and relevance to the project objectives. However, the EA did not conduct a wider search for stronger candidates as would have been expected, given the Government's preference for the use of domestic consultants. The Project used only 24 person-months of international consultant services against the 54 estimated at appraisal, and 80 person-months of national consultant services against the 212 estimated at appraisal. The federal PCU began recruitment about 2 years behind schedule; in April 2002, it recruited an individual international consultant for 24 person-months, as chief technical adviser for the planning and development of women-friendly district health systems in the project districts. The federal PCU did not use international consultant services for the health education program (24 person-months), domiciliary midwifery program (4 person-months), and other activities (2 person-months); according to the PCR, the federal PCU tended to view consultants as more of a liability than an asset. The Balochistan PCU recruited a national technical adviser for 26 person-months instead of the 24 person-months allotted. The federal PCU hired a national consultant for 54 person-months compared to the allotted 98 person-months, but only in the field of health education; it dispensed altogether with the national consultant services for the domiciliary midwifery program (18 person-months), civil works (36 person-months), and other activities (36 person-months).

³ TA 2577-PAK: *Women's Health Project*, for \$500,000, approved on 4 June 1996.

- (v) **Performance of the Borrower and Executing Agency.** The PCR does not rate the performance of the Borrower and the EA. However, OED concludes that it was “less than satisfactory.” Although cooperation among the MOH, provincial governments, and ADB review missions was satisfactory, and the Project’s progress reports and maintenance of records of accounts were also generally satisfactory, the less-than-satisfactory rating is given because of the late establishment and staffing of PCUs and lack of proper planning and effective coordination, which led to significant delays in mapping out effective implementation strategies, recruiting consultants, and procuring both civil works and goods.
- (vi) **Performance of the Asian Development Bank.** OED agrees that ADB performance was “satisfactory.” The PCR states that project supervision improved after the Pakistan Resident Mission assumed responsibility in 2003. However, the PCR notes there were weaknesses in outlining the plans for the procurement of works, goods, and consultant services. Deficiencies in the project design were discussed previously.

D. Evaluation of Performance (PCR assessment and Validation)

- (i) **Relevance.** The need for health services for women in rural Pakistan was fully demonstrated in the RRP, and the Project was consistent with ADB strategies and government policies for the health sector in Pakistan. The PCR rates the Project as “relevant” and OED agrees with this assessment. Flaws in the design referred to above preclude the assessment of “highly relevant.”
- (ii) **Effectiveness in Achieving Outcome.** The PCR rates the Project as “effective,” and OED concurs with this rating.

Component	OED Rating of Outputs Specified in the RRP
Component 1	Effective
Component 2	Effective
Component 3	Less Effective

As the PCR comments, a major defect was the disproportionate focus by all PCUs on inputs and physical progress that was not linked to outputs and outcomes during implementation; this was particularly true during the belated rush to complete the Project before the (extended) loan closure. However, although a number of outputs fell short of the targets at appraisal, training institutes were built or renovated and fully equipped, and short, medium, and long-term training programs were provided to train different categories of health personnel. Facilities visited by the PCR mission were found to be operating satisfactorily, with adequate staff and sufficient medical stocks. The records of hospital outpatient departments showed that the use of these health facilities, in particular antenatal visits and the use of other maternal health services, had increased. With improved and upgraded physical infrastructure, medical equipment, and supplies, the Project's health facilities resulted in more women making use of maternal care services. The PCR mission found that women using the Project's health-care services appreciated the facility upgrades. However, while expressing satisfaction with staff attendance at these facilities, the women clients were less happy with service delivery and the health workers' attitude toward patients. The community-based referral links through the 8,000 FHWs that were appointed and trained improved the Project's district level referral network. The IEC and behavior change communication initiatives and health education appear to have raised awareness of women's health issues among women and also among public officials, civil society, and communities. The institutionalization of District Health Management Teams in the project districts was a particularly noteworthy achievement, as this encouraged all four provincial governments to replicate the model in other districts as well. However, provision of comprehensive emergency obstetric care was generally unsuccessful due to a shortage of female professional staff. More than 50% of the approved posts for gynecologists, anesthetists, and female medical officers in the project districts remained vacant. The PCR mission found that 22 of 56 approved posts for gynecologists, 23 of 48 approved posts for anesthetists, and 95 of 304 approved posts for female medical officers in the project districts were vacant. It appears most medical staff appointed to districts to meet project requirements have now transferred elsewhere.

- (iii) **Efficiency in Achieving Outcome and Outputs.** OED agrees with the PCR rating of “less efficient.” The medical equipment supplied was of adequate quality, but there was inadequate post-sales service and maintenance. The overall performance of the civil works contractors was poor in terms of quality of works and timely completion, which adversely affected cost-effectiveness. The federal PCU used ADB's quality and cost-based selection procedures to recruit a national consulting firm to carry out a post-project evaluation, but after finding the first deliverable (inception report) submitted by the firm unacceptable, the PCU terminated the firm's contract, and dropped the idea of a post-project evaluation. This was a misguided economy. According to the PCR, the provinces of Punjab, Sindh, and Balochistan were subject to a government ban on foreign training, and thus converted the foreign fellowships into in-country scholarships. Against the appraisal estimate of 44 foreign fellowships and 276 in-country fellowships, 8 health professionals attended foreign training (18%), and 567 received in-country fellowships for a master's degree in public health or a diploma in obstetric surgery, emergency obstetrical services, or anesthesiology. Two women's health resource centers established in Islamabad (by the federal PCU), and Karachi (by the Sindh PCU) were to function as repositories and/or documentation centers for materials and publications related to women's health, with conference facilities. OED does not consider this an efficient use of Project resources, given other more pressing outputs that were neglected.
- (iv) **Preliminary Assessment of Sustainability.** OED agrees with the PCR rating that the Project is “likely to be sustainable.” With the MCH program in place, and the flow of funds to the project districts from the new program institutionalized and uninterrupted, the project interventions are likely to be sustained. The district governments have committed to continuing to provide adequate annual budgets for the operation and maintenance of health facilities. At the community level, the services of the 8,000 project-recruited FHWs have continued since 2005, with their salaries and supplies provided by the Government. However, the PCR notes that soon after the Project closed, many doctors in the project districts reportedly transferred elsewhere, having provided services during the Project to fulfill the undertaking given by the provincial governments to ADB.
- (v) **Impact (both intended and unintended).** The EA did not evaluate the Project to assess its impact, and data was not gathered to measure progress against the 13 indicators provided in the project framework for assessing achievement of objectives. However, the Project has focused the attention of the Government on the need to improve MCH services. Overall, the Project appears to have had a significant impact as it laid the foundation for the National Maternal, Neonatal and Child Health Program, launched recently by the Government.

E. Overall Assessment, Lessons, and Recommendations (Validation of PCR assessment)

- (i) **Overall Assessment.** The PCR rates the Project as “successful,” and OED concurs with this rating. The PCR rates the Project “relevant,” “effective,” “less efficient,” and “likely to be sustained.”
- (ii) **Lessons.** OED agrees with all the PCR assessment of lessons concerning project design, monitoring and evaluation, and specifications and requirements concerning consultants.
- (iii) **Recommendations.** OED agrees with the PCR recommendations related to (a) monitoring of EA performance, and (b) the need for the Government to (1) invest much more extensively in training a health workforce for rural areas, and (2) redress the decline in health sector funding. OED suggests that this should be a precondition for future ADB assistance.

F. Monitoring and Evaluation Design, Implementation, and Utilization (PCR assessment and Validation)

OED agrees with the PCR finding that project performance with regard to benefit monitoring and evaluation was poor. The National Health Management Information System (NHMIS) developed a monitoring tool for recording obstetric complications reported at district and/or tehsil (subdistrict) headquarters hospitals. A software program was also developed to integrate the Project's monitoring data into the NHMIS. However, technical and administrative difficulties prevented this integration. The Project conducted baseline surveys in all 20 target districts and had plans for post-project evaluation, which was contracted to a consulting firm but later dropped after it was learned that the firm lacked the required expertise. No evaluation of the Project to assess its impact has been made, and no data gathered on the 13 indicators provided in the framework attached to the RRP to assess progress in achieving the objectives.

G. Other (e.g., Safeguards, including governance and anticorruption; Fiduciary aspects; Government assessment of the Project, as applicable) (PCR assessment and Validation)

The PCR comments (as a "lesson") that a "system of accountability must be clearly defined for all parties involved and effective mechanisms for controlling leakages should be put in place to offset private interests (Section IV-B, para. 64, item [iv])." This obliquely suggests that some governance and corruption issues may have affected the Project, although the PCR does not spell these out. It notes that in one instance a supplier tried to discriminate on price by selling 20 ambulances to a province at a price significantly higher per unit than the price at which ambulances of the same specification had been supplied to another province. ADB pointed out the price difference and advised the EA to negotiate with the supplier; as a result, the EA received an equivalent discount on the total cost of this procurement.

H. Ratings	PCR	OED Review	Reason for Disagreement/Comments
Relevance:	Relevant	Relevant	
Effectiveness in Achieving Outcome:	Effective	Effective	
Efficiency in Achieving Outcome and Outputs:	Less Efficient	Less Efficient	
Preliminary Assessment of Sustainability:	Likely	Likely	
Borrower and EA:	Not Rated	Less than Satisfactory	Although cooperation among the MOH, provincial governments, and ADB review missions was satisfactory, and the Project's progress reports and maintenance of records of accounts were also generally satisfactory, a less than satisfactory rating was awarded due to the EA's failure to establish a viable PCU in a timely manner, the generally poor performance of the PCU, and the its failure to adequately monitor the Project.
Performance of ADB:	Satisfactory	Satisfactory	
Impact:	Not Rated	Significant	The Project has laid a foundation for the Government's new National Maternal, Neonatal and Child Health Program.
Overall Assessment:	Successful	Successful	
Quality of PCR:		Satisfactory	

I. Comments on PCR Quality

The PCR overall is very well documented and substantiated. Because there was no M&E, the Pakistan Resident Mission conducted a mission to assess outcomes. The PCR is generally candid and informative and the analysis of issues is highly satisfactory. The information to support the rating criteria for sustainability is satisfactory. More evidence should be presented in rating the Project's relevance, effectiveness, efficiency, and impact. Nevertheless, the PCR accurately assesses positive and negative external factors and attributes results. The lessons and recommendations are solidly based on evidence and analysis. Overall, the quality of the PCR is satisfactory. PPTAs resulting in a loan should be evaluated in the PCR for the loan project,⁴ but the PPTA was not evaluated in this PCR. Had this been covered, the PCR quality could have been highly satisfactory.

J. Recommendation for OED follow up

No follow-up action required.

K. Data Sources for Validation

- (i) PCR, RRP, legals documents, Government's PCR, TA completion report;
- (ii) Management review meeting and staff review committee documents and summary record of discussion of ADB's Board of Directors;
- (iii) Board reports and other progress reports;
- (iv) Supervision reports, including most recent midterm review or progress reports, and back-to-office report of PCR Mission, etc.; and
- (v) Other OED evaluations, including PCR reviews.

⁴ ADB. 2006. *Project Administration Instructions*. PAI 6.07: *Project Completion Report*. Manila (Appendix 2, page 8, February).

REGIONAL DEPARTMENT'S RESPONSE TO THE PROJECT COMPLETION REPORT VALIDATION REPORT

On 17 July 2008, Principal Evaluation Specialist, Operations Evaluation Department (OED), Division 1, received the following response from the Pakistan Resident Mission, Central and West Asia Department.

We have reviewed OED's earlier draft Project Completion Report (PCR) Validation Report circulated to us on 4 April 2008 and its final draft that was sent to us for review on 7 July 2008. We appreciate that the comments we made to OED on the earlier draft have been adequately incorporated in the final draft. Therefore, we have no formal comment to make on the final draft.