MILLENNIUM CHALLENGE CORPORATION
UNITED STATES OF AMERICA

LESOTHO

MCC Learning from

"LESOTHO HEALTH FINAL EVALUATION REPORT"

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MCC has identified the following programmatic and evaluation lessons based on the LESOTHO HEALTH FINAL EVALUATION REPORT.

PROGRAMMATIC LESSONS

- *Infrastructure can be an important investment but may only be part of the solution.* The evaluation suggests that the service delivery investments in Lesotho were key to achieving intermediate outcomes like expanded access to health services and the increased use of those services. Furthermore, trends in some health-related indicators are encouraging. However, the findings also indicate that most population-level health outcomes will require more time to materialize, contrary to MCC's expectations at the outset. Although the evaluator concurred with the issues described in the compact, he acknowledged that a comprehensive root cause and context analysis had not been conducted or documented, and the project's theory of change had not been clearly articulated upfront. In line with an unclear program logic, the evaluation findings also show that several project components either had an *unclear link* to the targeted outcomes (e.g., the provision of computers, tutors, and expanded dormitory capacity at the National Health Training College in order to graduate more nurses); were *underdeveloped* (e.g., the focus on infrastructure and equipment but not systems at the National Reference Laboratory and Blood Transfusion Center); or were *underfunded* (e.g., the intervention involving Village Health Workers (VHWs) was minimal even though VHWs are a key part of ensuring the availability of health services at the community level). So despite the consensus around the importance of the improved service delivery infrastructure, achieving the ultimate health and productivity aspects of the project's objective would likely have required a clearer understanding of the root causes of those problem, and a sharper focus on adequately funding the conditions that are necessary and sufficient to achieve that objective. This lesson about needing more thorough problem diagnostics to inform project design has been learned in a number of MCC countries and contexts and MCC has been attempting to address it in more recently-developed compacts. For example, building on a root cause analysis done in Georgia, MCC required that recipients of grants for technical training programs incorporate private sector participation and evidence of meeting industry demand to help address the government's lack of focus on the private sector's demand for skills.

- *Design/build contracts were not appropriate for this project.* The evaluator mentioned several times the shortcomings of the health center designs and that design of such facilities is a specialized skill that is not well-suited to a vaguely-scoped design/build contract. Due to a lack of experience with this type of contract and the upfront uncertainty involved, the vendors that bid on designing and building the health centers dramatically underestimated the cost. This contract modality – where one contractor completes design and proceeds to implement construction directly - provided little leverage for ensuring the works were fit for use. In the future, MCC either should use contracting modalities that provide more control over design or the MCAs needs to hire firms with relevant design expertise.
- *Involve end users in infrastructure design.* The evaluation highlights the importance of consulting with end users in the initial project scoping, conceptual, and detailed designs. This kind of consultation was undertaken for OPDs but not for health centers. While such participatory approaches may take more time, effort, and coordination, it is important to involve multiple levels of stakeholders to ensure that social infrastructure like health facilities are fit to their purpose. One key example of this oversight is that the needs of pregnant women (e.g., enough private space and kitchen facilities) were not accounted for sufficiently; designing and building around these needs may have helped overcome the apprehension some women continue to have about giving birth in health facilities. MCC has addressed this lesson by taking a much more participatory approach to the design of the Morocco II and Côte d'Ivoire schools. For example, rather than just repairing the existing main entrance of a school in Morocco, local consultation highlighted safety concerns caused by the existing entrance opening directly to a busy street; the Compact was able to move the entrance and address those concerns.
- *MCC should use compact development and five-year implementation periods more efficiently.* The evaluation incorporated findings from an audit of the Health Sector Project, including that the initial due diligence of the health center activity reflected visits to only 28 of the 150 facilities considered for support. After the compact started, MCA-Lesotho conducted a needs assessment of all 150 facilities under consideration, and modified the project plan based on the findings of that assessment. One of the changes made midcourse was to increase the number of large health centers to account for the Government of Lesotho's (GOL) introduction of free healthcare, and the potential it had to increase utilization rates of the health centers. These changes had an impact on the budget and timeline for the compact, as did other key planning and implementation decisions.
    - *Better planning can result in a more realistic budget.* The audit found that the budget for the health centers was too low. The original health project budget was $122m, while it actually cost nearly $230 to implement. Rather than reduce the project scope, the GOL contributed a significant amount of funding, with the largest increase going to the health centers.
    - *Better implementation can mitigate budget and timeline challenges.* The evaluator recommended flexibility in MCC's timelines for implementing compacts to avoid the need for works in Lesotho to extend so far beyond the Compact End Date. MCC's statute limits compacts to a maximum of five years so MCC does not have the authority to extending implementation timelines beyond five years. However, this project also demonstrates that MCC can use compact development, and even the immediate pre-entry into force (EIF) periods to do more comprehensive planning and provide a stronger foundation for implementation. For example, MCC and its country partners can (1) better plan for the impacts of known policy decisions (e.g., MCC and the GOL could have been more thoughtful *ahead of time* about where health center use was likely to increase in response to the introduction of free healthcare, rather than taking the time and budget to make this change after the five-year clock had begun); (2) use the pre-EIF

period to prepare for and possibly launch procurements, which would help maximize actual implementation time once the five-year clock starts; (3) award workloads to contractors that have the capacity to deliver rather than award large lots to unproven joint ventures as was done in Lesotho; (4) consolidate lots based on geographic location to reduce unnecessary logistical costs; (5) ensure sufficient resources for construction supervision considering the sheer volume of works being constructed simultaneously; (6) ensure MCAs have sufficient project management expertise given the complexity of this and lots of other MCC projects; and (7) create a staffing structure and management model that actively integrates the various disciplines needed to achieve joint outcomes, employs a reasonable distribution of labor, and ensure a sufficient number of staff to oversee implementation in the field. Improvements along these dimensions would have likely mitigated some of the severe budget and timeline challenges encountered here. MCC is attempting to address this lesson in secondary school construction in Côte d'Ivoire where, we've focused on implementing in just two regions and are doing the work in tranches. We plan to establish regional offices with sufficient staff resources to conduct frequent construction supervision. In addition, we are using a contracting mechanism that focuses on pre-qualified firms, which should speed up procurement timelines and provide flexibility in adjusting the work plan and awarding work packages.

- *End users need preparation to use and maintain new resources.* Many Lesotho outputs were delivered very late in the compact, and some were only completed post-compact. As a result of those delays and insufficient planning for handover and transition, end users were insufficiently prepared to use and maintain the compact investments. Better preparation in this regard is critical to sustainability.
    - *Maintenance planning needs to be explicit.* The evaluation reports that Lesotho does not have a culture of maintenance. When something is broken, decision makers acknowledge that it should be repaired but also consider it wasteful to invest resources and effort on what is essentially routine maintenance. However, such routine maintenance is the key to sustaining the kinds of investments made under the Lesotho Health Sector Project. Using the Lesotho Millennium Development Agency (LMDA), i.e., the successor entity to MCA-Lesotho, to maintain the health infrastructure has been challenging, particularly given the uncertainty of LMDA's funding for several years and tensions with the Ministry of Health. Furthermore, there could be a loss of efficiency if the entity prioritizing maintenance needs is not the same entity planning for and ensuring the provision of health service. Whatever the mechanism, compacts need to do maintenance and sustainability planning at the outset, including both how it will be funded and executed, and provide capacity building to develop an adequate maintenance strategy, if necessary. MCC is applying this lesson in the Morocco II Employability Project where a sub-Activity was included to develop, test, and begin to rollout a long-term school operations and maintenance policy.
    - *Given their unique conditions, utilities in small infrastructure and rural areas require careful design and sustainability planning.* Staff noted the shortcomings of water and electricity utilities at the health facilities and suggested ways of reinforcing the water supply and ensuring sufficient power for refrigerators and other electrical equipment. Aside from normal functioning, maintenance of the off-grid utility solutions is also considered problematic. In the future, MCC should look for ways to simplify utility solutions in locations beyond utility networks in order to minimize the need for specialized maintenance expertise.
    - *Data systems require more than hardware and software.* The evaluation reported that the Health Management Information System piloted under the compact had been

replaced by another system by the time of the evaluation. Similarly, the Electronic Record Management System that was expected to increase the efficiency of treatment in OPDs, was hardly used by staff and is also in the process of being replaced. It is clear now that the introduction of these kinds of investments require training, policy reform, and/or targeted behavior change to ensure that staff understand how their business practices must change—both in making inputs into the system, but also in using data outputs to help improve overall operations—in order to achieve adoption and reap the benefits of them. MCC is applying this lesson in the Côte d'Ivoire Education Project, where technical assistance is being provided for continuous performance improvement within the Ministry, to set performance targets, and to use the new data systems to be provided for decision-making.

- *Equipment purchases need to be well planned and procured.* The evaluation reported that furnishing and equipping in the health facilities were often of very low quality. It quoted a report by the independent engineer for this project that described broken and unusable goods at most sites. Future good procurements need to have much clearer minimum specifications that are developed based on adequate due diligence in order to ensure sufficient quality, i.e., we should be able to avoid another situation where delivery beds are too small or collapse in use. In addition, end users need to be trained on how to use and maintain the furniture and equipment, and have access to appropriate spare parts.
- *Reform interventions should target adoption and operationalization rather than just the introduction of policy reform.* The Health Systems Strengthening Activity fell short of expectations in a number of respects. It covered a large amount of small activities and contracts that all required close follow-up. Several aspects aimed to develop policies and guidelines or fund pilots; both required more implementation support in order to facilitate full adoption and systemic change, and not just result in the production of documents, policies, and procedures that were not implemented. MCC has been actively exploring how to do effective institutional reform and is considering Problem Driven Iterative Adaptation as a strategy in several programs. Another option might be to structure consultant contracts around a clear set of objectives, combined with a very detailed base period and less-detailed option periods that enable the contractors, MCAs, and MCC to learn from the base period how to best pursue the contractual objectives. The latter alternative was used in Georgia II for the TVET technical assistance contract.

EVALUATION LESSONS

- *Evaluations should be designed to assess the full program logic, not just those components that can be randomized.* The Health Sector Project originally had two separate evaluations planned: a randomized rollout of the health centers and a separate evaluation of the OPDs. This original design attempted to rigorously measure the impact of the health infrastructure on outcomes of interest. However, it neglected the rest of the project investments, which were arguably implemented to contribute to a joint set of health and productivity outcomes. A number of early compacts similarly focused evaluations on elements that lent themselves to randomization, and often neglected those elements that did not. When the health center randomization failed, the necessary redesign of that evaluation led MCC to hire an evaluator to evaluate the entire health project and its targeted outcomes together. The decision to expand the focus of the evaluation late in the implementation period reduced the evaluation options that were available, e.g., collecting baseline data on some indicators or practices of interest, but the broader view still offered important opportunities for learning and accountability about the full set of Health Sector Project investments. As documented in the Journal of Development Effectiveness in

2014, MCC broadened our focus beyond just impact evaluations many years ago, but is more recently considering the possible shortcomings of planning evaluations so late that potentially-attractive evaluation options are no longer feasible and how to balance that risk against the possibility of hiring evaluators too early. There might not be a one-size-fits-all solution to this challenge but MCC is committed to being intentional as we develop evaluations plans for all our investments and deciding the appropriate timeframe for procuring evaluation services.

- *Be cautious when pursuing pipeline randomization designs.* The Lesotho Compact attempted two pipeline randomizations where communities were randomly assigned to receive program interventions in early or late phases such that the evaluation could compare outcomes between the early and late groups to estimate program impacts. However, both programs suffered implementation delays that threatened the evaluations' internal validity and compromised their statistical power. Ultimately, the Rural Water evaluation was preserved, while the Health evaluation was not. Due to this failed evaluation, another independent evaluation had to be designed at a very late stage and evaluation design options were limited at that point. This challenge is not unique to Lesotho. Given MCC's five-year implementation timelines, the time taken to prepare for implementation, and the realities that often occur on the ground, completing one phase of implementation and ensuring a sufficient lag before the beginning of another phase, can be very difficult and should be considered carefully and commitment of relevant parties secured before investing significant resources in this type of design.
- *It is important to consider how an evaluation design could affect the project being evaluated.* In this case, some of the infrastructure lots may have been inefficiently packaged in order to facilitate the initial randomized rollout evaluation of the health centers, which made implementation more complicated and costly. However, given the experience MCC has amassed in implementing complex infrastructure projects, the agency is much better-placed to consider what kinds of construction packages and schedules can be accomplished in a five-year period, and whether it is possible to adjust them to facilitate a particular evaluation design. In addition, with the introduction of Evaluation Management Committees in 2013, MCC takes a more consultative approach to evaluation design and implementation, carefully considering the costs and benefits of various methodologies with key evaluation stakeholders, which should increase buy-in for selected designs and help mitigate implementation challenges.