EMERGENCY PROJECT PAPER

ON A

PROPOSED GRANT

IN THE AMOUNT OF US$16 MILLION

UNDER THE MULTI DONOR TRUST FUND FOR
KHYBER PAKHTUNKHWA AND FEDERALLY ADMINISTERED TRIBAL
AREAS AND BALOCHISTAN

TO THE

ISLAMIC REPUBLIC OF PAKISTAN

FOR A

REVITALIZING HEALTH SERVICES IN KHYBER PAKHTUNKHWA PROJECT

March 26, 2012

Human Development Unit
South Asia Region
CURRENCY EQUIVALENTS  
(Exchange Rate Effective September 30, 2011)  
Currency Unit = Pakistan Rupees  
PKR 87.39 = US$1  

FISCAL YEAR  
July 1 – June 30  

ABBREVIATIONS AND ACRONYMS

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADB</td>
<td>Asian Development Bank</td>
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<tr>
<td>ADP</td>
<td>Annual Development Plan</td>
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<td>AJK</td>
<td>Azad Jammu Kashmir</td>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>BHU</td>
<td>Basic Health Unit</td>
</tr>
<tr>
<td>CPS</td>
<td>Country Partnership Strategy</td>
</tr>
<tr>
<td>CQS</td>
<td>Selection based on Consultants Qualifications</td>
</tr>
<tr>
<td>DA</td>
<td>Designated Accounts</td>
</tr>
<tr>
<td>DCO</td>
<td>District Coordination Officer</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>DHIS</td>
<td>District Health Information System</td>
</tr>
<tr>
<td>DHO</td>
<td>District Health Office</td>
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<tr>
<td>DHQ</td>
<td>District Headquarter Hospital</td>
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<tr>
<td>DNA</td>
<td>Damage Needs Assessment</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DOTS</td>
<td>Directly Observed Treatment Strategy</td>
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<tr>
<td>EDOH</td>
<td>Executive District Officer, Health</td>
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<tr>
<td>EPA</td>
<td>Environment Protection Agency</td>
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<tr>
<td>ESMP</td>
<td>Environmental and Social Management Plan</td>
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<tr>
<td>ESSAF</td>
<td>Environmental and Social Screening Assessment Framework</td>
</tr>
<tr>
<td>FATA</td>
<td>Federally Administered Tribal Area</td>
</tr>
<tr>
<td>FBS</td>
<td>Fixed Budget Selection</td>
</tr>
<tr>
<td>FM</td>
<td>Financial Management</td>
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<tr>
<td>FMIS</td>
<td>Financial Management Information System</td>
</tr>
<tr>
<td>GoKP</td>
<td>Government of Khyber Pakhtunkhwa</td>
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<tr>
<td>GoP</td>
<td>Government of Pakistan</td>
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<tr>
<td>HSRU</td>
<td>Health Sector Reform Unit</td>
</tr>
<tr>
<td>IBRD</td>
<td>International Bank for Reconstruction and Development</td>
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<td>ICM</td>
<td>Implementation Completion Memorandum</td>
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<tr>
<td>ICB</td>
<td>International Competitive Bidding</td>
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<td>IDA</td>
<td>International Development Association</td>
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<tr>
<td>IFR</td>
<td>Interim Financial Reports</td>
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<td>IDP</td>
<td>Internally Displaced Persons</td>
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<tr>
<td>IPSAS</td>
<td>International Public Sector Accounting Standards</td>
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<td>ISU</td>
<td>Implementation Support Unit</td>
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<tr>
<td>JSDF</td>
<td>Japan Social Development Fund</td>
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<tr>
<td>KP</td>
<td>Khyber Pakhtunkhwa Province</td>
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<tr>
<td>LCS</td>
<td>Least Cost Selection LHW Lady Health Workers</td>
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<tr>
<td>LIB</td>
<td>Limited International Bidding</td>
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<tr>
<td>MC</td>
<td>Management Contract</td>
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<td>MDTF</td>
<td>Multi Donor Trust Fund</td>
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<tr>
<td>MIS</td>
<td>Management Information System</td>
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<tr>
<td>MNCH</td>
<td>Maternal, newborn, and child health</td>
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<tr>
<td>MoU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>MTBF</td>
<td>Medium Term Budgetary Framework</td>
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<tr>
<td>MU</td>
<td>Management Unit</td>
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<td>NADRA</td>
<td>National Database Registration Authority</td>
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<tr>
<td>NCB</td>
<td>National Competitive Bidding</td>
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<td>NDMA</td>
<td>National Disaster Management Authority</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<tr>
<td>ORAF</td>
<td>Operational Risk Assessment Framework</td>
</tr>
<tr>
<td>PEFA</td>
<td>Public Expenditure and Financial Accountability</td>
</tr>
<tr>
<td>PCNA</td>
<td>Post Crisis Needs Assessment</td>
</tr>
<tr>
<td>PDMA</td>
<td>Provincial Disaster Management Authority</td>
</tr>
<tr>
<td>PDO</td>
<td>Project Development Objectives</td>
</tr>
<tr>
<td>PFMAA</td>
<td>Public Financial Management and Accountability Assessments</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PIFRA</td>
<td>Project for Improvement of Financial Reporting and Auditing</td>
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<tr>
<td>PKR</td>
<td>Pakistan Rupee</td>
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<tr>
<td>QBS</td>
<td>Quality Based Selection</td>
</tr>
<tr>
<td>QCBS</td>
<td>Quality and Cost Based Selection</td>
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<tr>
<td>RHC</td>
<td>Rural Health Center</td>
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<td>SOP</td>
<td>Standard Operating Procedures</td>
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<tr>
<td>SSS</td>
<td>Single Source Selection</td>
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<tr>
<td>TA</td>
<td>Technical Assistance</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>WB</td>
<td>World Bank</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
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Vice President: Isabel M. Guerrero  
Country Director: Rachid Benmessoud  
Sector Director: Michal Rutkowski  
Sector Manager: Julie McLaughlin  
Task Team Leader: Tayyeb Masud
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PAKISTAN

REVITALIZING HEALTH SERVICES IN KHYBER PAKHTUNKHWA PROJECT

PROJECT PAPER

SOUTH ASIA
SASHN

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<tr>
<td>Country Director: Rachid Benmessaoud</td>
</tr>
<tr>
<td>Sector Manager/Director: Julie McLaughlin /Michał Rutkowski</td>
</tr>
<tr>
<td>Team Leader: Tayyeb Masud</td>
</tr>
<tr>
<td>Project ID: P126426</td>
</tr>
<tr>
<td>Expected Effectiveness Date: November 1, 2011</td>
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<td>Expected Closing Date: June 30, 2015</td>
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<tr>
<th>Project Financing Data</th>
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<tr>
<td>Source</td>
</tr>
<tr>
<td>Total Project Cost:</td>
</tr>
<tr>
<td>Total Bank Financing:</td>
</tr>
<tr>
<td>Multi-Donor Trust Fund</td>
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<tr>
<td>Borrower: Parallel Financing</td>
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<tr>
<td>Regular health budget</td>
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<tr>
<th>Financing Plan (US$m)</th>
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<tbody>
<tr>
<td>Source</td>
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<tr>
<td>Total Project Cost:</td>
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<tr>
<td>Total Bank Financing:</td>
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<tr>
<td>Multi-Donor Trust Fund</td>
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<table>
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<th>Client Information</th>
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<tbody>
<tr>
<td>Recipient: Government of Pakistan</td>
</tr>
<tr>
<td>Responsible Agency:</td>
</tr>
<tr>
<td>Health Sector Reform Unit (HSRU), Department of Health, Government of Khyber Pakhtunkhwa (KP)</td>
</tr>
<tr>
<td>KP Secretariat, Khyber Road</td>
</tr>
<tr>
<td>Peshawar, Pakistan</td>
</tr>
<tr>
<td>Tel: (+92-91) 9210878</td>
</tr>
<tr>
<td>Contact: Dr. Shabina Raza, Chief, HSRU (<a href="mailto:shabina.raza@gmail.com">shabina.raza@gmail.com</a>)</td>
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<th>Estimated disbursements (Bank FY/US$m)</th>
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<td>FY</td>
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<td>Cumulative</td>
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<tr>
<th>Project Development Objective and Description</th>
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<tr>
<td><strong>Project development objective</strong>: The project development objective (PDO) is to improve the availability, accessibility and delivery of primary and secondary healthcare services at the district level.</td>
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</tbody>
</table>
Project description: The project will be implemented in six crisis (militancy & floods) affected districts of Khyber Pakhtunkhwa Province (KP) for a period of three years. The project has three major components:

Component 1: Revitalizing health care services. (MDTF US$ 11.0 mil & GoKP US$ 45.0 mil) The primary health care centers will be reorganized into hubs and support will be provided to enable delivery of a comprehensive package of health care services. From the first year, management of all facilities in the hubs will be outsourced to a private firm/non-governmental organization (NGO), through a competitive process. The component will finance the contract. The selected firm/organization will be responsible for a comprehensive package of care to the communities through application of the hub approach. The secondary (District Head Quarter: DHQ) hospitals in the project districts will also be improved.

Component 2: Rehabilitation of Health Infrastructure in the Districts. (MDTF US$ 1.0 mil) Some health facilities damaged during the crisis will be rehabilitated to enable service delivery. No new facilities will be constructed and only existing infrastructure will be rehabilitated. The list of facilities will be finalized based on the resources available.

Component 3: Establish and operationalise a robust monitoring and evaluation system at district and provincial level. (MDTF US$ 4.0 mil) The component will support operationalizing the monitoring and evaluation systems to guide project implementation at the district level and dissemination of the results through province wide analysis. It will also support operationalization of District Health Information System (DHIS), and periodic third-party evaluation of the project in the selected districts including, baseline and endline surveys to assess results.

Safeguard and Exception to Policies

<table>
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<tr>
<th>Safeguard policies triggered:</th>
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<tbody>
<tr>
<td>Environmental Assessment (OP/BP 4.01)</td>
<td>[X]Yes [ ] No</td>
</tr>
<tr>
<td>Natural Habitats (OP/BP 4.04)</td>
<td>[ ]Yes [X] No</td>
</tr>
<tr>
<td>Forests (OP/BP 4.36)</td>
<td>[ ]Yes [X] No</td>
</tr>
<tr>
<td>Pest Management (OP 4.09)</td>
<td>[ ]Yes [X] No</td>
</tr>
<tr>
<td>Physical Cultural Resources (OP/BP 4.11)</td>
<td>[ ]Yes [X] No</td>
</tr>
<tr>
<td>Indigenous Peoples (OP/BP 4.10)</td>
<td>[ ]Yes [X] No</td>
</tr>
<tr>
<td>Involuntary Resettlement (OP/BP 4.12)</td>
<td>[ ]Yes [X] No</td>
</tr>
<tr>
<td>Safety of Dams (OP/BP 4.37)</td>
<td>[ ]Yes [X] No</td>
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<td>Projects on International Waters (OP/BP 7.50)</td>
<td>[ ]Yes [X] No</td>
</tr>
<tr>
<td>Projects in Disputed Areas (OP/BP 7.60)</td>
<td>[ ]Yes [X] No</td>
</tr>
</tbody>
</table>

Does the project require any exceptions from Bank policies? (OP 12.0)

[ ]Yes [X] No

Have these been approved by Bank management?

[ ]Yes [X] No

Conditions and Legal Covenants:

<table>
<thead>
<tr>
<th>Reference</th>
<th>Description of Condition/Covenant</th>
<th>Date Due</th>
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<tbody>
<tr>
<td>GA Schedule 2, Section IV.B.1(b)&amp;(c) &amp; PA Schedule, Section I.B.1&amp;2</td>
<td>The DoH shall prepare and adopted a Project Operations Manual satisfactory to the Bank.</td>
<td>Condition of disbursement for Category (1) and (2)</td>
</tr>
<tr>
<td>Schedule/Section</td>
<td>Condition of disbursement for Category (1) and (2)</td>
<td>Condition of disbursement for Category (2)</td>
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<tr>
<td>GA Schedule 2, Section IV.B.1(b) &amp; (c)</td>
<td>The DoH shall recruit and maintain a qualified financial management specialist and a procurement specialist.</td>
<td>45 days after the signing (Effective Date) of the Grant Agreement (thereafter recurrent)</td>
</tr>
<tr>
<td>GA Schedule 2, Section IV.B.1(c) &amp; PA Schedule Section I.E.1 &amp; 2</td>
<td>The DoH shall prepare a project-specific ESMP, in accordance with the ESSAF requirements; and hire a construction engineer to assist the HSRU in implementing the project</td>
<td>One month after effective date (thereafter recurrent)</td>
</tr>
<tr>
<td>PA Schedule Section I.C</td>
<td>The DoH shall establish and maintain a Grievance Redressal Mechanism satisfactory to the Bank in all Project districts.</td>
<td>One month after effective date (thereafter recurrent)</td>
</tr>
<tr>
<td>PA Schedule Section I.A.1(a)</td>
<td>The DoH shall establish and maintain a Project Steering Committee with participation of representatives of the selected districts.</td>
<td>Recurrent</td>
</tr>
<tr>
<td>PA Schedule Section I.A.1(b)</td>
<td>The DoH shall maintain the HSRU for the daily management and coordination of the Project</td>
<td>Recurrent</td>
</tr>
<tr>
<td>PA Schedule Section I.A.1(d)</td>
<td>The DoH shall maintain Executive District Officers (Health) in each Selected District to oversee contractors, monitor progress of civil works, and serve as the second tier decision maker under the Grievance Mechanism.</td>
<td>Three months after the effective date (thereafter recurrent)</td>
</tr>
<tr>
<td>PA Schedule Section I.A.3</td>
<td>The DoH shall hire and maintain monitoring and evaluation experts to establish data-base at district level, carry out validation activities and baseline, mid-term and end-line surveys.</td>
<td>One month after the effective date (thereafter recurrent)</td>
</tr>
<tr>
<td>PA Schedule Section I.A.1(c)</td>
<td>DoH shall establish, operationalize and maintain, in each selected district, a District Health Management Team (DHMT), responsible for reviewing, monitoring and evaluating project implementation at district level.</td>
<td></td>
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<tr>
<td>PA Schedule Section</td>
<td>Description</td>
<td>Frequency</td>
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<tr>
<td>I.B.4</td>
<td>The DoH shall undertake to regularly allocate and promptly transfer (as a lump sum and a single line item) to the contractors selected for the outsourced management of the health facilities, the necessary funds for operation and maintenance of the respective health facilities and the payments of staff salaries for the following quarter, as well as the full authority for any reallocations required.</td>
<td>Recurrent (30 days after the beginning of each calendar quarter, commencing in the first quarter of FY2012/13)</td>
</tr>
<tr>
<td>I.B.3</td>
<td>The DoH shall prepare annual work plans each year and implement the Project accordingly</td>
<td>Recurrent (by August 15 of each year)</td>
</tr>
<tr>
<td>I.E.3</td>
<td>No land taking shall be carried out under the Project. Any purchase of land shall be done on a willing buyer- willing seller basis. The Grant shall not be utilized for any such purchase.</td>
<td>Recurrent</td>
</tr>
<tr>
<td>I.E.4</td>
<td>DoH shall ensure that the contractors awarded management responsibilities over health facilities comply with the Standard Operating Procedures for the Handling and Disposal for Medical Wastes to be included in the Operations Manual</td>
<td>Recurrent</td>
</tr>
<tr>
<td>I.E.5</td>
<td>DoH shall vest the Executive District Officers (Health) with powers and responsibilities to ensure the contractors’ compliance with the ESMP and the MDTF-ESSAF, and other obligations under their respective contracts</td>
<td>Recurrent</td>
</tr>
<tr>
<td>II.B.4</td>
<td>The DoH, in coordination with PIFRA Directorate, shall prepare and implement an action plan for the incorporation of the project accounts to the financial accounting and budgeting systems established under the PIFRA Project.</td>
<td>Six month after effective date (thereafter recurrent)</td>
</tr>
<tr>
<td>PA Schedule Section III.2</td>
<td>DoH to establish and maintain, a fully operational procurement documentation and record keeping systems and a system for the handling of procurement complaints, satisfactory to the Bank</td>
<td>By 45 days after the Effective Date (thereafter recurrent)</td>
</tr>
</tbody>
</table>
A. Introduction

1. This Project Paper seeks the approval of the Regional Vice President to provide a grant from the Multi Donor Trust Fund (MDTF) for Khyber Pakhtunkhwa and Balochistan in an amount of US$16 million to Pakistan for Revitalizing Health Services in Khyber Pakhtunkhwa (KP) Project, in accordance with the Rapid Response to Crises and Emergency (OP/BP 8.00).

2. The proposed Grant would help finance the costs associated with strengthening the health services affected by the crisis and militancy in KP, and provide the population in the affected districts with improved access to health care services. The proposed support will help respond to the situation by improving management as well as availability of services at the primary care level, and improving the functionality of secondary care hospitals to provide referral services through contracting out management of the primary health care system. The project will be implemented in six crisis affected districts of KP for a period of three years. It is expected that by the end of the project there would be: a) increased utilization and coverage of primary and secondary health care services in the districts; b) adequately equipped and functional health infrastructure; c) improved supervision and timely utilization of allocated resources through key management decisions based on evidence; and d) increased community satisfaction with publicly provided health services.

3. The Government of KP has recently finalized its Comprehensive Development Strategy (CDS) based on which a health sector strategy has been prepared. The project as envisaged is part of a larger engagement with the health department in KP based on the sector strategy and in line with the principles of the International Health Partnership, to which Pakistan is a signatory. The project is designed to support the implementation of the strategy by the Department of Health (DoH), the Government of KP (GoKP), through strengthening the required aspects of provincial level functions of governance, monitoring and evaluation and planning. It is part of a continuing dialogue with the department to enable transition of health functions to the provincial level in line with the 18th constitutional amendment.

4. Partnership arrangements: The project currently does not have any bilateral or multilateral partners directly involved, although the Government of KP is seeking support from other partners, which could materialize during project implementation. The project could develop partnerships during implementation with: a) USAID support (US$7.8 million) focused on reconstruction in Malakand Division; b) proposed social protection (health micro insurance) project for three districts with KfW (€10mil); c) results based management project for district health systems with DFID and d) broader nutrition engagement through AusAID.


5. During the past few years Pakistan is facing an emergency of historic proportions, caused by the still ongoing militancy crisis in KP and the Federally Administered Tribal Areas (FATA), compounded by an earthquake, and floods. These regions of Pakistan have historically held strategic importance as the gateway between Central Asia, the Middle East and the vast plains of the South Asian subcontinent. During the last two hundred years of colonialism, the region became a buffer zone in the struggle between global powers in Central Asia to the north and...
those in the sub-continent to the south and was, as a result, further isolated, thereby remaining severely under-developed. When the war in Afghanistan intensified, militants were pushed into this region of Pakistan and attempted to establish themselves as a local power in collaboration with indigenous partners. Over time, militant groups pushed further east across the settled districts of KP into Swat. In early 2009, the GoP launched major military operations in KP Province and FATA to root out the local pockets of militants. Starting from the valley of Swat, bordering the tribal areas, the Government’s military operations have gradually moved westward. The offensive led to significant damage to physical infrastructure and services while creating a large number of internally displaced persons (IDPs). In 2009, approximately three million people were displaced in KP and FATA. About seven percent of displaced families moved to camps, the rest occupied schools, public buildings or moved in with host families mostly in Swabi and Mardan districts of KP. The militancy crisis affected not only the IDPs but also those who stayed behind, some of whom being just as poor and vulnerable as the IDPs. The recent floods resulted in further enormous destruction, large scale internal migration/displacement, and massive loss of livelihoods. After successful completion of military operations, large parts of FATA and KP still await the return of any major economic activity.

6. **Sectoral Context:** Health indicators for Khyber Pakhtunkhwa have been improving but remain poor in comparison to countries in the region. The intra-provincial inequities in service provision and the resulting health status are of concern. Health facilities in Khyber Pakhtunkhwa suffer from lack of equipment, medicines and other essential supplies. The frequent and continuous emergencies / crises faced by the province have had a severe impact on health care provision. Militants have attacked facilities, carried out vandalism (theft of expensive equipment), coercions, killings and kidnappings of health personnel. Provision of health services is also hampered by lack of qualified personnel, vacant posts and high levels of absenteeism. The population of the province is not satisfied with the quality of health services delivered in the public sector institutions. Only eight percent of parents of children with diarrhea preferred visiting public sector first level care facilities (basic health units and rural health centers) as against 64 percent of parents visiting private practitioners (Pakistan Social & Living Standards Measurement Survey 2007-08).

7. **Government Response:** The GoP has undertaken various assessments for defining strategic needs and investment in short, medium to long-term for the region. A Damage and Needs Assessment (DNA) was completed in 2009 with Asian Development Bank (ADB) and World Bank (WB) support covering the areas first affected by the GOP's action to combat the militants and a subsequent Post Crisis Needs Assessment (PCNA) was completed in October 2010 with the assistance of ADB, European Union (EU), United Nations (UN) and WB. The PCNA assessed and quantified the short and medium-term social and economic needs of the region.

8. The PCNA provides the underpinning for long term peace building in KP, FATA and Balochistan. Drawing on extensive stakeholder consultations, the report identifies key crisis drivers and the consequent priority areas that need to be addressed to support a coherent and durable peace-building strategy. The key strategic objectives to achieve this are: (i) enhance

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1 Based on the household survey data analysis reported by ‘Food Security and Market Assessment in Crisis Affected Areas of KP and FATA’, World Food Program, 2010
responsiveness and effectiveness of state to restore citizen trust; (ii) stimulate employment and livelihood opportunities; (iii) ensure provision of basic services; (iv) counter-radicalization and reconciliation.

9. The PCNA has recommended the establishment of a PCNA Federal Steering Committee with the Prime Minister as the Chair. The PCNA assessment itself was completed through an institutional structure led by the Strategic Oversight Council (SOC) chaired by the Prime Minister.

10. The Government of Pakistan’s (GoP) Special Support Group (SSG) and the National Database and Registration Authority (NADRA) had registered and verified nearly 383,000 internally displaced families after the post-conflict crisis in Malakand Division in September 2009. Department of Health’s (DoH) emergency response has been in the forefront to contain the health impact of these crisis and address the needs of IDPs (Internally Displaced Persons) in collaboration with UN organizations, national and international NGOs through camps in Swabi, Mardan, Peshawar and Nowshera to provide them shelter, food and health services. Many of these families were accommodated by host communities, for which special arrangements were made by DoH to keep the health facilities functional in the evening to provide them health services. Post conflict disruption in the delivery of healthcare services in many districts of KP demands immediate revitalization and strengthening of these services at the district level. Based on the successful experience of revitalizing and improving healthcare services under a public-private-partnership model in Batagram, an enhanced version of the Batagram model will be replicated in selected crisis affected districts of the province through this project.

11. **Project Focus and Integration in the government response:** The project addresses some key priorities of the government in the health sector related to service provision, infrastructure and monitoring and evaluation capacity. The project will intervene in three areas: a) out-sourcing of management of health services to a third party; to provide flexibility in management and linking of service delivery to outputs/results, to ensure provision of comprehensive package of PHC and secondary care services besides supplementing the low levels of non salary budgets provided to the districts; b) rehabilitation to some facilities damaged by the crises to enable service delivery; and c) the strengthening of management systems with an emphasis on monitoring and evaluation in the affected districts.

12. To improve service delivery the health department is implementing the following: currently 13 districts in the province are contracted to the Peoples Primary Health Care Initiative (PPHI) in which the management of Basic Health Units has been outsourced with full autonomy on financial matters and authority to recruit against vacant positions. The department has also successfully completed a management outsourcing project in Batagram district with Bank support. However both projects focused on management of the health facilities and availability of services without ensuring a comprehensive package of health care services to the population. This project takes this experience a step further. It will contract delivery of a comprehensive health care package for the district population, with the contractor being given flexibility in management of health facilities both in terms of staffing and logistics to ensure optimum coverage of the population including administrative control of the community based and outreach programs, e.g. Lady Health Workers (LHWs), Malaria, Expanded Program on
Immunization (EPI), Tuberculosis “Directly Observed Treatment Short course (TB-DOTS)”, which was not part of the Batagram initiative (Box 1.1).

13. At present the rehabilitation of health facilities in Malakand division is being supported by a USAID grant. There are some resources allocated in the Annual Development Plan (ADP) for reconstruction. The Government of KP, at present, is not able to support all the rehabilitation effort from the development budget.

14. The monitoring and evaluation capacity of the department of health both at the provincial and district levels has been a long standing weakness in the health systems and requires strengthening. The post devolution role of the department of health as the overseer and guarantor of health services to the population needs to be institutionalized by building capacity at the provincial level and District Health Offices to closely supervise and monitor the performance of health services.

C. Bank Response: The Project

15. In order to respond to the KP-FATA 2009 DNA, and subsequent PCNA 2010 Report, the Bank has established, with support from a variety of development partners, the MDTF for the crisis affected areas of KP, FATA and Balochistan. The MDTF is supporting the implementation of a program for reconstruction and development aimed at facilitating rapid recovery from the impact of the armed conflict and reducing the potential for escalation or resumption. The MDTF is mobilizing donor support to finance critical investments in support of reconstruction and peace building in

Box 1.1: Innovation from the Batagram model - The Hub Approach

A massive earthquake struck the northern areas of Pakistan in October 2005, causing loss of many lives and extensive damage to infrastructure. In KP province, five districts, namely, Abbottabad, Batagram, Mansehra, Shangla, and Kohistan were severely affected. The Department of Health with the World Bank assistance through the Japan Social Development Fund has collaborated with Save the Children, an international NGO, on a public-private partnership project entitled “Revitalizing and Improving Primary Healthcare Services”. The project contracted out management of primary healthcare (PHC) services to the NGO with full administrative and financial powers. Innovative measures such as “the Hub Approach” for service provision and “performance based incentive” were distinct hallmarks of the project resulting in positive outcomes. The findings of an independent evaluation of the project indicate: i) a four-fold increase in health facility utilization, ii) improvement in core indicators – child immunization increased from 10 percent to 76 percent, ANC visits from 33 percent to 63 percent, and hospital based delivery from 33 percent to 50 percent (Apex Consulting, June 2010).

The core of “the Hub Approach” is to make Rural Health Center (RHC) or above level to function as a hub for 8-10 Basic Health Units (BHUs), provides 24/7 emergency obstetric and neonatal care with a functional ambulance and resident male and female staff, and devolves financial and administrative powers to RHC/Hub manager. At hubs, all the staff is resident and is provided with accommodation and some indoor recreational facilities. All the hub centers are equipped with an ambulance for patients requiring referral to a secondary or tertiary level facility. In addition, medicines and equipment are supplied to the attached BHUs from the hub center.

Save the Children supported the rapid re-establishment of three RHCs and 26 BHUs in Batagram district in collaboration with the District Government with the purpose to improve the coverage and utilization of PHC services ensuring quality of care, equity of access, community satisfaction, and facilitation of existing health workers in the public sector. The Project implemented a service package including maternal and child immunizations, antenatal, natal, and postnatal care, family planning services, diagnosis and treatment of major infectious diseases like TB, basic curative services, nutritional support such as improvement of micronutrient deficiencies, promotion of breast feeding, and participation in special health activities such as national immunization days.
crisis affected areas. To date ten donors have contributed a total of US$140.0 million for the MDTF (Australia, Denmark, European Union, Finland, Germany, Italy, Sweden, Turkey, UK, and USA). The MDTF provides flexibility to finance stand-alone projects or program activities, including those co-financed by the government, bilateral or multilateral agencies.

16. There are four MDTF financing strategy pillars:

Pillar 1. Restoring Damaged Infrastructure and Disrupted Services
Pillar 2. Improving Governance and Service Delivery
Pillar 3. Supporting Livelihood and Creating Employment Opportunities
Pillar 4. Building Capacity and Institutional Strengthening

17. The proposed US$16.0 million ‘Revitalizing Health Services in KP project’ is supporting Pillar 1, 2 & 4 of the MDTF strategy directly, and will finance the improvements in health service availability in six districts of KP through rehabilitation of health facilities, outsourcing of management of health facilities and strengthening management of health systems at the provincial and district levels. The project is designed as a pilot, which brings previous JSDF experience to some scale in six districts. However, if the project is successful and more funds become available, further scale-up will be considered.

18. The project envisages transfer of the district health budget as a single line item to the contractor to provide fiscal space for the contractor to manage the logistics and support staffing issues within the district through reallocation of budget under different heads/ expenditure lines. The total allocation for last year to these districts excluding the national and provincial preventive care programs was approximately US$15 million out of which 85 percent was allocated for salary. The project will add to the non salary component of the districts taking it up to 30 percent of salary budget and would thus enable effective provision of quality services.

**Project Development Objectives**

19. The development objective of the proposed three year project is to improve the availability, accessibility and delivery of primary and secondary healthcare services at the district level. It is expected that by the end of the project the following key results will be achieved: a) increased utilization and coverage of primary and secondary health care services in the districts; b) adequately equipped and functional health infrastructure; c) improved supervision and timely utilization of allocated resources through key management decisions based on evidence; and d) increased community satisfaction with publicly provided health services. The project is the stepping stone to improving the capacity of health systems in KP to deliver relevant services to the population in a phased manner by rolling out interventions and testing their efficacy on a larger scale before scaling up to the whole province. It also provides the necessary ingredients for a sectoral reform program with the GoKP in the leadership role. The project as designed is modular in nature; the types of facilities within the districts can be increased once the management outsourcing exhibits positive results. The number of districts can be increased as funding becomes available.

20. **Key performance indicators.** The indicators include: i) People with access to a defined basic package of health, nutrition, and reproductive health services; ii) Births (deliveries)
attended by skilled health personnel; iii) Contraceptive prevalence rate for any modern methods; iv) Percent of children with severe acute malnutrition provided adequate nutrition services; and v) Community satisfaction with health care services delivery by public sector.

21. The Project has three components:

A. Component 1: Revitalizing health care services. (US$11.0 million). The primary health care centers will be reorganized into hubs and support will be provided to enable delivery of a comprehensive package of health care services. From the first year, management of all the facilities in the hubs will be outsourced to private firms/non government organizations, through a competitive process. The component will finance the contract. The selected firms/organizations will be responsible for a comprehensive package of care to the communities through application of the hub approach. The secondary care DHQ hospitals in the project districts will be improved to enable optimal functioning as referral level hospitals. Support to the DHQ Hospital in District will also be part of the management contract. In the first year, management of DHQ Hospital Buner will be contracted out and based on evaluation other DHQs may follow. The GoKP will supply the regular budget of US$45 million in parallel to the districts for recurrent cost of the health facilities.

B. Component 2: Rehabilitation of Health Infrastructure (US$1.0 million) in the Districts. Some of the health facilities damaged during the crisis will be rehabilitated to enable service delivery. No new infrastructure will be constructed under the project, and only rehabilitation to existing infrastructure will be carried out. The list of works will be finalized based on the resources available. Parallel to the project, the GoKP is already financing rehabilitation of some health facilities through its development budget by the Communication and Works department.

C. Component 3: Establish and operationalise a robust monitoring and evaluation system at the district and provincial levels (US$4.0 million). The component will strengthen and operationalize monitoring and evaluation systems to guide project implementation at the district level and dissemination of the results through province wide analysis. It will also support capacity-building and operationalization of a District Health Information System (DHIS), and periodic third-party evaluation of the project in the selected districts including, baseline and endline surveys to assess results.

Eligibility for Processing under OP/BP 8.00

22. The project is in line with the guiding principles under the Bank’s operational policy/business process OP/BP 8.00, namely, speed, simplicity, and flexibility, and addresses adverse economic impact on KP resulting from the crisis. The project is adapted to the emergency's particular circumstances and takes into account the Bank’s assistance strategy for the country, which highlights under Pillar 2 “accelerating delivery of human development and social protection services”. All projects financed by the MDTF shall be processed under OP/BP 8.00 as the Trust fund is established in response to the crisis.
**Consistency with Country Partnership Strategy**

23. The proposed project is consistent with Pakistan’s Country Partnership Strategy (CPS) for FY 10-13 which recognizes the need to enhance delivery of health, nutrition and population services under Pillar 2 “accelerating delivery of human development and social protection services”. The project is consistent with the focus of the CPS in the health sector for Pakistan, i.e.: (i) better governance and management of delivery of basic health services; (ii) coverage and quality of essential health services, especially in disadvantaged areas; and (iii) developing service delivery models which will help the country to sustain service delivery levels when these systems come under duress due to natural and man-made disasters, by providing support for emergency services both at community and facility level.

**Consistency with Multi Donor Trust Fund (MDTF)**

24. In alignment with the MDTF objective, the project will focus on the guidance in the PCNA regarding the challenge of post crisis reconstruction to cope with the longer-term issues of capacity building and governance. The project focuses on provision of basic services to the population in the crisis affected districts, building the capacity of the health system for management, including monitoring, supervision and contracting, and supports rehabilitation of affected health infrastructure in the districts. The project inputs are sustainable in the long run as the GoKP is already actively pursuing contracting out service provision in the province. The project takes the concept a step further to ensure delivery of a basic minimum package of services as defined in the draft Minimum Health Services Delivery Package for Primary Health Care Facilities document and the Primary Care Standards Manual. The design and execution of the project is government owned and allows the department to take the concept of holistic service delivery to the next level through engaging partners for implementation. The geographical scope of the project may be expanded if early results show success and if more funding becomes available.

**D. Appraisal of Project Activities**

**Financial Arrangements**

25. An assessment of the Financial Management (FM) arrangements has been carried out for the project. A segregated designated account (DA) will be established for the HSRU. Government procedures will apply for budgeting. Disbursements will follow the ‘report-based’ principle whereby funds will be front-loaded to the DAs based on cash forecasts for the following two quarters provided in Interim Un-audited Financial Reports. Comprehensive project financial statements shall be prepared using Cash Basis IPSAS including details of expenditures by components and activities. These will be audited by the Auditor General of Pakistan and must be submitted to the Bank no later than 6 months after the year-end.

26. A Financial Management Specialist and an Internal Auditor will be recruited for the HSRU Management Unit (MU) to specifically work on this project with terms of reference agreed with the Bank. Financial Management Manual (FMM) will be prepared for the project. FMM will embody a strong internal control framework. Internal Audit of the project will be carried out annually and reports will be discussed in the steering committee. The Firm/ NGO
hired to manage health facilities and services under Component 1 of the project shall also maintain a financial management system in accordance with acceptable standards. Internal Auditor of HSRU will carry out periodic financial management review of the Firm/ NGO and AGP shall have the right to audit accounts of the Firm/ NGO related to government budget.

27. Based on the implementation of the proposed actions, the FM arrangements, as designed and proposed are considered adequate and there will be reasonable assurance that funds are used for intended purposes with economy and efficiency, and that the requirements of OP 10.02 will be met. The implementing entities will ensure that the Bank’s guidelines on Preventing and Combating Fraud and Corruption in Bank Financed Projects are followed in the project.

**Procurement arrangements**

28. The procurement arrangements for the project have been agreed upon. Major procurements shall be procurement of consultancy services, goods and some civil works. The World Bank’s procurement procedures shall be applicable to all procurement processes. HSRU shall hire a procurement focal point preferably with engineering background, who shall be responsible for handling all the procurement actions, and contract management of civil works as well as consultancy contracts. All contracts shall be awarded by HSRU. The detailed procurement plan is being prepared by HSRU. As soon as the procurement staff is hired, the Bank shall conduct a procurement training session.

**Safeguards**

*Environmental Safeguards*

29. The rehabilitation of the health infrastructure proposed under component 2 of the project may potentially cause negative environmental impacts, such as soil erosion, water and soil contamination, air quality deterioration, and safety hazards for workers and surrounding population. Similarly, inappropriately disposed medical wastes from the health facilities could pose a health hazard for the nearby population. However, none of these impacts are likely to be irreversible, wide-spread, or unprecedented, and can be addressed with the help of appropriately designed and effectively implemented mitigation plan. Therefore, the proposed project has been classified as Environment Category B, in accordance with OP 4.01. No other environmental operational policy is triggered.

30. To address the potentially negative environmental and/or social impacts associated with the projects under MDTF, the Bank has prepared an Environmental and Social Screening and Assessment Framework (ESSAF), in accordance with the OP 8.00 for emergency operations. Since the Revitalizing Health Services Project is being proposed under MDTF, ESSAF is applicable to this project also. The ESSAF specifies the environmental and social assessment requirements the implementing agency will need to fulfill before initiating the works under any Project under the MDTF can be implemented. The Framework also describes the generic environmental/social monitoring and reporting requirements to be fulfilled during the Project implementation, in addition to defining the broad institutional arrangements required for environmental and social safeguard aspects associated with the individual projects under the
MDTF. The ESSAF has been shared with the Department of Health, GoKP. It has been disclosed locally by the Department, and also at the InfoShop.

31. In accordance with ESSAF requirements, the GoKP will prepare a project-specific Environmental and Social Management Plan (ESMP). GoKP will hire key safeguards staff as soon as ESMP is finalized. Meanwhile, the Project Director will be responsible for all environment and social aspects of the project intervention, including ensuring compliance of the civil works. The ESMP will identify the negative environmental impacts that are likely to be caused by the project during its various phases, and also proposes mitigation measures to address these impacts, including the safe disposal of medical wastes generated by the health facilities. The ESMP will also propose the institutional arrangements to manage the environmental aspects of the project, identify environmental monitoring requirements to ensure the effective implementation of the mitigation measures, describe the environmental training needs, and will also specify the reporting and documentation requirements. The ESMP will also propose appropriate contract clauses and control measures for hospital waste management of the health facilities to be out-sourced under the project component 1, and monitoring arrangements for hospital waste management to be included in component 3 of the project. Site specific ESMP will be developed by the client and clearance will be obtained from the Bank, before the physical works under the project can be commenced. The ESMP will also be disclosed by the Bank and the GoKP prior to implementation.

32. The DoH has currently designated the Chief HSRU as the environmental focal person who will ensure compliance with the project specific ESMP as well as ensure implementation of the Government-prepared Standard Operating Procedures (SOPs) on handling and disposal of medical wastes. The provincial governments have already issued these SOPs though there are implementation issues with them.

Social Safeguards

33. Social aspects. The rehabilitation and renovation of health facilities will be limited to the existing structures on the already occupied land within the existing premises; no expansion is planned under this project so there will be no negative impact of this project in terms of land acquisition, involuntary resettlement or indigenous people. Therefore, social safeguard policies will not trigger.

34. The proposed project is intended to focus on efficient and effective primary health care service delivery. During the selection of implementing consultants of the contracted health services, the DoH and the Bank will ensure that the identification of the health facility locations is appropriate to properly reflect local variations and social constraints of marginalized populations, such as the poor and women whose mobility is restricted. The project mandates the provision of clinical services and strengthened care and home visits. Improved availability of staff particularly female health providers was deemed as one of the drivers of the high level of achievement of the JSDF-funded Batagram project.
E. Implementation Arrangements and Financing Plan

35. Implementation period – 3.0 Years; Implementing Agency: The project has been prepared by the Health Sector Reform Unit (HSRU) of the Department of Health, GoKP and its implementation shall rest with the same unit. The HSRU was established in 2002, and was the first reform unit in Pakistan. The unit was established in the Department with a view to prioritize the reform initiatives, harmonize donor support, provide technical support to the districts, and coordinate human resource development according to the needs of the organization. The unit is at the forefront of reforms for the health sector in KP and has a very good grasp of the overall situation and intricacies involved in managing and reforming the system. A mid-term review is planned 18 months after Grant effectiveness to adjust the implementation period as needed.

36. Overall oversight arrangements: A Steering Committee for the project shall be established with the Additional Chief Secretary as chairperson. The Steering Committee shall meet biannually and provide guidance to the project team. Chief HSRU shall provide day to day supervisory and a project coordinator shall be appointed from within the staff working at the HSRU.

37. Project management: No separate Project Implementation Unit shall be established and the project shall be managed by a Management Unit (MU) within the HSRU. The HSRU shall be provided cross support by the Implementation Support Unit (ISU) proposed to be established by the MDTF funded Governance project at the Planning and Development department. The HSRU will be responsible for overall coordination, internal/external processing of all approvals including PC-1, procurement and management of consultant services, contracting of civil works, operating the special account and financial management.

38. District Health Office: The functions, responsibilities and structure of the district health office will be reviewed in consultation with Health Department and stakeholders in the district. This should lead to a better understanding of the management needs at the district and sub district levels, and enable clear delineation of roles and responsibilities for different levels of health facilities.

39. District level implementation: The supervision of implementation at the district level shall be through the District Health Management Team (DHMT). The field implementation of the project shall be overseen by the Executive District Officers, Health (EDOH) and their supporting staff in the respective districts. The EDOH shall be responsible for oversight of the environmental and social safeguards, and monitoring the implementation of the civil works. The EDOH shall also provide supervisory support to the management firm as well as verify the data provided by the management contractor for onward submission to the provincial office. The EDOH shall also act to address any grievance/ complaints from the community regarding service provision, and closely monitor the performance of outreach work. In addition, the EDOH shall also act as the main coordination point for the national/priority programs with the management firm.

40. Health Services Contracts: The management firms/organizations will be private entities that will be selected competitively. Contractual Agreements will be signed between the DoH,
Management Firm, and the district government outlining details of the roles and responsibilities of each partner. In order to carry out the activities to achieve the objectives of the project under this arrangement, the firm shall have the authority to provide performance based incentives and other management actions.

**Financing Plan**

41. The total project cost will be US$61 million out of which US$16 million will be financed through the MDTF. The GoKP will supply the regular budget of US$45 million in parallel to the districts for recurrent cost of the health facilities.

<table>
<thead>
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<th>Bank Project Costs (MDTF)</th>
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<th>Year 2</th>
<th>Year 3</th>
<th>Total</th>
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<td>4.5</td>
<td>9.0</td>
</tr>
<tr>
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<td>15.0</td>
<td>15.0</td>
<td>45.0</td>
</tr>
</tbody>
</table>

42. As the government’s PC-1 indicates, the GoKP’s regular recurrent and development budget may be used in parallel to the MDTF contribution for extra support in civil works. However, the success of the project is not dependant on the allocation or execution of the additional amount.

**F. Project Risks and Mitigating Measures**

43. The proposed project faces moderate operational and reputational risks, which could be aggravated by the volatile country situation, including macroeconomic, political, and security related. The Bank team assesses the overall risk at preparation as “High” and “Substantial”; however, considering a strong demand for the Bank to respond to the PCNA and emergency crisis on an urgent basis, the Bank team and counterparts have incorporated mitigation measures in the project design. The Operational Risk Assessment Framework (ORAF), analyzes major risks and their mitigation measures, and is attached as Annex 4. The following summarizes key risks and its mitigation measures derived from ORAF:

a) **Volatile Country Context and ambiguity in the direction after the 18th Amendment of the Constitution:** Prevailing political challenges being faced by the coalition government has exacerbated the economic distress. The military operations in KP and FATA and the catastrophic floods in July 2010 have contributed to the resettlement of three million IDP’s as well as adding further pressures to the fiscal deficit. After the US raid in Abbotabad district of KP Province, in May 2011, the security situation in KP has deteriorated.

In addition to this worsened security situation, Pakistan is undergoing significant political and constitutional changes with an increased emphasis on provincial autonomy and devolution of authority that eliminates the federal government’s role in 40 areas of
service delivery, including Ministry of Health. This results in weak and uncertain leadership in the health sector with possible frequent reversal of decisions and slow progress. Furthermore, as these details are chalked out, questions are being raised on the financing of key federal vertical programs such as Lady Health Workers, Maternal, Newborn, and Child Health (LHW, MNCH and TB DOTS) as well as whether the provincial governments have sufficient capacity and leadership to be able to function as an effective authority after June 30, 2011.

In spite of the above uncertainties posing a great challenge, the Bank team has been actively engaging with the government high-level officials both at federal and province levels to explore ways that the Bank assistance can be used in achieving the health goals under a fragile transition period. In parallel, the Bank team is focusing on provincial level capacity strengthening to hedge the ambiguity in the direction of the post 18th Amendment in the demarcation of the role and responsibility between the provinces and the Federal government. The proposed project will support management capacity building at the provincial and district levels to efficiently delivery health services in the KP province.

b) Lack of experienced and qualified FM and procurement staff in the DoH: Limited fiduciary capacity, especially large contracts management, can be a major hindrance in project implementation. The DoH has no direct experience with a Bank financed project; therefore, compliance with the Bank guidelines without delaying the process of contracting will be key to successful implementation. The DoH will address such capacity constraints by hiring consultants/staff with the requisite skills. In addition, the timing of processing of contracts for six districts will be coincided to reduce the overall workload and increase efficiency. In order to meet the procurement and FM requirements, the Bank staff will also provide training to designated project staff, complemented with intensive supervision by Bank teams throughout the project’s life, particularly in the initial stages of the project.

c) Ensuring transparency in the selection and hiring of managing NGOs: International experience shows that the contracting process is highly susceptible to fraud and corruption instances. The project will establish the Provincial Steering Committees, which will oversee implementation of the project and address any irregularities, and agreed actions include dissemination of selection process, award and contract implementation. In addition, Internal Audits will be carried out periodically, and the Auditor General will carry out external audit of the project annually.

d) Possible weakness in the M&E capacity of the district as well as the DoH levels: The Implementation Completion Memorandum (ICM) prepared for the Batagram project underscores lessons for M&E of future contracting efforts. The project design therefore includes the following multi-layered M&E strategies: (i) strengthening of Provincial M&E Cell; (ii) establishing District Health Management Teams to quarterly review the progress; (iii) hiring an independent consultancy firm for baseline, mid-term and endline data collection; (iv) strengthening DHIS and external validation of DHIS data; and (v) periodic supervision by a third party consultant. As indicated in the above mentioned
ICM, the Bank team has already started the process of hiring a qualified entity to undertake the independent monitoring.

G. Terms and Conditions for Project Financing

44. The project will be financed by a grant from the KP/FATA/Balochistan Multi-Donor Trust Fund (MDTF) through a Revitalizing Health Services in KP Project, and the disbursement percentage will be 100 percent. Retroactive financing will be provided for certain goods and services and consulting services necessary to complete project preparation, with prior agreement from the MDTF administrator. The project requires retroactive financing to meet eligible expenditures paid prior to the signing of the Grant Agreement but after July 1, 2011. The retroactive financing is allowed up to 10 percent of the amount of the Grant.
Annex 1: Detailed Description of Project Components

**PAKISTAN: Revitalizing Health Services in Khyber Pakhtunkhwa Project**

**Proposed Goal and Objectives**

1. **PCNA Goal:** To build responsiveness and effectiveness of the state to restore citizen’s trust by revitalizing, strengthening and sustaining the delivery of quality health care services in the post-conflict/crisis affected districts across Khyber Pakhtunkhwa.

2. **Project Development Objective:** In order to improve access and availability of quality healthcare services to the affected population, the proposed three year project will have the following objective:

   “To improve the availability, accessibility and delivery of primary and secondary healthcare services at the district level.”

**Key Results**

3. The project will be implemented in six crisis affected districts of KP for a period of three years. It is expected that by the end of the project the following key results will be achieved:

   a) Increased utilization and coverage of Primary Health Care services and secondary care services in the districts,
   b) Adequately equipped and functional health infrastructure,
   c) Improved supervision and timely utilization of allocated resources through key management decisions based on evidence, and
   d) Increased community satisfaction with publicly provided health care services.

**Key performance indicators**

4. The key performance indicators include:
   i) People with access to a defined basic package of health, nutrition, or reproductive health services,
   ii) Percentage of children with Severe Acute Malnutrition provided adequate Nutrition services,
   iii) Births (deliveries) attended by skilled health personnel
   iv) Contraceptive prevalence rate for modern methods,
   v) Community satisfaction with health care services delivery by public sector

**Project Context**

5. **Concept:** The project proposes to revitalize and rehabilitate health services in the crisis affected districts of KP in terms of their infra-structure, equipments, furniture, improved management and a robust monitoring and evaluation system so as to provide quality MNCH,
nutrition and family planning services to its communities in line with the Batagram model (box 1.1) of public-private-partnership (a World Bank project funded through a JSDF grant).

**Project Description**

6. **Selection of Districts:** Based on criteria developed by the project team (crisis affected district, poor indicators, other funding available from provincial Annual Development Plan or developmental partners) the following districts have been agreed for inclusion in the project subject to overall resource requirements: i) Batagram (continuation of the previous successful model); ii) Buner; iii) Lower Dir; iv) Dera Ismail Khan; v) Kohistan; and, vi) Tor Ghar.

7. **District Health Office:** The functions, responsibilities and structure of the district health office will be reviewed in consultation with health department and stakeholders in the district. This should lead to a better understanding of the management needs at the district and sub district levels and enable clear delineation of roles and responsibilities for different levels of health facilities. While preparing the contracts for outsourcing, roles and responsibilities of each partner will be clearly defined, the relationship of EDO Health and management firm and working with vertical programs at the district level will be clearly spelled out. The expected outputs and health outcomes in the district shall also form a part of the contract and be the basis for disbursement. The budgetary resources allocated by the government for the identified districts except for the District Health Office operational budget and specific EDO Office functions shall be transferred as a single line item to the management contractor with full authority for reallocation.

8. **Component 1:** Improve accessibility and quality of healthcare services at the district level through outsourcing of management (MDTF US$11.0 million)

   **Subcomponent 1A:** *Revitalize and strengthen provision of primary health care services through Hub Approach:* In the selected districts, hubs will be established in appropriate geographic locations for efficient delivery of services. All the population of the district shall be covered through the hub approach, where appropriate the hubs, according to their geographic and strategic location, will be established at RHC, Civil Hospital, Category D hospital or even at Tehsil Head Quarter (THQ) hospital. Functional health facilities will be repaired and renovated. These health facilities will also be equipped, furnished and staffed at optimal levels. A logistics management system will be put in place to ensure continued availability of medicines and other supplies in these facilities. Ambulances will be made functional. The Hub Manager will be responsible to monitor and supervise the attached health facilities, outreach and community based. Outpatient Therapeutic Program (OTPs) will be established at selected health facilities for community based management of acute malnutrition. In order to maintain and improve the quality of MNCH, family planning and nutrition services at all levels in the district a comprehensive capacity building activity will be undertaken in the project districts. A training needs assessment will be carried out which will feed into a training strategy and the activity will be conducted in close coordination with the Provincial Health Services Academy. The contract shall provide for a fixed number of days per district for each quarter which will then be allocated to different trainings based on the training plan.
Subcomponent 1B: Revitalize and strengthen healthcare services at secondary level (DHQ) hospitals: The DHQ hospitals in the project districts will be strengthened to enable optimal functioning as referral level hospitals. This will be achieved by ensuring the functionality of surgical, medical, gynecology and obstetrics, pediatric and emergency units of the hospitals, in addition to support units of operation theater, labor rooms, laboratory, blood bank and pharmacy. Repairs and renovations will be conducted where required as well as gaps in equipment will be filled through this project. Sanctioned staff positions at the hospital shall be filled and utilization of incentives to ensure full complement and availability of staff shall be explored. In the first year management of DHQ Hospital Buner shall be outsourced to the management firm, while the rest of the DHQ hospitals shall be provided support. At the end of first year, the performance of the contractor for DHQ Buner shall be reassessed, and if successful, the model will be replicated during contract extensions for the rest of the districts except for teaching hospitals.


A mapping exercise of all the health facilities in the district shall be conducted verifying the existing database of damaged health facilities. As some resources are available in the Annual Development Plan of the province, priority will be given to health facilities not included in the ADP. Cost estimates for the final list of damaged health facilities shall be prepared and a non-consulting services contract in line with Bank Procurement guidelines shall be awarded. A professional consulting firm will be hired and responsible for Contract Administration & Construction Supervision. The firm will be fully empowered as the ‘Engineer’ in accordance with International Federation of Consulting Engineers (FIDIC) stipulations. HSRU will act as the Employer. The Project Coordinator will be designated as the Employer’s Representative. In addition a civil engineer will be hired at the HSRU to support implementation.

10. Component 3: Establish and operationalise a robust monitoring and evaluation system in each district and provincial level (US$4.0 million).

a. Establishment of Provincial Steering Committee: A provincial steering committee will be established with the Additional Chief Secretary as the chairperson. The committee will meet every six months to review the project activities in all the districts as per the agreed work plan of the project.

b. Quarterly Review Meeting of the project activities: The Provincial Health Department shall organize a quarterly review meeting with the District Health Management Team (DHMT) and Management firm in the project districts to review project progress and set targets for the next quarter.

c. Management support to the HSRU: One full time Accountant and one M&E expert shall be hired for support to the HSRU, in addition to short term consultants to provide specific support for project activities. At the provincial
level, capacity building of health officials involved in the project shall be conducted. This shall include support to the EDOH and staff on supervision of contracts and results based monitoring.

d. Strengthening of Provincial **Monitoring and Evaluation Cell**: The provincial M&E Cell shall be responsible for monitoring the overall progress in the districts and providing comparisons with other districts.

e. Establish and operationalise **District Health Management Team**: District Health Management Team (DHMT) comprising of the District Coordination Officer (DCO), EDO Health, EDO Planning, EDO Finance and elected representatives will be notified. The DHMTs will review, monitor and facilitate project implementation at district level.

f. **Operationalization of DHIS** in project districts: The management firm will be tasked to operationalize the District Health Information System (DHIS). The district and facility based staff will be trained on DHIS hard and software, data entry and report generation. The project will also work towards improving the disease surveillance in the project districts. The DHIS will be used to provide evidence for decision making to the various levels of management and oversight as identified above.

g. **Periodic Evaluations** of the project: **Baseline Survey**: A base line survey will be conducted in order to assess the baseline situation in terms of available infrastructure, services, equipments, human resource, staff accommodation, utilization of services and establish benchmarks for well recognized MNCH, family planning and PHC indicators. A consultant/third party will be hired for this purpose. **Mid Term Review**: In the second year of the project a mid-term review will also be conducted to review the progress of the project. **End line Evaluations**: Third party end-line evaluations will be carried out through a consultant on the same parameters as the baseline upon completion of the project.

h. The **payment mechanism** for the health services contract is designed to be simple yet incentivize the firm for service delivery. There will be two streams of payment to the firm: one stream shall be the district budget for the health facilities contracted out and as this is 85 percent salary, it will be transferred to the firm on a regular basis. The other component of the budget which shall be from the HSRU (project funds), shall be released on a sliding scale mechanism based on achievement of agreed indicators. Thus the financing mechanism ensures that the firm will have a basic amount to cover salaries, utilities, some supplies etc., and then depending on performance, would be able to get additional resources for expansion of services. As this is a relatively new mechanism of financing interventions in the health sector, appropriate resources are allocated for strengthening of the monitoring mechanism of the health department to manage these contracts. The firm would be paid the amount from the project based on services delivered.
i. **Grievance Mechanism:** This will be at three levels: the first level will be at the health facility where the hub manager shall be responsible for responding to complaints, the second level will be at the EDOH office and the third level will be the provincial level (HSRU). The mechanism for registering complaints will be simple; at each facility information will be displayed on which facility person to contact in case of complaints/ grievance, in addition the telephone number of the responsible person in the contract management agency and the EDOH will also be displayed. In addition mobile/cell number for registration of complaints through short message service (SMS) will be displayed. The SMS data will feed into a server at the provincial level where monthly monitoring of total complaints registered and resolved will be conducted. The information about the contacts for grievance shall also be disseminated locally through the media as well as posters.

<table>
<thead>
<tr>
<th>Source</th>
<th>Population</th>
<th>Sex ratio (males per 100 females)</th>
<th>Area (km²)</th>
<th>Population density (per sq. km²)</th>
<th>Geography</th>
<th>Earthquake 2005</th>
<th>Under Taliban control 2009</th>
<th>Flood 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>KP Province</td>
<td>17,743,645</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Batagram District</td>
<td>307,278</td>
<td>106.6</td>
<td>1,301</td>
<td>236.2</td>
<td>Scenic mountain scenery, thick forests, fertile lands and enchanting streams</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Buner District</td>
<td>506,048</td>
<td>100.0</td>
<td>1,865</td>
<td>271.3</td>
<td>A small mountain valley, dotted with villages</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>D. I. Khan District</td>
<td>852,995</td>
<td>111.1</td>
<td>7,326</td>
<td>116.4</td>
<td>Arid area located on the west bank of the Indus River</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Kohistan District</td>
<td>472,570</td>
<td>124.4</td>
<td>7,492</td>
<td>63.1</td>
<td>A land of mountains sparsely populated. One of the most isolated and deprived district in KPK</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Lower Dir District</td>
<td>717,649</td>
<td>98.3</td>
<td>1,583</td>
<td>453.3</td>
<td>A rugged mountainous area with peaks rising to 5,000 meters</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Tor Ghar District</td>
<td>185,000</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>Previously Kala Dhaka Tehsil of Mansehra District</td>
<td>N/A</td>
<td>Partial</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Table 1a.2: KP Population Data (Estimated) and Demographics for selected Districts

<table>
<thead>
<tr>
<th>S.No</th>
<th>District</th>
<th>Population 1998</th>
<th>Annual Growth Rate (%)</th>
<th>Population 2008</th>
<th>Under 15 Years (45%)</th>
<th>Under 5 Years (16%)</th>
<th>Under 1 Year (3.533%)</th>
<th>Pregnant Ladies (4.1%)</th>
<th>Child Bearing Age (22%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Batagram</td>
<td>307,278</td>
<td>0.58</td>
<td>325,573</td>
<td>146,508</td>
<td>52,092</td>
<td>11,502</td>
<td>13,348</td>
<td>71,626</td>
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<tr>
<td>2.</td>
<td>Buner</td>
<td>506,048</td>
<td>3.86</td>
<td>739,052</td>
<td>332,573</td>
<td>118,248</td>
<td>26,111</td>
<td>30,301</td>
<td>162,591</td>
</tr>
<tr>
<td>3.</td>
<td>D.I.Khan</td>
<td>852,995</td>
<td>3.26</td>
<td>1,175,622</td>
<td>529,030</td>
<td>188,100</td>
<td>41,535</td>
<td>48,201</td>
<td>258,637</td>
</tr>
<tr>
<td>4.</td>
<td>Dir Lower</td>
<td>717,649</td>
<td>3.42</td>
<td>1,004,517</td>
<td>452,033</td>
<td>160,723</td>
<td>35,490</td>
<td>41,185</td>
<td>220,994</td>
</tr>
<tr>
<td>5.</td>
<td>Kohistan</td>
<td>472,570</td>
<td>0.09</td>
<td>476,840</td>
<td>214,578</td>
<td>76,294</td>
<td>16,847</td>
<td>19,550</td>
<td>104,905</td>
</tr>
<tr>
<td>6.</td>
<td>Tor Ghar</td>
<td>185,000</td>
<td>2.4</td>
<td>234,515</td>
<td>105,532</td>
<td>37,522</td>
<td>8,285</td>
<td>9,615</td>
<td>51,593</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>3,041,540</td>
<td></td>
<td>3,956,119</td>
<td>1,780,254</td>
<td>632,979</td>
<td>139,770</td>
<td>162,201</td>
<td>870,346</td>
</tr>
</tbody>
</table>

Table 1a.3: Social Development Indicators for selected Districts

<table>
<thead>
<tr>
<th>Source</th>
<th>Adult literacy (women aged 15-24)</th>
<th>Using improved sources of drinking water and using sanitary means of excreta disposal</th>
<th>Source of drinking water located in 1 hour or more</th>
<th>Net primary school attendance ratio (% Female)</th>
<th>Net secondary school attendance ratio (% Female)</th>
<th>Households with health facility within their community (%)</th>
<th>Households visited by Lady Health Worker during the last month (%)</th>
<th>Birth registration (%)</th>
<th>Newborn breastfed within one hour of birth (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>KP Province</td>
<td>44.8</td>
<td>47.7</td>
<td>9.1</td>
<td>43.1</td>
<td>24.9</td>
<td>72.3</td>
<td>27.4</td>
<td>20</td>
<td>14.2</td>
</tr>
<tr>
<td>Batagram</td>
<td>31.2</td>
<td>37.6</td>
<td>18.7</td>
<td>35.5</td>
<td>12.5</td>
<td>54.8</td>
<td>7.5</td>
<td>10.4</td>
<td>4.7</td>
</tr>
<tr>
<td>Buner</td>
<td>34.6</td>
<td>28.9</td>
<td>23.6</td>
<td>50.7</td>
<td>23.0</td>
<td>76.0</td>
<td>8.4</td>
<td>7.1</td>
<td>15.1</td>
</tr>
<tr>
<td>D.I.Khan</td>
<td>31.2</td>
<td>35.2</td>
<td>11.3</td>
<td>31.9</td>
<td>21.8</td>
<td>72.8</td>
<td>37.4</td>
<td>43.5</td>
<td>7.0</td>
</tr>
<tr>
<td>Kohistan District</td>
<td>4.6</td>
<td>16.2</td>
<td>19.3</td>
<td>14.8</td>
<td>4.8</td>
<td>32.4</td>
<td>0.3</td>
<td>6.9</td>
<td>5.1</td>
</tr>
<tr>
<td>Lower Dir District</td>
<td>41.0</td>
<td>45.7</td>
<td>10.2</td>
<td>42.8</td>
<td>15.9</td>
<td>73.3</td>
<td>8.7</td>
<td>5.3</td>
<td>6.9</td>
</tr>
<tr>
<td>Tor Ghar District</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Table 1a.4: Reproductive Health Indicators for selected Districts

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Batagram District</td>
<td>47.1</td>
<td>47.2</td>
<td>42.3</td>
<td>28</td>
<td>38.5</td>
<td>13.0</td>
<td>23.6</td>
<td>49</td>
<td>62.6</td>
</tr>
<tr>
<td>Buner District</td>
<td>24.9</td>
<td>32.4</td>
<td>42.3</td>
<td>16</td>
<td>41.2</td>
<td>6.9</td>
<td>16.1</td>
<td>31</td>
<td>62.1</td>
</tr>
<tr>
<td>D.I. Khan District</td>
<td>37.8</td>
<td>48.1</td>
<td>34.0</td>
<td>19</td>
<td>31.0</td>
<td>7.2</td>
<td>19.0</td>
<td>63</td>
<td>61.8</td>
</tr>
<tr>
<td>Kohistan District</td>
<td>40.8</td>
<td>47.2</td>
<td>23.7</td>
<td>12</td>
<td>19.0</td>
<td>7.5</td>
<td>18.5</td>
<td>36</td>
<td>60.3</td>
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<tr>
<td>Lower Dir District</td>
<td>15.5</td>
<td>9.0</td>
<td>17.2</td>
<td>7</td>
<td>16.7</td>
<td>8.6</td>
<td>0.9</td>
<td>15</td>
<td>30.5</td>
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<tr>
<td>Tor Ghar District</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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</table>

Source: MICS 2008

Table 1a.5: District Budget of Five* Districts for the last two years (Pak Rupees)

<table>
<thead>
<tr>
<th>District</th>
<th>2009-10 Budget</th>
<th>2010-11 Budget</th>
<th>2010-11 Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bunair</td>
<td>104,660,350</td>
<td>250,562,093</td>
<td>1,210,800,366</td>
</tr>
<tr>
<td>D.I.Khan</td>
<td>705,046,830</td>
<td>960,248,273</td>
<td>1,210,800,366</td>
</tr>
<tr>
<td>Dir (lower)</td>
<td>809,707,180</td>
<td>133,219,329</td>
<td>1,210,800,366</td>
</tr>
<tr>
<td>Kohistan</td>
<td>62,622,040</td>
<td>340,899,090</td>
<td>1,210,800,366</td>
</tr>
<tr>
<td>Battagram</td>
<td>133,219,329</td>
<td>72,622,040</td>
<td>1,210,800,366</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,210,800,366</td>
<td>1,210,800,366</td>
<td>1,210,800,366</td>
</tr>
</tbody>
</table>

*Tor Ghar is a new district and was part of District Mansehra in previous budget

Hub Approach Batagram Project

11. Batagram is among the poorest and most marginalized districts in the Khyber Pakhtunkhwa Province (KPK). According to Save the Children’s baseline survey, only 10 percent of children under two years of age were fully vaccinated, only 33 percent of pregnant women visited a facility for antenatal care, 67 percent of births took place at home, and 98 percent of these births were attended by unskilled attendants. The needs of its inhabitants became even more desperate when a high magnitude earthquake jolted the district in October 2005.
12. Health Department, Khyber Pakhtunkhwa and District Government Batagram, with assistance from the World Bank/Japan Social Development Fund (WB/JSDF), entered into a tripartite arrangement with Save the Children for revitalizing and managing all health care facilities as well as providing primary healthcare services across the district for a period of three years. A Memorandum of Understanding (MoU) was signed between Health Department Government of KPK, the District Government Batagram and Save the Children to revitalize, improve and manage the healthcare services in the district. Through this MoU, the salary and non-salary health budget of the district was transferred to Save the Children (SC) as one line item. The additional costs required for rehabilitating the health facilities, provision of equipment, hiring of additional staff, building technical and management capacity of the health care providers and managers and provision of performance based incentives to the traumatized staff of the district were covered by the JSDF grant from World Bank.

The Model:

13. Besides operationalising and managing all primary health care facilities in the district, the project specifically focused on improving immunization, antenatal, natal and post natal services, prompting institutional deliveries, and improving access to quality basic obstetric newborn and nutrition care in the district.

14. With a view to strengthen the management, supervision and information based decision making, the project aimed to establish a District Health Management Team at the district level, and Quality Improvement Teams (QITs) comprising of health facility and community representatives at each health facility level and building capacity of the management staff in Health Planning and Budgeting. In order to ensure efficient and effective management of health services in the district, the project employed three public health professionals as Project Manager, Manager Health and Manager M&E.

15. Besides this, two innovative approaches, “the hub approach” and “the performance based incentive approach” were adopted by the project as distinct hallmarks of this project. The hub approach aims to make available a higher level of service than usually are provided at an RHC. It also helps to improve the management of satellite BHUs located within catchments area of RHC. The performance based incentive approach aims to reward staff who are providing a high standard of health services, thus improving the quality of health care services available in Batagram.

16. Under the Hub Approach three existing Rural Health Centers (RHCs) located in Thakot, Banna and Kuzabanda were identified as hubs. Each hub centre functions as the referral centre for all the BHUs linked to it, is equipped to provide a complete package of primary health care including basic Emergency Obstetric and Newborn Care (EmONC) and 24 hour emergency services. Each hub centre RHC is staffed by five medical officers including two woman medical officers. The medical officers work in shifts and in each shift two men and one woman medical officer are on duty. The other two medical officers visit the attached BHUs on rotation. All medical officers are resident and are provided a reasonably furnished accommodation at hub. All the hub centers are equipped with an ambulance for patients requiring referral to a secondary or
tertiary level facility. In addition, medicines and equipment are supplied to the attached BHUs from the hub centers. The hub in-charge monitors the activities of the RHC and the attached BHUs. The hub in-charges are provided transport facility and have been connected to BHUs by telephone.

17. The project has also adopted a structured and transparent system of performance based incentive (PBI), which is an addition to the basic salary paid to staff in the three hubs. The healthcare staff’s performance is assessed against the targets set in the monthly health management information system (HMIS) report. In addition, supervisory visits are carried out to each facility which is given a score for the quality of services being provided. The visiting supervisors include members of the District Health Management Team and Save the Children staff. The total points allocated to the supervisors’ report are 40 while the performance against the targets set as per HMIS report carries 60 points in total. The cumulative scores of both the supervisory checklist and HMIS report for each facility are used to calculate the level of incentive allowance payable to the staff. This may vary between 20% and 35% of basic salary. The introduction of PBI system has led to a positive effect on staff attendance in the facilities. The employees regard the PBI system as a source of motivation for them to deliver quality health care to the communities of Batagram.

18. Save the Children implemented a modified Community Therapeutic Nutrition Care in Allai for treating nutritional disorders among children under five. This model has been scaled up as a full-fledged Community-based Management of Acute Malnutrition (CMAM) intervention in Batagram. Save the Children has trained Lady Health Workers and Female Health Volunteers in identifying, screening and referring children with nutritional disorders to BHUs. All BHUs in Batagram have been equipped with Outpatient Therapeutic Points and staffed with trained health care providers who can treat moderately malnourished children. BHUs refer severely malnourished children to hub RHC. All three hub RHCs are equipped to provide outpatient care to severely malnourished children and are currently in a process of establishing stabilization centers for inpatient care for these children.

19. In order to ensure uninterrupted supply of medicines and other consumable and non consumable items, the project has put in place a Logistics and Inventory Management System. This is customized software to control logistic operations, deployed in all hubs, to provide a complete hard to soft environment. All relevant staff has been trained in the use of this software.

20. The projects also focused on operationalising the Health Management Information System (HMIS) through building staff capacity, provision of HMIS tools and instruments and enhance data quality and compliance. The DHMT is regularly meeting on monthly basis to review, guide and support the project activities. The QITs are participating, supporting and monitoring the quality improvement process at health facility level. The Health Management Information System is fully functional as a result of staff training, provision of equipment and tools at various levels and by linking it to assess staff performance.

21. It is pertinent to note that Batagram model is very different from other models like People Primary Healthcare Initiative (PPHI) in following respects:
### Terms of references

<table>
<thead>
<tr>
<th></th>
<th>Batagram Model</th>
<th>P PHI Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Management</td>
<td>Public Health Professionals hired for project managed</td>
<td>Non technical staff hired for project management</td>
</tr>
<tr>
<td>District Health Management Team</td>
<td>DHMT fully functional to review and guide project activities</td>
<td>DHMT not functional</td>
</tr>
<tr>
<td>Health Facilities managed</td>
<td>Management of all health facilities including RHCs, BHUS, MCHCs and CDs outsourced</td>
<td>Management of only BHUs outsourced</td>
</tr>
<tr>
<td>Vertical Programs</td>
<td>All vertical programs included in the scope of the project</td>
<td>Vertical programs were not included in the scope</td>
</tr>
<tr>
<td>HMIS</td>
<td>HMIS operationalised</td>
<td>Separate reporting registers used with no link to HMIS</td>
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<td>Key Performance Indicators</td>
<td>Both process and impact indicators</td>
<td>Only process indicators</td>
</tr>
<tr>
<td>Staff Capacity Building</td>
<td>Focused on competency based hands on trainings</td>
<td>Lectures were organized on certain topics</td>
</tr>
<tr>
<td>Community Involvement</td>
<td>Quality Improvement Teams established at each health facility</td>
<td>Health Committees established</td>
</tr>
<tr>
<td>Working Model</td>
<td>Built strong horizontal linkages with EDO Health and District Government</td>
<td>Vertical approach adopted for implementing project activities</td>
</tr>
</tbody>
</table>

**The Results:**

22. The project was successful in renovating, staffing, equipping and operationalizing 41 health facilities which includes 28 Basic Health Units (BHUs), 3 Rural Health Centers (RHCs), 8 Dispensaries, 1 Tuberculosis Centre, and 1 Mother and Child Health Centre (MCH) in the district. In addition, 43 health care providers including 9 Medical Officers, 3 Women Medical Officers, 13 Medical Technicians, 8 Lady Health Visitors and 10 EPI technicians have been recruited. The project is also strengthening local capacities at the district level for effective and efficient health service delivery. Save the Children has trained 586 participants in effective management of health services including monitoring and supervision, and implementation of the HMIS.

23. In addition to strengthening health care at the facility level, the project is ensuring provision of health care to the communities in far flung mountainous areas. In coordination with the Department of Health, Save the Children organizes Health Days (free medical camps) which provide communities with diagnostic facilities, treatment of minor illnesses, referral of complicated cases, and vaccination of children and women. So far, 3,609 of men, 3,421 women and 1,317 children have benefited from Health Days.
24. This partnership worked miracles for the earthquake and flood devastated people of Batagram. In the three years of this partnership, there was 1000% increase in the average monthly Family Planning clients registered (56 to 616), prevalence of low birth weight has decreased from 10.5 to 3.4 percent, prevalence of moderate and severe malnutrition in under three year old children, has almost been halved (11 to 6.9 and 4.4 to 2.7 percent, respectively) and HMIS reporting compliance has increased from 25 to 95 percent.

25. The third party end line evaluations confirm the significant improvement of health facility utilization, improved core indicators and successful hub approach. The MoU established following eight key performance indicators for benchmarking any progress in the PHC services:

- Number of health facilities fully operational providing a package of services
- Monthly OPD utilization of fully functional PHC facilities
- Proportion of pregnant women who receive two or more doses of TT vaccine
- Proportion of children 12-23 months fully immunized
- Proportion of pregnant women attending at least one antenatal care clinic
- Proportion of births attended by skilled attendants
- Proportion of parents able to spontaneously name the danger signs of Diarrhea, ARI and the appropriate response
- Percentage of parents who report hand washing with soap after using toilet and before preparing food

The Way Forward:

26. During the extension phase the scope of the project will be modified to include the development and implementation of an agreed transition road map vis-à-vis role of EDO health and inclusion of activities like Polio Eradication and management of LHWs Program. The participants were also unanimous in recommending establishment of functional referral arrangements with District Headquarter Hospital Batagram and strengthening its obstetrics, pediatrics and general emergencies management capacity.
**Annex 2: Results Framework and Monitoring**

**PAKISTAN: Revitalizing Health Services in Khyber Pakhtunkhwa Project**

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**Project Development Objective (PDO):**
To improve the availability, accessibility and delivery of primary and secondary healthcare services at the district level

<table>
<thead>
<tr>
<th>PDO Level Results Indicators²*</th>
<th>Core</th>
<th>Unit of Measure</th>
<th>Baseline</th>
<th>Cumulative Target Values**</th>
<th>Frequency</th>
<th>Data Source/Methodology</th>
<th>Responsibility for Data Collection</th>
<th>Description (indicator definition etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 1: People with access to a defined package of health, nutrition, and reproductive health services</td>
<td>% and #</td>
<td>TBD (1st year of implementation)</td>
<td>50</td>
<td>75</td>
<td>90</td>
<td>Annually</td>
<td>DHIS, Project progress monitoring reports</td>
<td>DoH</td>
</tr>
<tr>
<td>Indicator 2: Percent of children with Severe Acute Malnutrition provided adequate nutrition services</td>
<td>%</td>
<td>TBD (1st year of implementation)</td>
<td>10</td>
<td>25</td>
<td>50</td>
<td>Quarterly</td>
<td>DHIS, Project progress monitoring reports</td>
<td>DoH</td>
</tr>
<tr>
<td>Indicator 3: Percent of births attended by skilled health personnel¹</td>
<td>% and #</td>
<td>Birth assisted %, doctors, nurses, midwives, MICS</td>
<td>5 percentage points increase over baseline</td>
<td>10 percentage points increase over baseline</td>
<td>15 percentage points increase over baseline</td>
<td>Annually</td>
<td>DHIS and Surveys</td>
<td>DoH</td>
</tr>
</tbody>
</table>

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² The baseline Indicators will be finalized for each district based on the data from the following sources in order of priority: PSLSM, PDHS, MICS, Admin data, and verified by baseline survey.
| Indicator 4: Contraceptive prevalence rate (any modern method) | % | MICS 2008 | Batagram | 16 | Buner | 19 | D. I. Khan | 18 | Kohistan | 1 | Lower Dir | 24 | Tor Ghar | N/A | 5 percentage points increase over baseline | Annually | DHIS and Surveys | DoH |
| Indicator 5: Community satisfaction with health care services delivery by public sector | % and # | PSLSM 2008 | Batagram | 32 | Buner | 64 | D. I. Khan | 61 | Kohistan | 2 | Lower Dir | 24 | Tor Ghar | N/A | 5 percentage points increase over baseline | 10 percentage points increase over baseline | 15 percentage points increase over baseline | Annually | Exit Interviews and Surveys | DoH |

**INTERMEDIATE RESULTS**

**Intermediate Result - Component 1:** Increased utilization and coverage of primary health care services and secondary care services in the selected districts

<table>
<thead>
<tr>
<th>Indicator 1: Number of districts contracted out for management of services</th>
<th>Number</th>
<th>0</th>
<th>6</th>
<th>6</th>
<th>6</th>
<th>Annually</th>
<th>Project progress monitoring reports</th>
<th>DoH</th>
<th>Annual review of contract extensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 2: Percentage of ‘Hubs’ established and assessed as fully functioning by DoH</td>
<td>%</td>
<td>0</td>
<td>50%</td>
<td>100%</td>
<td>100%</td>
<td>Annually</td>
<td>Project progress monitoring reports</td>
<td>DoH</td>
<td>Appropriate groups of facilities identified as hubs and hubs are staffed, providing services and reporting</td>
</tr>
<tr>
<td>Indicator 3: Training needs assessment and strategy for the district completed within six months from the contract date, % of trainings conducted according to plan</td>
<td>Text, %</td>
<td>0</td>
<td>25%</td>
<td>75%</td>
<td>100%</td>
<td>Quarterly</td>
<td>Project progress monitoring reports</td>
<td>DoH</td>
<td># of care providers trained out of total care providers according to plan based on assessment</td>
</tr>
<tr>
<td>Indicator 4: Health Facility Utilization Rate: Visits per person per year.</td>
<td>1.0</td>
<td>Annually</td>
<td>DHIS &amp; Project progress</td>
<td>DoH</td>
<td># of OPD seen at HF/Total population in catchment area</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Intermediate Result - Component 2:
**Adequately equipped and functional health infrastructure available in the selected districts**

<table>
<thead>
<tr>
<th>Indicator 1: Health facilities reconstructed, renovated, and/or equipped (number)</th>
<th>□</th>
<th>?</th>
<th>Annually</th>
<th>Project progress monitoring reports</th>
<th>DoH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 2: # of DHQ hospitals refurbished</td>
<td>□</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>Annually</td>
</tr>
<tr>
<td>Indicator 3: Health facilities adequately refurbished</td>
<td>□</td>
<td>0</td>
<td>25%</td>
<td>75%</td>
<td>100%</td>
</tr>
</tbody>
</table>

## Intermediate Result - Component 3:
**Improved supervision and timely utilization of allocated resources through key management decisions based on evidence**

| Indicator 1: Timely disbursement of funds to a consultant/NGO implementing contracting out | □ | 90% | 90% | 90% | Quarterly | Project progress monitoring reports | DoH | “Timely”: Funds released within 30 days of receipt of invoice |
|---|---|---|---|---|---|---|---|
| Indicator 2: Biannual meetings held for Provincial Steering Committee | □ | 2 | 2 | 2 | Annually | Project progress monitoring reports | DoH | 1st meeting held within one month from the project effectiveness |
| Indicator 3: Number of Health facilities submitting monthly reports on time to district | □ | # | 50% | 90% | 90% | Quarterly | DHIS | DoH | Numerator: # of reports received. Denominator: # of reports expected per month |
| Indicator 4: Establishment within two months from the contract date and operationalization of District Health Management Team | □ | | | | 100% | Annually | Project progress monitoring reports | DoH | “Operationalized”: Documented meetings have occurred at least once every two months prior to the end of each FY |
Annex 3: Summary of Estimated Project Costs

PAKISTAN: Revitalizing Health Services in Khyber Pakhtunkhwa Project

(US$ million)

<table>
<thead>
<tr>
<th>Component</th>
<th>MDTF (Bank)</th>
<th>%age</th>
<th>GoKP</th>
<th>%age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component 1: Improve accessibility and quality of healthcare services at the district level through outsourcing of management</td>
<td>11.0</td>
<td>20%</td>
<td>45.0</td>
<td>80%</td>
</tr>
<tr>
<td>Component 2: Rehabilitation of the Health infrastructure in the districts</td>
<td>1.0</td>
<td>100%</td>
<td>0.0</td>
<td>0%</td>
</tr>
<tr>
<td>Component 3: Establish and operationalise a robust monitoring and evaluation system in each district and provincial level</td>
<td>4.0</td>
<td>100%</td>
<td>0.0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>16.00</td>
<td>18%</td>
<td>45.0</td>
<td>82%</td>
</tr>
</tbody>
</table>
Annex 4: Operational Risk Assessment Framework (ORAF)

PAKISTAN: Revitalizing Health Services in Khyber Pakhtunkhwa Project

<table>
<thead>
<tr>
<th>Project Development Objective(s)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve the availability, accessibility and delivery of primary and secondary healthcare services at the district level</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PDO Level Results Indicators:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. People with access to a defined basic package of health, nutrition, or reproductive health services</td>
<td></td>
</tr>
<tr>
<td>2. Percentage of children with severe acute malnutrition provided adequate nutrition services</td>
<td></td>
</tr>
<tr>
<td>3. Birth attended by skilled health personnel</td>
<td></td>
</tr>
<tr>
<td>4. Contraceptive prevalence rate (any modern method)</td>
<td></td>
</tr>
<tr>
<td>5. Community satisfaction with health care services delivery by public sector</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Risk Rating</th>
<th>Risk Description</th>
<th>Proposed Mitigation Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Stakeholder Risks</td>
<td>Low</td>
<td>Currently, service users’ perception towards government health service provision is poor and may be an obstacle to boost service utilization. In the transition process, possible resentment and confusion by some of service providers may occur due to introduction of a new service provision system.</td>
<td>Evidence shows increased client satisfaction by improving quality and availability of health services in the district through contracting out in Batagram (the experience upon which this project builds). In addition, the project will strengthen communication between service providers and community. Their satisfaction towards services will be monitored through survey. To ensure a good working environment for service providers, a grievance redressal mechanism will be put in place to respond to complaints raised. NGO will also address motivation of service providers.</td>
</tr>
<tr>
<td>Implementing Agency Risks</td>
<td>High</td>
<td>While the implementing agency’s technical capacity is adequate, with no previous experience with the Bank project, its fiduciary capacity especially in managing several large contracts in accordance with the Bank’s guideline without delay would be a challenge. In addition, there are possible governance issues around the contract management such as transparency in the selection of managing NGOs and rent seeking behaviors. At the local level, there is possible risk of elite capture and of distortion in the monitoring and reporting on performance results. Capacity at District Health</td>
<td>The Bank team is working on strengthening fiduciary capacity within the DoH. The DoH is in the process of hiring a full-time procurement consultant to expedite the contracting process for contracting out health services. Internal Audits of the project will be carried out periodically. The Provincial Steering Committee will provide overall guidance, oversee implementation of the project and make decisions to address irregularities. As for the governance issues, the project will incorporate robust third party monitoring to ensure objectivity in monitoring. Grievance redressal mechanism will be in place, which will allow service users to directly assess performance of health facilities. Client service satisfactory level will be assessed through a survey. The project will</td>
</tr>
</tbody>
</table>
Office to monitor and supervise a large-scale project is unknown. provide extensive capacity building component with direct support to DHO.

<table>
<thead>
<tr>
<th>Project Risks</th>
<th>Design</th>
<th>Social &amp; Environmental</th>
<th>Program &amp; Donor</th>
<th>Delivery Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Severe security constraints in most of the conflict-affected districts may hamper the implementation and supervision of the project. The HR management will be challenging for NGOs, especially in the treatment of existing staff and filling vacant posts in remote districts. The selected districts with lagging health outcomes at the beginning of the project may not achieve expected progress due to other attributing factors such as poverty and education level.</td>
<td>Due to refurbishment of the health facilities, some low to medium level, reversible in nature and short term environmental issues may be encountered.</td>
<td>Being funded by MDTF, future funding of the project is depending upon the procedures governed by MDTF and its requirements.</td>
<td>There is possible weakness in M&amp;E capacity of the district level as well as at the DoH. The interventions may be discontinued after the project completion.</td>
</tr>
<tr>
<td></td>
<td>Contracting out of service deliver to NGOs is proven to be an appropriate design when security is heightened and mobility is limited. The multi-layers of supervision mechanisms, namely, (i) Monitoring and validation by DHO, (ii) DoH regular supervision, (iii) third party monitoring, and (iv) community involvement through grievance redressal. As for the HR management, the project allows flexibility for selected NGO to hire a new staff on contract and design incentives such as a higher salary, provision of transportation and accommodation, according to the local condition. The project will periodically review the backward district’s progress and revise its targets to ensure that they are realistic and evidence-based.</td>
<td>These risks can be with adequate house-keeping practices ensured through project specific environmental mitigation and monitoring plan. The DoH will be hiring a consultant to develop an environmental management plan for the project.</td>
<td>The Bank team and counterpart will explore alternative funding avenues including the GoKP budget and other donors.</td>
<td>The project design includes multi-layered monitoring and evaluation strategies: (i) Strengthening of Provincial M&amp;E Cell, (ii) Establishing District Health Management Team, (iii) Hiring an independent consultant to prepare baseline, mid-term and endline data collection, (iv) Strengthening DHIS, and (v) periodic supervision by a third party consultant. Given current tight fiscal situation in GoKP, government health budget allocation is suboptimal. Even in the current situation health has a major share of provincial budget. However, once the fiscal situation improves, it is expected that GoKP would allocate a significant share of its resources to health given the Province’s commitment to these aims.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall Risk Rating at Preparation</th>
<th>Overall Risk Rating During Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Substantial</td>
</tr>
</tbody>
</table>
Annex 5: Financial Management and Disbursement Arrangements

PAKISTAN: Revitalizing Health Services in Khyber Pakhtunkhwa Project

Country Issues

1. The Bank has carried out extensive analytical work on public financial management (PFM) systems in the country, Public Financial Management and Accountability Assessments (PFMAA), using the PEFA PFM Performance Measurement Framework have been carried out at national and sub-national levels. The framework includes a set of high level indicators, which measures and monitors performance of PFM systems, processes and institutions. The assessments for the province of Balochistan, Punjab, and KP were completed in May 2007. Assessments at Federal level and for the province of Sindh using the same framework were delivered in 2009. The PFMAA noted that reforms underway have contributed towards improvements in country’s PFM systems. Most notable are the ones initiated under the Bank-funded Project for Improvement of Financial Reporting and Auditing (PIFRA) and the implementation of a Medium Term Budgetary Framework (MTBF) which is supported by DFID. These reforms cover core government ministries and departments. A government wide Financial Management Information System (FMIS) has been implemented under PIFRA. However, donor-funded projects and a number of self accounting entities remain outside the government FMIS. The government is yet to develop an effective internal audit function and continuing efforts are needed to improve effectiveness of tax collection and the management of cash balances impacting the predictability in availability of funds.

FM Staffing

2. A qualified professional accountant with adequate financial management experience would work in the HSRU as the Financial Management Specialist (FMS) with terms of reference agreed with the Bank. Reporting to the Project Coordinator/ Director, the FMS will lead the FM functions of the project with the assistance of an Accounts Officer who will be deputed from the Accountant General’s Office.

Budgeting

3. The Project is a part of Annual Development Plan (ADP) and is reflected in the GoKP’s development budget (ADP Scheme no. 110543). Rules and procedures for budgeting issued by Finance Department GoKP will apply. Annual budget for the project will be prepared by the HSRU on the basis of planned activities. The project’s steering committee will review and approve the budget estimates to be submitted to Finance Department.

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3 Public Expenditure and Financial Accountability (PEFA). The PEFA Program was founded in December 2001 as a multi-donor partnership between the World Bank, the European Commission, and the UK’s Department for International Development, the Swiss State Secretariat for Economic Affairs, the French Ministry of Foreign Affairs, and the Royal Norwegian Ministry of Foreign Affairs, and the International Monetary Fund.
Accounting

4. Separate books of account, on cash basis, will be maintained by the HSRU for the Project activities using the Chart of Accounts under the New Accounting Model (NAM). HSRU will keep accounting record in both Pak Rupees and US Dollars. Sufficient subsidiary records will be kept to facilitate preparation of quarterly reports and annual financial statements providing details of receipts and expenditures by project components and activities.

5. Complete manual books will be maintained including cash book, appropriation register, stock register and vouchers. Within one month of Effectiveness, the HSRU will start working with the PIFRA Directorate for incorporation of the project in the national Financial Management Information System (FMIS), and shall prepare an action plan to ensure that the same is completed within six months of project Effectiveness. Once the HSRU has live access to the national FMIS, complete manual books will be discontinued and only a Cash Book will be maintained.

Internal Controls

6. The HSRU shall prepare a Financial Management Manual (FMM) which will cover areas such as payroll processing, payment processing, fixed assets, cash and bank management etc. The FMM will embody a strong and comprehensive internal control framework for activities under this project. Payments to: i) firms/ NGOs for managing health facilities; and ii) contractors for rehabilitation of health facilities, will constitute the majority of the payments under this project. For payment to firms/NGOs, invoices will be certified by the respective District Health Officer as well as the HSRU. A third party hired by the bank will also evaluate the performance of the firms/NGOs, but this evaluation will not be a pre-condition for payment. The work of the contractors will be supervised by a design and supervision firm who will also certify their invoices before forwarding to the HSRU for payment.

7. Monthly Budget Execution Reports and Bank Reconciliations will be reviewed by the Project Coordinator to monitor budget turnover and financial position. Project Steering Committees will review progress periodically.

8. HSRU will hire a professional accountant for internal audit of the project with terms of reference agreed with the Bank. Internal Auditor will be responsible for the internal audit of the project and will also review the financial management systems of firms/ NGOs, hired for managing health facilities, on periodic basis. The report of internal audit will be reviewed by the Steering Committee and will also be shared with the Bank.

Funds Flow and Disbursement Arrangements

9. In accordance with agreed procedures for operation and maintenance of the Designated Accounts, circulated by the Finance Division, Government of Pakistan; relating to the maintenance and operation of Revolving Fund Accounts of loans/credits/grants, a segregated Designated Accounts (DA) in US Dollars, will be established for the receipt of funds from the Bank. Disbursement from the grant proceeds, expected in US Dollars, will be translated into Pak
Rupees by the State bank of Pakistan, and the equivalent amount of local currency will be released to the Designated Account (DA) maintained with National Bank of Pakistan. The DA will be operated by joint signatories ensuring segregation of duties.

**Chart I: Funds Flow**

10. Disbursements will be made quarterly using the report-based principle. HSRU shall prepare and submit Interim Unqualified Financial Reports (IUFRs) within 45 days of the end of each quarter. The format and content of IUFRs will be agreed during Negotiations. Advances will be provided for the following six months based on the budgeted/forecast expenditures for that period. Subsequent IUFRs will document expenditures against the advance received and provide forecast expenditures for the further six months on the basis of which the amount of funds to be disbursed will be determined.

**Allocation of Grant Proceeds**

<table>
<thead>
<tr>
<th>Disbursement Category</th>
<th>Amount of Grant (expressed in USD)</th>
<th>Percentage of Expenditures to be Financed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1:</strong> Component 1 and 3 Goods, Non-Consulting Services, Consultants’ services, Training and Workshop and Incremental Operating Costs</td>
<td>15,000,000</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Category 2:</strong> Component 2 Goods, Works, Non-Consulting Services and Consultants’ services</td>
<td>1,000,000</td>
<td>100%</td>
</tr>
<tr>
<td><strong>TOTAL AMOUNT</strong></td>
<td>16,000,000</td>
<td>100%</td>
</tr>
</tbody>
</table>
11. The MDTF financing is inclusive of import duties and taxes.

12. “Incremental Operating Costs” means the reasonable expenditures for office rent, office supplies, utilities, conveyance, travel and boarding/lodging allowances, per diem, operating and maintenance expenditures of office equipment and vehicles, bank charges, insurance, advertising, media projections, newspaper subscriptions, periodicals, printing and stationary costs incurred by the Project Implementing Entity for purposes of carrying out Project activities, which expenditures would not have been incurred in the absence of the Project. The term “Incremental Operating Costs” does not include salaries or salary supplements of the neither the Recipient’s nor the Project Implementing Entities’ civil servants.

**Retroactive financing**

13. The Project requires retroactive financing to meet eligible expenditures paid prior to the signing of the Grant Agreement, but after July 1, 2011. The retroactive financing is allowed up to 10 percent of the amount of the Grant.

**Financial Reporting**

14. The Project reports and financial statements will identify the uses of funds according to the pre-defined eligible expenditure elements, adequate notes, and disclosures consistent with acceptable international practice will be provided. Annual financial statements will be prepared according to Cash Basis IPSAS.

15. Quarterly Interim Unqualified Financial Reports (IUFRs), including cash forecasts for two quarters in a format agreed with the Bank will be prepared for disbursement of funds and monitoring by the Bank. These reports will be submitted to the Bank within forty five days of the end of each quarter.

**Auditing**

16. Annual financial statements of the project will be audited by the Auditor General of Pakistan, which is acceptable to the Bank. The audited financial statements will be submitted to the Bank within six months after the close of the fiscal year ending June 30.

<table>
<thead>
<tr>
<th>Audit Report Type</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project Audited Financial Statements for Financial Year ended June 30 each year</td>
<td>December 31 each year.</td>
</tr>
</tbody>
</table>

17. HSRU and Department of Health, Government of KP are currently not implementing any Bank funded project and therefore no audit reports are outstanding and there is no overdue ineligible expenditure.
Financial Management at Firms/ NGOs

18. The firms/ NGOs, to whom management of health facilities in the hubs will be outsourced under Component 1 of the project, will be required to maintain a financial management system and prepare financial statements in accordance with consistently applied accounting standards (IPSAS or IUFRS) acceptable to the World Bank, both in a manner adequate to reflect the operations, resources and expenditures related to the Project.

19. As part of their proposal, the Firms/ NGOs will be required to provide a detailed financial management plan. During proposal evaluation the proposed financial management arrangements for the project will be evaluated and an assessment of the bidder’s existing FM systems may be carried out, if required.

20. During project implementation, the Firms/NGOs will also be responsible for managing health budget of the selected districts and therefore Auditor General of Pakistan shall have the right to audit accounts and records of the Firms/NGOs related to government budget. The Firms/NGOs shall also permit HSRU to periodically review its financial management system to ensure that it is being operated as proposed in the proposal and in accordance with acceptable accounting standards. The Internal Auditor of HSRU shall carry out these reviews periodically.

21. The Firms/NGOs shall submit periodic financial reports to the HSRU including periodic budget execution reports, cash flow statement, cash forecasts, spending against each indicator, details of procurements, inventory record, payroll reconciliations etc. Format of these reports will be agreed with the Firms/NGOs as part of contract.

Supervision Plan

22. Intensive FM supervision will be required in the initial year of implementation given the challenges and the capacity of the sector’s financial management staffing. However, security risk can limit the field supervision and desk review may remain the most feasible supervision option. Another option would be to hire supervision consultant for field supervision if security situation do not improve over the medium term. During Project implementation, the Bank will review: (a) the Project IUFRs and audited financial statements, including the budget execution report, together with the management letters; and (b) the Project’s financial management and disbursement arrangements to ensure compliance with the agreed requirements. With the implementation of the sound financial management by the professional staff proposed for the MU, the Bank’s normal implementation review procedures will suffice.
Annex 6: Procurement Arrangements

PAKISTAN: Revitalizing Health Services in Khyber Pakhtunkhwa Project

1. Procurement for the proposed Project would be carried out in accordance with the World Bank’s “Guidelines: Procurement under IBRD Loans and IDA Credits” dated January 2011; and “Guidelines: Selection and Employment of Consultants by World Bank Borrowers” dated January 2011, as well as the provisions stipulated in the Financing Agreement. The general description of various items under different expenditure categories are described below. For each contract to be financed by the Grant, the different procurement methods or consultant selection methods, estimated costs, prior review requirements, and time frame are to be agreed between the Borrower and the Bank Project team in the Procurement Plan. The borrower is preparing a procurement plan, which shall be discussed and finalized by negotiations. The Procurement Plan will be updated at least annually or as required to reflect the actual Project implementation needs and improvements in institutional capacity. A General Procurement Notice shall be published as soon as procurement plan is prepared, provided that any procurements subject to international competition are identified. The GoKP shall ensure that the Project is carried out in accordance with the provisions of the Anti-Corruption Guidelines.

Procurement of Works

2. Several contracts of civil works are identified which are allocated US$1.0 million for the reconstruction of the damaged health facilities in the districts. Given the size of the contracts, the law and order situation of the project area and the presence of ample number of national contractors working in the vicinity, these contracts shall be awarded based on national competitive bidding. No ICB contracts are envisaged for civil works in this project, and contracts up to the cost of US$ 200,000 may be procured through shopping procedures. Direct contracting may be used to carry out emergency works (if any), after prior approval of the Bank. The Bank’s agreed bidding document for NCB shall be used.

Procurement of Goods

3. There could be some requirements of office equipment (furniture, and computers) and field vehicles.

4. Contracts for goods under ICB are not expected at this stage. Procurement methods for goods under the Project will consist of shopping for contracts costing up to US$200,000, NCB for contracts up to US$300,000, and ICB for contract costing more than US$300,000. Direct contracting may be used for any urgently required goods after prior approval of the Bank.

Procurement of non-consulting services

5. Some services for data collection/surveys may be required. If any such procurement is agreed, the Banks sample documents for such procurements shall be used.
Additional Provisions and Procedures for National Competitive Bidding (NCB)

6. When procuring works pursuant to the provision of rules 18 through 22, 24, 31, 35 and 36 of the NWFP Public Procurement rules (SO)FR)/9-7/2002 for KP, it shall be ensured that the following additional provisions are applied:

(i) Invitations to bid shall be advertised in at least one (1) national newspaper with a wide circulation, at least thirty (30) days prior to the deadline for the submission of bids.

(ii) Bid documents shall be made available, by mail or in person, to all who are willing to pay the required fee.

(iii) Foreign bidders shall not be precluded from bidding and no preference of any kind shall be given to national bidders in the bidding process.

(iv) Bidding shall not be restricted to pre-registered firms.

(v) Qualification criteria shall be stated in the bidding documents.

(vi) Bids shall be opened in public, immediately after the deadline for submission of bids.

(vii) Bids shall not be rejected merely on the basis of a comparison with an official estimate without the prior concurrence of the World Bank.

(viii) Before rejecting all bids and soliciting new bids, the World Bank’s prior concurrence shall be obtained.

(ix) Bids shall be solicited and works contracts shall be awarded on the basis of unit prices.

(x) Contracts shall not be awarded on the basis of nationally negotiated rates.

(xi) Single bids shall also be considered for award.

(xii) Contracts shall be awarded to the lowest evaluated and qualified bidder.

(xiii) Post-bidding price negotiations shall not be allowed with the lowest evaluated or any other bidders.

(xiv) Draft contracts would be reviewed by the World Bank in accordance with the prior review procedures.

(xv) State-owned enterprises shall be eligible to bid only if they can establish that they are legally and financially autonomous, operate under commercial law, and are not a dependent agency of the Recipient

(xvi) A firm declared ineligible by the World Bank, based on a determination by the
World Bank that the firm has engaged in corrupt, fraudulent, collusive, coercive or obstructive practices in competing for or in executing a World Bank-financed contract, shall be ineligible to be awarded a World Bank-financed contract during the period of time determined by the World Bank.

(xvii) The World Bank shall declare a firm ineligible, either indefinitely or for a stated period, to be awarded a contract financed by the World Bank, if it at any time determines that the firm has, directly or through an agent, engaged in corrupt, fraudulent, collusive, coercive, or obstructive practices in competing for, or in executing, a contract financed by the World Bank.

(xviii) Each contract financed from the proceeds of the Grant shall provide that the suppliers, contractors and subcontractors shall permit the World Bank, at its request to inspect their account and records audited by auditors appointed by the World Bank. The deliberate and material violation by the supplier, contractor or subcontractor of such provision may amount to obstructive practice.

Selection of Consultants

7. The major consultancy assignments would be for contracting the management of health services in the districts, the total amount of the contracts is estimated at US$11.0 million for the six districts. Other major consultancy service is that for the supervision of civil works. Contracts with consulting firms will be procured in accordance with Quality and Cost Based Selection (QCBS) procedures or other methods given in Section III of the Consultants’ Guidelines. Consulting services selection would be carried out through QCBS for contracts with consulting firms costing more than US$300,000 equivalent, and through Consultants Qualification (CQ) for contracts costing up to US$300,000. Other methods as mentioned in Section III of Consultants’ Guidelines shall be used as required.

Individual Consultants

8. This is envisaged to include any full-time or part-time technical assistance required for the Project. Services for assignments that meet the requirements set forth in paragraph 5.1 of the Consultant Guidelines may be procured under contracts awarded to individual consultants in accordance with the provisions of paragraphs 5.2 through 5.3 of the Consultant Guidelines, which stipulate that the selection should be made through comparison of at least 3 CVs that meet the requirements of the Terms of Reference including those for qualifications and experience. Under the circumstances described in paragraph 5.4 of the Consultant Guidelines, such contracts may be awarded to individual consultants on a sole-source basis.

Operational Costs

9. Costs related to the implementation of the project will be financed by the Grant.
Assessment of the Agency’s Capacity to Implement Procurement

10. The identified risks for procurement and contract implementation and mitigation measures are provided below. Given the readiness status of the project the overall project risk for procurement is High.

11. The Department of Health, GoKP will be responsible for project implementation. The HSRU within the DoH supported (if required) by the ISU at the P&D shall be responsible unit for project implementation. A procurement officer will be hired /designated in the HSRU, before any procurement action is commenced. Districts shall be responsible for the selection of the management firms under guidance of and with approval of the HRSU. Contract implementation focal points at districts shall also be identified. Procurement capacity assessment for the implementing agency shall be done once the project is functional and the staff is hired. The Bank will conduct a training workshop for the project staff soon after identification/hiring of the staff.

Procedural Clarity

12. Given the emergency nature of the project, quick turnaround in procurement decisions is essential. There shall be agreement with GoKP that the HSRU shall be empowered to take procurement decisions. Moreover, the management contracts could be either tripartite among the firm, HRSU and district, OR between the district and the firm, whereas roles and responsibilities of HRSU and the district shall be documented in an MOU. Such agreements shall be agreed and documented in the project operations manual.

Market Constraints

13. Consulting firms may be reluctant to participate in the project given the law and order situation. The assignments shall be developed in a manner that local as well as external participation is encouraged and the contract sizes are large enough to solicit good response. There shall be adequate dissemination of the opportunities.

Transparency

14. The official websites of the DoH shall have a specific procurement link for adequate dissemination. All procurement notices, bid documents /RFPs, evaluation reports, and award data shall be posted on the website. These websites shall also be used for posting of grant evaluations, awards, and performances. Bank’s guidelines on publication of award paragraph 2.31 of consultancy guidelines and 2.60 of the procurement guidelines shall be followed for disclosure.

Complaints

15. The DoH shall manage the complaint handling system. This system would include documentation and addressing of complaints within a period of seven days. The DoH shall keep the Bank informed by forwarding to it any complaints within three days of the receipt. A second tier for appeals for the complainant will be the Additional Chief Secretary of the province.
Table 6a.1: Procurement Actions (Summary of the above identified issues and agreed actions)

<table>
<thead>
<tr>
<th>Issues</th>
<th>Action</th>
<th>Timeline</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>i.  Capacity of HSRU</td>
<td>Hiring of respective Procurement staff and Focal points</td>
<td>Before commencing any procurements (tentative by November 30, 2011)</td>
<td>DoH/districts</td>
</tr>
<tr>
<td></td>
<td>Training session of Project staff</td>
<td>After hiring of staff</td>
<td>Bank</td>
</tr>
<tr>
<td>ii. Procedural clarity</td>
<td>Agreement on Recipients’ internal approval procedures</td>
<td>Before commencing any procurements</td>
<td>DoH</td>
</tr>
<tr>
<td>iii. Market Constraints</td>
<td>Adequate packaging</td>
<td>Ongoing</td>
<td>DoH</td>
</tr>
<tr>
<td></td>
<td>Wide circulation</td>
<td>Ongoing</td>
<td>DoH</td>
</tr>
<tr>
<td>v.  Transparency</td>
<td>Functional web site</td>
<td>DoH website exists procurement link to be developed before commencing any procurements</td>
<td>DoH</td>
</tr>
<tr>
<td></td>
<td>Disclosure on website</td>
<td>Continuous process</td>
<td></td>
</tr>
<tr>
<td>vi. Complaints</td>
<td>Independent complaint redressal mechanism</td>
<td>45 days after the signing (Effective Date) of the Grant Agreement</td>
<td>DoH</td>
</tr>
</tbody>
</table>

Procurement Plan

16. The Recipient has developed a Simplified Procurement Plan for project implementation which provides the basis for the procurement methods. Procurement plan will be made available in the Project’s database, Project website, and the Bank’s external website. The Procurement Plan will be updated in agreement with the Project Team annually or as required to reflect the actual project implementation needs and improvements in institutional capacity.

Table 6a.2: Simplified procurement plan

<table>
<thead>
<tr>
<th>Action</th>
<th>Tentative award timeline</th>
<th>Method</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>i) Environmental Monitoring</td>
<td>Jun 2012</td>
<td>CQS/SSS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ii) Hiring of (management) implementing firms (up to six contracts)</td>
<td>May 2012</td>
<td>QCBS</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>iii) Hiring of staff and individual consultants</td>
<td>November 2011</td>
<td>Competitive</td>
<td></td>
<td>√</td>
<td></td>
</tr>
<tr>
<td>iv) Selection of firm for M&amp;E</td>
<td>January 2012</td>
<td>CQS</td>
<td></td>
<td>√</td>
<td></td>
</tr>
</tbody>
</table>
**Frequency of Procurement Supervision**

17. In addition to the prior review supervision to be carried out from Bank offices, the capacity assessment of the Implementing Agency has recommended frequent supervision missions to visit the field to carry out post review of procurement actions.

**Review of Procurement by the Bank**

18. Thresholds for prior review of contracts under eligible expenditures are given in the table below. All other contracts will be subject to Post-Review by the Bank. HSRU will send to the Bank a list of all contracts for post-review on a quarterly basis. Post-reviews as well as the implementation reviews would be done six monthly. Such review of contracts below threshold will constitute a sample of about 15-20 percent of the contracts.

**Table 6a.3: Thresholds for Procurement Methods and Prior Review**
Aligned with the Rapid Response to Crisis and Emergencies: Streamlined Procurement Procedures

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>Contract Value (US$)</th>
<th>Procurement Method</th>
<th>Contracts Subject to Prior Review (US$)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Works</td>
<td>&gt;=200,000</td>
<td>NCB</td>
<td>First Contract</td>
</tr>
<tr>
<td></td>
<td>&lt;200,000</td>
<td>Shopping</td>
<td>First contract</td>
</tr>
<tr>
<td></td>
<td>Regardless of value</td>
<td>Direct Contracting</td>
<td>All</td>
</tr>
<tr>
<td>2. Goods</td>
<td>&gt;300,000</td>
<td>ICB</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>&lt;300,000</td>
<td>NCB</td>
<td>First Contract</td>
</tr>
<tr>
<td></td>
<td>&lt;200,000</td>
<td>Shopping</td>
<td>First contract</td>
</tr>
<tr>
<td></td>
<td>Regardless of value</td>
<td>Direct Contracting</td>
<td>All</td>
</tr>
<tr>
<td>3. Consulting Services</td>
<td></td>
<td></td>
<td>All TORs and Training Programs to be reviewed by Bank’s TTL</td>
</tr>
<tr>
<td>3.A Firms</td>
<td>&gt;100,000</td>
<td>QCBS, CQS, QBS, FBS, LCS</td>
<td>First contract by any process and thereafter as provided in Proc. Plan</td>
</tr>
<tr>
<td></td>
<td>Regardless of value</td>
<td>Single Source</td>
<td>All</td>
</tr>
<tr>
<td>Individual Consultants</td>
<td></td>
<td>Comparison of 3 CVs</td>
<td>All</td>
</tr>
</tbody>
</table>
Details of the Procurement Arrangement for major contracts

a. Works.

List of contract Packages which will be procured following ICB and direct contracting:

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Contract Description</th>
<th>Estimated Cost (US$)</th>
<th>Procurement Method</th>
<th>PQ</th>
<th>Domestic Preference</th>
<th>Review by Bank (Prior / Post)</th>
<th>Expected Bid-Opening Date</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Civil works</td>
<td>US $ 1.0 m (1-3 contracts)</td>
<td>NCB</td>
<td>No</td>
<td>No</td>
<td>Prior (first contract)</td>
<td>March 2012</td>
<td></td>
</tr>
</tbody>
</table>

b. Consulting Services.

List of Consulting Assignments

<table>
<thead>
<tr>
<th>Ref No.</th>
<th>Description of Assignment</th>
<th>Estimated Cost</th>
<th>Selection Method</th>
<th>Review by Bank (Prior / Post)</th>
<th>Expected Proposals Submission Date</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M&amp;E firm</td>
<td>US $ 0.275 m</td>
<td>CQS</td>
<td>prior</td>
<td>End Dec 2011</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Environmental monitoring</td>
<td>US $ 0.03m</td>
<td>CQS/SSS</td>
<td>/prior</td>
<td>Feb 2012</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>District management implementation contracts</td>
<td>Six contracts collectively costing US $11m.*</td>
<td>QCBS</td>
<td>prior</td>
<td>December 2011</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Civil Works Supervision contracts</td>
<td>US$0.05m</td>
<td>QCBS</td>
<td>prior</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Each of these contracts is expected to cost not more than US$ 200,000. In the RFP for every district, a fixed sum of about US$ 6.5 million shall be indicated which will be salary budget and other fixed costs transferred to the selected management firm. For evaluation purposes however, the estimated cost is US$ 200,000.
Annex 7: Implementation and Monitoring Arrangements

PAKISTAN: Revitalizing Health Services in Khyber Pakhtunkhwa Project

A. Implementation Arrangements and Financing Plan

1. Implementation period – 3.0 Years; Implementing Agency: The project has been prepared by the Health Sector Reform Unit of the Department of Health KP and its implementation shall rest with the HSRU. HSRU was established in early 2002, and was the first unit established in Pakistan. The unit was established in the Health Department with a view to prioritize the reform initiatives, harmonize the donor support, provide technical support to the districts and coordinate human resource development according to the needs of the organization. The unit is at the forefront of reforms for the health sector in KP and as such has a very good grasp of the overall situation and intricacies involved in managing and reforming the system. The Unit is headed by a full time Director, supported by a deputy director and has 2-3 coordinators responsible for various areas of work. The Unit reports directly to the Secretary Health and has a very close working relationship with the Planning Department as well as the Directorate General of Health. The Unit has successfully conducted the following initiatives:

- **Public Private Partnership (PPP):** Contracted seven districts to Sarhad Rural Support Program and MoUs at provincial & district level have been signed, developed a PC-I for autonomy of EDO's in two districts with performance based incentives, developed various indicators to assess performance of the district government.

- **Health Financing:** Social health insurance (concept of social health insurance is being worked out for implementation, draft SHI laws are being examined in line with the Philippines health insurance model after which laws for NWFP would be formulated shortly. Also working on developing insurance scheme for the formal sector (only government employees), and working on private health insurance.

- **Health policy formulation for KP:** meetings with stakeholders from various sections of the population have been held, draft policy has been formulated, and donor coordination within health sector,

- **Management information system** and geographic information system are being introduced.

- **Support to health sector reforms program:** Technical and financial prospects of districts, mechanisms of flow of budget, establishment of monitoring and evaluation cell,

- **Quality management:** The Health Regulatory Authority has been established for quality control and management, revising and updating existing standards for clinics, hospitals and laboratories, accreditation of private sector hospital and clinics, standard protocols have been developed for first and second level health care facilities, tools for assessment of these standards protocol are in process of development, categorization of health facilities/hospitals in the district.

2. Overall oversight arrangements: A Steering Committee for the project shall be established within the department with Additional Chief Secretary as the Chairman, and the Secretary Finance. Secretary Health, Additional Secretary Health (Development), Director General Health Services, Chief HSRU, Chief Planning Officer, Director M&E Cell Health Department, DCO /EDO (H) of the concerned districts, and Project Director IQHCS as members
and the Project Coordinator as the Secretary. The steering committee shall meet bi-annually and provide guidance to the project team. The Additional Secretary (Development) Health shall provide supervisory support to the project and will be a co-signatory on the project finances. A Project Coordinator (most likely Chief HSRU) shall be appointed from within the staff working at the HSRU. At the District level the DHMT shall provide the oversight support and monitor and report project progress to the Provincial Steering Committee.

3. **Project Management.** No separate project implementation unit shall be established and the project shall be managed by a Management Unit (MU) within the HSRU. The HSRU shall be provided cross support by the ISU established by the MDTF funded Governance project established at the Planning and Development department. The HSRU shall also engage a full time accountant on market rates with relevant experience in project management, in addition to an M&E expert and management consultant to support the unit. The capacity of the unit shall be assessed, and as required, short term consultants shall be hired to provide support during implementation. The HSRU functioning as the project secretariat shall support the project steering committee. The HSRU will be responsible for overall coordination, internal/external processing of all approvals including PC-I, procurement and management of consultant services, operating special account and financial management.

4. **District level implementation.** The field implementation of the project shall be overseen by the EDOH and their supporting staff in the respective districts. The EDOH shall be responsible for oversight of environmental and social safeguards, monitoring of civil works and performance monitoring implementation of management contracts. The EDOH shall also provide supervisory support to the management contractor as well as verify the data provided by the management contractor for onward submission to the provincial office. The EDOH shall also act to address any grievance/complaints from the community regarding service provision and closely monitor the performance of outreach work. In addition, the EDOH shall also act as the main coordination point for the national/priority programs with the management contractor.

5. **Health Services Contracts:** The implementing agencies will be private entities that will be selected competitively. The DoH shall issue EOIs in the newspapers and hold a one day briefing to explain the overall concept to the firms/entities showing willingness to participate. Detailed TORs and RFPs shall be issued to the firms where they will identify proposed hubs for service provision based on the mapping provided by the department. Contractual Agreements will be signed between the Health Department KP, management contractor, and the district government outlining details of the roles and responsibilities of each partner. The Government of KP shall authorize transfer of the salary and non-salary budget of all District level services, and the national priority programs like EPI, Malaria, TB DOTS, and National Program for FP&PHC, MNCH program, consistent with guidelines applied to the vertical programs of the proposed districts to management contractor. In order to carry out the activities to achieve the objectives of the project under this arrangement, the contractor shall have the authority to provide performance based incentives and other management actions. To enhance the competitive environment to perform better, individual performance and blanket performance of the health facility will be assessed and provision of incentives, on mutually agreed rates between the tripartite partners, to high performing staff will be part of the TORs.
**Financing Plan**

6. The total project cost will be US$61 million out of which US$16 million will be financed through MDTF and the rest is the regular budget of the districts for recurrent cost of the health facilities.

<table>
<thead>
<tr>
<th>Bank Project Costs (MDTF)</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment Costs</td>
<td>1.0</td>
<td>3.5</td>
<td>2.5</td>
<td>7.0</td>
</tr>
<tr>
<td>Recurrent Costs</td>
<td>0.5</td>
<td>4.0</td>
<td>4.5</td>
<td>9.0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1.5</td>
<td>7.5</td>
<td>7.0</td>
<td>16.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Government Costs parallel Financing</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent (Regular budget)</td>
<td>10.0</td>
<td>15.0</td>
<td>15.0</td>
<td>45.0</td>
</tr>
<tr>
<td></td>
<td>19.5</td>
<td>22.5</td>
<td>21.0</td>
<td>61.0</td>
</tr>
</tbody>
</table>

7. GoKP’s regular recurrent and development budget may be used in the area in parallel to the MDTF contribution for extra support in goods, services or works. However the success of the project is not dependant on the allocation or execution of the additional amount.

**Bank Supervision, Monitoring, and Evaluation (M&E) Arrangements:**

8. The supervision of the project in the current security constrained situation of the country is a challenging task; however keeping the limitations of the access for Bank staff in view, a comprehensive supervision framework has been developed for the project consisting of multiple tiers. Although these may not be as satisfactory as having direct access, the proper application of the proposed methods should lead to a level of supervision that will enable effective oversight of project implementation.

9. For this project, the proposed supervision mechanisms include:

   a. **Supervision Missions (Bank Premises or Peshawar):** Six-monthly regular supervision missions shall be fielded in the Bank premises or in Peshawar city if the security situation permits. Participants shall include the Bank’s Task Team, HSRU officials, EDO Health of the project districts.

   b. **Third Party Monitoring.** For quality assurance and cross verification, a third party monitoring mechanism has been inbuilt in the project with the third party being hired by the recipient to conduct a baseline survey, verifying the current data, conducting a midterm review and an endline assessment.

   c. **District Health Information System:** The progress in achieving the Project's objectives against the performance indicators will also be measured through the District Health Information System, as well as the MIS of the national/priority
programs. The EDOH shall verify the data produced by the MIS during routine supervisory visits in the districts.

d. **Supervisory Reports:** The supervisory reports by the EDOH and the provincial team shall also be utilized for monitoring purposes and these will be supported by referencing the grievance data generated at the district level.

e. **Independent Monitoring:** The Bank team shall be assisted by an independent consulting agency hired for the project life with the ability to field local consultants in the districts with access to the project areas. The reports of the consultants shall comprise of pictures of the proposed sited for renovation/ rehabilitation with before and after images, data collected from the MIS of the health facility as well as interviews/ interaction with the community.
Annex 8: Project Preparation and Appraisal Team Members

PAKISTAN: Revitalizing Health Services in Khyber Pakhtunkhwa Project

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tayyeb Masud</td>
<td>Task Team Leader, Health Specialist</td>
<td>SASHN</td>
</tr>
<tr>
<td>Inaam Haq</td>
<td>Senior Health Specialist</td>
<td>SASHN</td>
</tr>
<tr>
<td>Kees Kostermans</td>
<td>Lead Public Health Specialist</td>
<td>SASHN</td>
</tr>
<tr>
<td>Tekabe Ayalew Belay</td>
<td>Senior Economist</td>
<td>SASHN</td>
</tr>
<tr>
<td>Naoko Ohno</td>
<td>Operations Officer</td>
<td>SASHN</td>
</tr>
<tr>
<td>Maria Gracheva</td>
<td>Senior Operations Officer</td>
<td>SASHN</td>
</tr>
<tr>
<td>Martin Serrano</td>
<td>Senior Counsel</td>
<td>LEGES</td>
</tr>
<tr>
<td>Chau-Ching Shen</td>
<td>Sr. Financial Officer</td>
<td>CTRFC</td>
</tr>
<tr>
<td>Javaid Afzal</td>
<td>Senior Environmental Specialist</td>
<td>SASDI</td>
</tr>
<tr>
<td>Chaohua Zhang</td>
<td>Lead Social Development Specialist</td>
<td>SASDS</td>
</tr>
<tr>
<td>Samina Mussarat Islam</td>
<td>Social Development Specialist</td>
<td>SASDS</td>
</tr>
<tr>
<td>Robert Bou Jaoude</td>
<td>Program Manager - MDTF</td>
<td>SASPK</td>
</tr>
<tr>
<td>Uzma Sadaf</td>
<td>Senior Procurement Specialist</td>
<td>SARPS</td>
</tr>
<tr>
<td>Waseem Kazmi</td>
<td>Financial Management Specialist</td>
<td>SARFM</td>
</tr>
<tr>
<td>Anwar Ali Bhatti</td>
<td>Financial Analyst</td>
<td>SACPK</td>
</tr>
<tr>
<td>Nasreen Shah Kazmi</td>
<td>Team Assistant</td>
<td>SASHD</td>
</tr>
</tbody>
</table>
Annex 9: Safeguards Policy Issues

PAKISTAN: Revitalizing Health Services in Khyber Pakhtunkhwa Project

1. To address the potentially negative environmental and/or social impacts associated with the projects under MDTF, the Bank has prepared an Environmental and Social Screening and Assessment Framework (ESSAF), in accordance with OP 8.00 for emergency operations. Since the Revitalizing Health Services Project is being proposed under MDTF, the ESSAF is applicable to this project also. The key aspects of the Framework are summarized below.

Impact Screening, Assessment and Mitigation Planning

2. While preparing any operations or projects for financing under the MDTF, the ESSAF will be followed to screen environmental and social impacts and plan any required mitigation measures. The screening process and its findings as well as the proposed mitigation measures will be documented as part of the project/subproject package. The following guidelines, codes of practice and requirements will be followed in the selection, design and implementation of any operations financed under the MDTF.

   a. Environmental impact assessment will be conducted for all projects/subprojects under MDTF, during the project implementation. Criteria for the type of assessment to be conducted for individual projects/subprojects are provided in Table 9.1. Full Environmental Assessments (EAs) will need to be conducted and clearance obtained from the Bank prior to initiating environmental category ‘A’ projects/subprojects. Environmental and Social Management Plans (ESMPs) will need to be prepared and clearance obtained from the Bank prior to initiating environmental category ‘B’ projects/subprojects. The EAs and ESMPs will also be submitted to the relevant EPA for obtaining No Objection Certificate (NOC) before commencing the project/subprojects implementation, in line with the national regulatory requirements in the Country. For smaller subprojects, environmental and social screening and assessment will be conducted with the help of checklists (a typical checklist is provided in the ESSAF).

   b. Each implementing agency for the projects under the MDTF will appoint/designate an environmental and social focal point (ESFP), who will be responsible for ESSAF implementation within his/her organization, and also for the preparation and submission of quarterly monitoring reports to the Bank on the screening of and the rationale for the proposed environmental categorization of each project.

   c. While conducting environmental assessment, cumulative impacts of a large number of projects/subprojects will also be considered.

   d. All projects/subprojects will be screened for need of land acquisition and resettlement. If confirmed, necessary planning efforts will be carried out to develop mitigation measures. A guideline for land compensation and resettlement planning is provided in ESSAF.

   e. All projects/subprojects will be screened for impacts on physical cultural resources and necessary mitigation measures. Procedures for the protection of cultural
property, including the chance discovery of archaeological artifacts, unrecorded graveyards and burial sites are outlined in ESSAF.

f. All construction contracts for the projects/subprojects financed by the MDTF will include appropriate clauses to ensure effective implementation of the mitigation measures identified in EA/ESMP/Checklist. A sample environmental safeguards procedure for inclusion in the technical specifications of contracts is provided in ESSAF.

g. The Environment, Health and Safety Guidelines developed by the International Finance Corporation (IFC) and the World Bank will also be applicable to the activities under the emergency projects/subprojects. The Guidelines are provided in ESSAF.

h. The procurement plans for the proposed projects/subprojects will include milestones for preparation of EA/ESMP/Checklist, and obtaining clearance from the Bank.

i. Subject to the needs as determined by the Bank’s safeguards’ team, the implementing agency will engage an independent consultant or consulting firm to conduct an annual environmental and social audit as third party validation, of the subprojects undertaken during each year of the Project implementation.

Consultations

3. Consultations will be mainstreamed in the preparation of new operations under the MDTF. For environmental Category ‘A’ and ‘B’ operations, the implementing agencies will consult the potentially affected groups and local nongovernmental organizations on the project environmental and social aspects, and will take their views into account. The implementing agencies will initiate these consultations as early as possible, and for meaningful consultations, will provide relevant material in a timely manner prior to consultation, in a form and language(s) that are understandable and accessible to the groups being consulted.

4. For Category ‘A’ projects/subprojects, the implementing agencies will consult these groups at least twice: (a) shortly after the environmental screening and prior to finalization of the terms of reference for the EA and Resettlement Plan (RP); and (b) once a draft EA report and RP are prepared. For the initial consultation, the implementing agencies will provide a summary of the proposed subproject's objectives, description, and potential impacts. For both Category ‘A’ and ‘B’ projects, the implementing agencies will provide these groups with a summary of the EA report and RP (including the conclusions of the assessment). In addition, the implementing agencies will make the draft reports publicly available to project-affected groups and local nongovernmental organizations.

Planning, Review and Approval

5. The entire environmental and social screening and assessment procedure described above will be integrated within the preparation of the operations under the MDTF. To this end, the screening and planning to address environmental and social impacts would be initiated during the operation preparation phase. The operation preparation agencies will be responsible for the

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As defined in World Bank Operational Policy 4.01, Environmental Assessment.
screening and planning of any environmental and social action plans required in line with this Framework. The EA or ESMP and RPs will be submitted to the project approving authority as part of the project/subproject application package. The implementation agencies will assign specialists to review the environmental and social safeguard action plans, such as screening report, EA, ESMP and RP. The implementation agencies will submit the safeguard documents for World Bank’s review and clearance, in accordance with the procedures as described earlier in the Annex. The implementation agencies will not approve the proposed operations until the required environmental and social safeguard action plans are cleared for compliance with the Framework by the World Bank. A simplified flow chart for subproject preparation, approval and execution along with the EA/ESMP/Checklist requirements is provided below.

6. The implementing agencies will implement the projects under MDTF in close coordination with the relevant line departments, local governments, and political agents. Each implementing agency and in turn, each line department, will be responsible for applying the safeguard screening and mitigation requirements to its own projects. Separate environmental and social focal points (ESFPs) will be identified in each of the implementing agencies, with responsibility for overseeing the implementation of the ESSAF. The provincial EPAs (for KP and Balochistan), and Federal EPA (for FATA projects) will be responsible for environmental clearance for operations or projects/subprojects that require statutory environmental clearance, in accordance with the law. Although the national/provincial environmental clearance procedures are adequate and fairly reliable, the Bank will still review a samples of the EAs/ESMPs prepared under each subcomponent and provide necessary concurrence for the approval of disbursements of funds.

7. All agencies and departments who are preparing and will implement operations under the MDTF will appoint officers as the environmental and social focal points (ESFPs), who will liaise and coordinate with relevant agencies to ensure compliance with this Framework.

**Capacity-Building and Monitoring of ESSAF Implementation**

8. As part of the capacity-building to be provided for implementation of the proposed operations, the ESFPs and relevant staff of the concerned line departments will also receive training in ESSAF’s application. The World Bank will monitor and provide guidance in the implementation of the ESSAF. The World Bank will also assist in this capacity-building in the implementation of approved safeguard action plans.
9. The implementing agencies through their ESFPs will be responsible, besides other functions, to monitor and supervise the implementation of any safeguard action plans. For this purpose, the implementing agencies will establish a monitoring mechanism as part of the project management system over the implementation of agreed safeguard action plans. In addition, the implementing agencies will also engage external monitors over the implementation of agreed safeguard action plans. The monitoring mechanisms should be detailed in the required action plans.

**Disclosure**

10. This ESSAF has been shared with all relevant agencies, line departments of the provincial and federal governments, concerned nongovernmental organizations, and development partners. Subsequently, it has also been disclosed in Urdu and English by the implementing agencies, and also made available at the websites of GoP, GoKP, FATA Secretariat, GoBalochistan and the relevant line departments including FHA. Copies of ESSAF have also been sent to Federal EPA, KP EPA, and Balochistan EPA. The document is also disclosed at the World Bank’s InfoShop. Relevant project specific safeguard documents/mitigation plans to be prepared subsequently will also be disclosed in a similar manner.

**Table 9.1: Criteria for Type of Environmental Instrument**

<table>
<thead>
<tr>
<th>Type of Subproject</th>
<th>Category A Projects/Subprojects</th>
<th>Category B Projects/Subprojects</th>
<th>Smaller Projects/Subprojects</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full EA Required</td>
<td>ESMP Required</td>
<td>Environmental Screening Required</td>
</tr>
<tr>
<td>Infrastructure (such as water supply, sanitation, solid waste management, access roads, drainage, and street lighting)</td>
<td>Cost: Rs 25 million or above</td>
<td>Cost: less than Rs 25 million, but more than 1 million</td>
<td>Cost: up to 1 million</td>
</tr>
<tr>
<td>Roads</td>
<td>Cost: Rs. 50 million or above</td>
<td>Cost: less than Rs 50 million, but more than 2 million</td>
<td>Cost: up to 2 million</td>
</tr>
<tr>
<td>Schools and health care facilities</td>
<td>Cost: Rs. 50 million or above</td>
<td>Cost: less than Rs 50 million, but more than 2 million</td>
<td>Cost: up to 2 million</td>
</tr>
</tbody>
</table>

Note: These criteria may need to be customized for individual projects under MDTF and approval obtained from the Bank.

**Project-specific Environmental and Social Management Plan**

11. The rehabilitation of health facilities under the proposed project may potentially cause negative environmental impacts, such as soil erosion, water and soil contamination, air quality deterioration, and safety hazards for workers and surrounding population. Similarly, the medical waste from the health facilities under the project poses health hazard to the nearby population.
However, none of these impacts are likely to be irreversible, wide-spread, or unprecedented, and can be addressed with the help of appropriately designed and effectively implemented mitigation plan. Therefore the proposed project has been classified as Environment Category B, in accordance with the WB Operational Policy 4.01, and also according to the ESSAF summarized above, since the individual interventions under the project component 2 are likely to be much less than Rs. 50 m – the upper limit prescribed by ESSAF for the Category B projects (see Table 1 presented above).

12. In order to address the potential impacts of the project and in accordance with ESSAF requirements described earlier, the GoKP will prepare a project-specific Environmental and Social Management Plan (ESMP). The key elements of this ESMP are listed below.

   a) Potential impacts of the project activities on soils, air, water, and people
   b) Mitigation measures to address the above impacts
   c) Hospital waste management in line with the Government issued SOPs
   d) Institutional arrangements for the environmental management of the project. These will include appointment/designation of the environmental focal person within DoH.
   e) Monitoring mechanism to ensure the implementation of the mitigation measures during the implementation of the Project.
   f) Reporting and documentation protocol for environmental and social management.
   g) Environmental training and capacity building requirements.
   h) Contract clauses and control measures addressing safe disposal of medical wastes from the health facilities to be outsourced under component 1 of the project.
   i) Monitoring requirement for medical waste management under the component 3 of the project.
   j) Annual third party validation to determine the performance of environmental mitigation and control measures, including safe disposal of medical waste, in all components of the project.

13. The ESMP will need to be cleared by the Bank before the works under the project can be started. In addition, the ESMP will be made part of the construction contract(s), making its effective compliance as one of the contractual requirements. The ESMP will also be included in the legal covenants of the agreement between the GoP and the Bank.

14. **Social aspects.** The rehabilitation and renovation of health facilities will be limited to the existing structures on the already occupied land within the existing premises; no expansion is planned under this project so there will be no negative impacts of this project in terms of land acquisition, involuntary resettlement or indigenous people. Therefore, social safeguard policies will not trigger.
15. The proposed project is intended to focus on efficient and effective primary health care service delivery on improving outcomes for those who currently have suboptimal health outcomes, especially in the area of maternal and child health and access to services. The level of poverty as well as other social indicators including education and health has been undesirable in the selected six districts. In addition, they have been severely damaged by militancy and/or the historical flood and accordingly the disruption of basic service provision. Therefore, during the selection process of implementing consultants for contracting out of health services, the DoH and the Bank will take a close look at the proposed methodology in the proposals and ensure that the identification of the health facility locations is appropriate to properly reflect local variations and social constraints of marginalized populations, such as the poor and women whose mobility is restricted. The project mandates the provision of mobile clinic services and strengthened care and home visits by Lady Health Workers through contracting out, to address the limitation in women’s mobility and accessibility to health services at the fixed health facilities.

16. Available evidence points out the following constraints identified in health service delivery in KP:

A. Demand-Side Barriers to Accessing Services:
   (i) High cost of medicines and services in the private sector, many direct and indirect costs to accessing Government sector services, non availability of medicines and critical and emergency services in the government facilities;
   (ii) Poor connectivity to health centers because of distance, topography, and lack of public transport;
   (iii) Poor work culture in government centers - corruption, slow work culture, lack of proper and even basic equipment, and lack of suitable staff such as lady doctors and male health workers;
   (iv) System of referrals to higher health facilities increasing cost of treatment;
   (v) Social and cultural barriers especially for women.

B. Structural constraints
   (i) Lack of flexibility and reduced responsiveness to local diversity and needs;
   (ii) Scarcity of funds for non-salary expenditure including innovative activities;
   (iii) Human resource management weaknesses;
   (iv) Low morale and high absenteeism of staff; lack of incentives to promote good performance;
   (v) Mismatch between medical training and job specifications of primary care doctors;
   (vi) Poor work environments and dissatisfaction amongst the workforce;
   (vii) Understaffing of remote or even semi-remote facilities;
   (viii) Shortage of female doctors is particularly acute in rural areas in states where the status of women; and
   (ix) Other poverty and social indicators are low.

C. Provider attitudes
   (i) Strong stereotype of community groups in providers hampering provision of sensitive and client-centered services.
17. The proposed project is built on the successful experience of the JSDF-funded project “Revitalizing and Improving Primary Health Care in Battagram District”, which was intended to address the issues related to health care service provision. Contracting of an NGO to manage service delivery was deemed appropriate to the needs of the post earthquake emergency. Available evidence, mainly drawn from Health Management Information System (HMIS) reports, point to substantial improvement in utilization of services and the findings of the facility survey indicate positive effects on availability of medicines, staff, and equipment and high levels of patient satisfaction. Improved availability of staff particularly female health providers was one of the drivers to the high level of achievements of the project.
1. Promoting human development is one of the fundamental objectives of modern social and economic development. The Revitalizing Health Services in KP Project seeks to assist the province to attain the PCNA goal of building responsiveness and effectiveness of the state to restore citizen’s trust by revitalizing, strengthening and sustaining the delivery of quality health care services in the post-conflict/crisis affected districts across Khyber Pakhtunkhwa, in addition to human development related Millennium Development Goals (MDGs), such as improving maternal and child health, and reducing the prevalence of life-threatening communicable diseases.

Rationale for Public Sector Investment

2. The social and economic benefits of promoting basic human development are considerable. The rational for public investment comes from the difference between private and social returns from the investment. The health interventions under the project represent typical examples of services that have substantial externality and many are public goods (e.g., treatment of TB). In the absence of public involvement, the market equilibrium results in under utilization of the services. The health interventions included in the project are largely promotive and preventive in nature. Reducing the prevalence of infectious and contagious diseases not only benefits the individuals who have been cured, but also helps decrease the spread of these diseases to other people. There are also significant inter-generational externality benefits from improved health outcomes. Healthier parents are more likely to have healthy children. Moreover, the attainment of human development levels sufficient to enable individuals to live healthy and long lives, and have competencies and capabilities to function effectively in society that are at the heart of national development have disproportionately higher impact on the poor (see below). Second, improving health levels of a population means that they can work more efficiently and contribute better to economic growth. This, in turn, will lead to improved incomes and enable households to experience higher living standards. In addition, the interventions in health will benefit girls and women from poorer households, promoting gender and economic equity in the province.

Expenditure on Health: Level of Expenditure

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Public Sector Expenditure (Federal and Provincial)</th>
<th>Percentage Change</th>
<th>Health Expenditure as % of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Health Expenditures</td>
<td>Development Expenditure</td>
<td>Current Expenditure</td>
</tr>
<tr>
<td>2000-01</td>
<td>24.28</td>
<td>5.94</td>
<td>18.34</td>
</tr>
<tr>
<td>2001-02</td>
<td>25.41</td>
<td>6.69</td>
<td>18.72</td>
</tr>
<tr>
<td>2002-03</td>
<td>28.81</td>
<td>6.61</td>
<td>22.21</td>
</tr>
<tr>
<td>2003-04</td>
<td>32.81</td>
<td>8.50</td>
<td>24.31</td>
</tr>
<tr>
<td>2004-05</td>
<td>38.00</td>
<td>11.00</td>
<td>27.00</td>
</tr>
<tr>
<td>2005-06</td>
<td>40.00</td>
<td>16.00</td>
<td>24.00</td>
</tr>
</tbody>
</table>
3. The current spending on health in Pakistan is mostly out of pocket and the increase in public expenditure on health has been on the low side. Although it would have been expected that with increase in GDP to over $1000 per capita would lead to a disproportionate increase in health expenditures due to the income elasticity of health expenditures, however in the case of Pakistan it has stagnated compared to GDP. Even in real terms the increase is partially nullified by inflation. When we look at the share of private expenditure we find that almost 98 percent is out of pocket and even that as a proportion of GDP is falling and thus leads to a fall in total health expenditures. The expansion on the government side during the previous years has not been able to keep up with the decline in the private spending and this indicates that there is a serious shortfall of investment in the health sector and in overall health care delivery within the country.

### Trends: The movement of THE over the past 10 years

![Graph showing trends in health expenditures](image)

Source: World Bank development data

**Government commitment and fiscal space**

4. **Health and Welfare Sectors.** Health care is the second largest budget expenditure in the province of KP. A sum of Rs.4.025 million was allocated in the budget 2009-10 for provincial Health Sector, an increase of 13.87 percent over 2008-09. Allocation for the District Level Devolved health setup was about Rs. 3,220 million, an increase of 10 percent over the 2008-09 estimates.

5. **Share of Provinces in Federal Revenue Transfers.** The Federal Government has a formula for dividing resources among the provinces for each of three major funding sources, The
Divisible Pool (Population based), Special Grants, and 1/6th of the Sales Tax. The KP share in the aggregate transfers is 14.78 percent for 2009-10 following Punjab (53.20 percent) and Sindh (24.96 percent). The total KP transfer is estimated at Rs. 90.492 million. The revenue transfer to the provincial governments is to increase from 45 to 50 percent over a period of five years.

**Fiscal Sustainability Analysis**

6. This section reviews the KP fiscal situation and education, health and social protection budgets in light of the MTBF and projected provincial revenues. The $16m KP operation spread over three years is well within the capacity of the province to absorb.

7. Currently the KP district budget allocations comprise of 85 percent salary expenditure with the increasing cost of utilities and transportation expenditures, this leaves a minimal amount to finance consumables in health facilities like drugs and medicines. This gap combined with the affects of the crisis has had a serious negative effect on service delivery. This project will leverage the existing health allocations in the districts by approximately $15million annually and allow for a better execution of expenditures by providing flexibility to the management contractors. The project will allow the management contractors to utilize the district budget in accordance with the priorities in the district, in addition to giving them flexibility to vary incentives for the staff. In addition savings from different heads will be fungible and allow for reallocations to heads where they are required. The bank resources will be used to provide the management cost of the contractor and in the short run will be filling in a vital gap in the supply side by making resources available to increase the non salary expenditure in the district to minimally 30 percent.

8. The current project in financial terms will be equivalent to almost 20-30 percent of the district budget and keeping in view the financial crisis, it is expected that as the overall situation improves the government will increase allocations to health. The project does not add additional liabilities, while it should improve efficiency gains, and the small amounts for management through the project may be taken up later with a mechanism similar to the one used for financing the PPHI which is running BHUs in 13 districts of the province.

9. Although, both federal and provincial resources have been drained into combating the insurgency and handling internally displaced populations, they have understood that providing basic services is an essential part of successfully combating the insurgency and maintaining viability hence ownership of these sector interventions is high. They are also amply supported by other development partners.

10. The Medium Term Budgetary Framework (MTBF). The KP has a functioning three year MTBF. The primary (93 percent) revenue source is the federal government and Federal Tax Assignment is estimated to increase by 15 percent each year due to inflation and new taxes. National growth is estimated at 3.3 percent for 2009-10, up from 2.1 percent in 2008-9. If this materializes it gives additional comfort that federal transfer estimates will be realized. Growth, according to the White Paper will increase to 5.0 percent in 2012-13 which may be optimistic in light of provincial and national political and economic uncertainties. Regardless of the outcome, growth will have little impact on provincial finance which accounts for only 7 percent of total
revenue. The MTBF indicates that in 2009-10 the province will run a Rs.3.827 million (around $45m) deficit which will decline by about 25 percent in 2012-13 to Rs.2,836 million.

<table>
<thead>
<tr>
<th>Table10a.2 MTBF 2009-10 through 2012-13 (Rs. Millions nominal)*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revenues &amp; Expenditures</strong></td>
</tr>
<tr>
<td><strong>2009-10</strong></td>
</tr>
<tr>
<td>Total Revenue Receipts</td>
</tr>
<tr>
<td>Transfers to District Governments</td>
</tr>
<tr>
<td>Net Revenue after Transfers</td>
</tr>
<tr>
<td>Current Expenditures</td>
</tr>
<tr>
<td>Development Expenditure</td>
</tr>
<tr>
<td><strong>Primary Balance</strong></td>
</tr>
<tr>
<td>Grants and Interest Payments</td>
</tr>
<tr>
<td>Federal and Foreign Grants</td>
</tr>
<tr>
<td>Interest Payments</td>
</tr>
<tr>
<td><strong>Overall Balance</strong></td>
</tr>
<tr>
<td>Estimated National GDP Growth (%)</td>
</tr>
<tr>
<td>Estimated Inflation Rate (%)**</td>
</tr>
</tbody>
</table>

*White Paper p. 76
**2008-09 estimated inflation was 20.0%

11. Financing of the debt, which amounts to Rs.44 million in 2011-11 and declines to around Rs.33 million by 2012-13 relies partially upon Rs.15-20 million of foreign credits. Also, the budget is significantly lower than the MTBF estimates (see above) as exemplified by the latter projecting 2009-10 revenues at Rs.80 million.

12. **Comprehensive Development Strategy.** The MTBF and sector development agenda is based in a seven year rolling CDS. While the estimates are far more optimistic than the MTBF and hence from actual estimates, (education expenditures in 2008-9 are about Rs.22 million versus Yr 1-2 estimates of Rs.30 million) it is comforting that this work has been done and that education (24.4 percent of seven year total), health (18.7 percent) continue the largest line items.

13. **Overview of Fiscal Situation.** The above diagnostic indicates that the KP is committed to supporting health sector.

14. **Institutional sustainability:** The project will be implemented by the Health Sector Reforms Unit in the Department of Health. The HSRU has played a vital role in the design and conceptualizing the project and has been identified as the best option to support implementation of this initiative. As part of the design process the project has a built in mechanism for testing new interventions like the contracting out of secondary care hospitals (DHQ). If at the midterm review of the project this component is successful, the idea is to expand the contracts to include DHQ hospitals in all the districts. The project does not envisage setting up of a separate Implementation Unit, and will be managed by the HSRU, this will not only build the capacity of the HRSU to implement similar projects but will also simplify the implementation mechanism as the institutional frameworks and mechanisms are already developed at HSRU and new procedures will not have to be developed/ designed.

**Equity and efficiency of current spending**
When we look at the financing agents responsible for health expenditure as presented in the National Health Accounts 2005-6, we find that the out-of-pocket expenditure (OOP) varies across provinces and unfortunately is the highest in KP. When we compare this with the actual service utilization statistics we find that the poor use inferior forms of health care (traditional healers, home delivery, and informal providers) to cope with the high OOP. The poor are left out of the public spending and this results in a large gap in availability of services to the poor.

Table 10a.3 Type of Health Expenditure by Province, National Health Accounts 2005-6

<table>
<thead>
<tr>
<th>Type of Health Expenditure</th>
<th>In percent of total expenditures (per province or country)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Punjab</td>
</tr>
<tr>
<td>Military Health Expenditure</td>
<td>5.8%</td>
</tr>
<tr>
<td>Provincial/Federal Government</td>
<td>9.6%</td>
</tr>
<tr>
<td>District Government</td>
<td>8.1%</td>
</tr>
<tr>
<td>Cantt. Boards</td>
<td>0.1%</td>
</tr>
<tr>
<td>Social Security Institutions</td>
<td>1.5%</td>
</tr>
<tr>
<td>Zakat Health Expenditure</td>
<td>0.1%</td>
</tr>
<tr>
<td>Private Insurance</td>
<td>-</td>
</tr>
<tr>
<td>OOP Health Expenditure</td>
<td>74.7%</td>
</tr>
<tr>
<td>Donors Organizations</td>
<td>0.2%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The coverage gap is from the countdown to 2015 for maternal, newborn and child survival 2010 report. It consists of aggregation of 8 indicators (CPR, ANC, Skilled birth attendance, (BCG, DPT3, measles coverage), ORT and care seeking for ARI)

Innovative payment system: contracting for services
16. The payment mechanism for the health services contract is designed to be simple yet incentivize the contractor for improved service delivery. There will be two streams of payment to the contractor: one stream shall be the district budget for the health facilities contracted out and as this is 85 percent salary it will be transferred to the contractor on a regular basis, the other component of the budget which shall be from the HSRU (project funds) shall be released on a sliding scale mechanism based on achievement of agreed indicators. Thus the financing mechanism ensures that the contractor will have a basic amount to cover salaries, utilities, some supplies etc. and then depending on performance would be able to get additional resources for expansion of services. As this is a relatively a new mechanism to finance interventions in the health sector, appropriate resources are allocated for strengthening of the monitoring mechanism of health department to manage these contracts. This move away from input and process based financing would allow focus on achievement of numerical targets/outputs by the contractor and also focus the attention of the department of health KP on the costs associated with achieving these targets. The contractor would be paid the amount from the project based on services delivered.

Analyses of Project Benefits

Health

17. The interventions in the health sector are focused on maternal and child health, including pre-natal care, safe deliveries and post-natal care; immunization against diseases such as tetanus and polio; and the reduction of key and life-threatening communicable diseases such as TB. The information in Table 10a.4 shows that there is considerable disparity in access and coverage of health care services between poor households and wealthy households, among urban and rural residents, and between districts. For instance, the risk of child mortality is substantially higher among the poorest household quintile (109 per 1,000 live births) compared to the richest household quintile (66 per 1,000 live births). There is also a considerable difference in child mortality between urban (77 per 1,000 live births) and rural (104 per 1,000 live births) areas. The contraceptive prevalence rate ranges from 14 percent among the lowest household quintile to 34 percent among the highest household quintile (66 per 1,000 live births). There is also a considerable difference in child mortality between urban (77 per 1,000 live births) and rural (104 per 1,000 live births) areas. The contraceptive prevalence rate ranges from 14 percent among the lowest household quintile to 34 percent among the highest household quintile; from 22 percent in rural areas to 31 percent in urban areas; and from 9 percent in Lakki Marwat District to 42 percent in Chitral District. The percentage of births attended by skilled personnel ranges from 25 percent among the lowest household wealth quintile to 73 percent among the highest wealth quintile; from 22 percent in rural areas to 31 percent in urban areas; and from 9 percent in Lakki Marwat District to 42 percent in Chitral District. Protection against neonatal tetanus shows similarly wide variations. The proportion of women protected during the last pregnancy ranges from 28 percent among the lowest household wealth quintile to 65 percent among the highest wealth quintile; from 41 percent in rural areas to 58 percent in urban areas; and from 9 percent in Lakki Marwat District to 73 percent in Chitral District.

Table 10a.4: Difference in Health Status and Service Coverage by Wealth Quintiles, Rural Urban Residence and by Districts-2008

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Under 5 mortality rate (per 1000 live births)</th>
<th>Contraceptive prevalence rate (modern methods; %)</th>
<th>Births attended by skilled personnel (%)</th>
<th>Neonatal tetanus protection (received at least 2 doses) during last</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
18. The focus of the project is on the health care needs of the poorer households in the population, on rural areas, and on more disadvantaged districts. The project, if successful, will help generate strong social benefits in terms of improving the equity of health services available to the more disadvantaged groups in the province.

19. The social and economic benefits of the health interventions will consist of two further types of benefits. First, direct benefits, which are the reduction of premature mortality, the extent to which averting diseases enables individuals to live normal lives, and the savings on health care costs. Second, indirect benefits, which are the decreases in the number of additional disabilities and deaths that would have been caused through the spread of infectious and contagious diseases, and their associated costs.

20. The Disability-Adjusted Life Years (DALYs) lost for several of the diseases and conditions that the BHDS seeks to reduced, including maternal care, child heath, and communicable diseases such as TB, are given in Table 10a.5 below for all South Asian countries. Pakistan’s DALYs lost are high, implying that the burden and cost of disease is considerable. In childhood cluster diseases Pakistan has the highest DALYs lost among all South Asian countries, surpassing even Afghanistan. In peri-natal conditions Pakistan has the second highest DALY lost among South Asian countries, after Afghanistan. And the DALYs lost for several other diseases and conditions are also well above the levels observed in the more advanced countries in the region such as Sri Lanka, the Maldives and Bhutan.

| Table 10a.5 Disability Adjusted Life Years (DALYs) lost for South Asian Countries |
|---------------------------------|-----------------|----------------|-------------|-------------|--------------|-------------|---------------|-------------|
|                                 | Afghanistan     | Bangladesh     | Bhutan       | India       | Maldives     | Nepal        | Pakistan      | Sri Lanka   |
| All Causes                      | 61,622          | 27,532         | 25,734       | 27,825      | 23,507       | 30,799       | 26,693        | 3,120       |
| Communicable, maternal, peri-natal and nutritional conditions | 33,092          | 10,857         | 9,709        | 10,529      | 5,319        | 12,301       | 10,819        | 236         |
| Tuberculosis                   | 1,589           | 1,362          | 588          | 726         | 141          | 686          | 1,118         | 15          |
| Childhood-cluster diseases     | 817             | 392            | 427          | 736         | 64           | 408          | 850           | 371         |
| Maternal                       | 6,039           | 962            | 835          | 702         | 612          | 1,541        | 848           | 840         |

<table>
<thead>
<tr>
<th>conditions</th>
<th>KP</th>
<th>NWFP</th>
<th>WAP</th>
<th>NWA</th>
<th>P&amp;K</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perinatal conditions (h)</td>
<td>4,112</td>
<td>2,479</td>
<td>1,833</td>
<td>2,458</td>
<td>1,990</td>
<td>3,020</td>
</tr>
<tr>
<td>Injuries</td>
<td>3,330</td>
<td>2,300</td>
<td>2,301</td>
<td>2,784</td>
<td>2,992</td>
<td>2,086</td>
</tr>
</tbody>
</table>


21. There are no estimates of DALYs lost by province in Pakistan. The KP health attainment levels are better than average for some clusters of diseases and conditions and lower than average for others, but overall less than the national average, especially in the context of violence related conditions such as injuries. The reduction of such diseases and health conditions will have substantial benefits for the health status of individuals in the KPK, especially of women and children, as seen from the high DALYs lost.

22. The indirect benefits of improving health care have not been estimated. However, these benefits will raise the overall social benefit of the health component. There is also the indirect effect of substitution, the amount spent by the households on health care, whatever the quality, is reduced due to increased availability of services from the public sector and this in turn provides some financial space to the households to increase expenditure on goods other than health care.

**Project Benefits**

23. The overall project benefits will consist of the benefits through improved coverage of preventive health interventions, enhanced access to quality health care services through public sector facilities and improvement of the public sector health infrastructure of the crisis affected districts. No attempt is made to quantify and add these benefits, as this would require heroic assumptions. But it is clear that the benefits of the project, covering such areas as reduced disease burden and improved life expectancy, are very substantial. As the project impact will mainly be on improving the human development outcomes of poor households, the benefits will also have a strong equity dimension.
Annex 11: Documents in Project Files

PAKISTAN: Revitalizing Health Services in Khyber Pakhtunkhwa Project

5. World Bank. KP, FATA and Balochistan MDTF: Administration Agreement, 2010
10. World Bank. Implementation Completion Memorandum for JSDF supported Revitalizing and Improving Primary health Care in Battagram District, April, 2011.
## Annex 12: Statement of Loans and Credits
### PAKISTAN: Revitalizing Health Services in Khyber Pakhtunkhwa Project

<table>
<thead>
<tr>
<th>Project ID</th>
<th>FY</th>
<th>Purpose</th>
<th>Original Amount in US$ Millions</th>
<th>Difference between expected and actual disbursements</th>
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<tr>
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<td>P115638</td>
<td>2010</td>
<td>Social Safety Nets DPC</td>
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<td>50.06 -158.91 0.00</td>
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<td>P114508</td>
<td>2009</td>
<td>3rd Partnership for Polio Eradication</td>
<td>0.00 74.68 0.00 0.00 0.00</td>
<td>14.70 -18.14 0.00</td>
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<td>P101684</td>
<td>2009</td>
<td>Second Trade and Transport Facilitation</td>
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<td>24.48 -1.37 0.00</td>
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<td>P107300</td>
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<td>SINDH EDUCATION SECTOR PROJECT (SEP)</td>
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<td>P102608</td>
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<td>Punjab Education Sector Project</td>
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<td>P105075</td>
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<td>--------------</td>
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<td></td>
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<td>KCT</td>
<td>6.46</td>
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**Total:** 608.60 3,048.27 0.00 0.00 5.78 1,403.76 -473.32 14.42

**PAKISTAN**

**STATEMENT OF IFC’s**

**Held and Disbursed Portfolio**

**In Millions of US Dollars**
<table>
<thead>
<tr>
<th>Year</th>
<th>Company</th>
<th>Loan</th>
<th>Equity</th>
<th>Quasi</th>
<th>Partic.</th>
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<td>CSIBL</td>
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<tr>
<td>2006</td>
<td>JSPE Fund</td>
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<td>0.02</td>
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<td>Habib Bank</td>
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<td>2006</td>
<td>Paktel 2005</td>
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<td>Tameer Bank</td>
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Total pending commitment: 0.07 0.07 0.00 0.06
Annex 13: Country at a Glance

PAKISTAN: Revitalizing Health Services in Khyber Pakhtunkhwa Project

Pakistan at a glance

Key Development Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Pakistan</th>
<th>South Asia</th>
<th>Lower middle income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population, mid-year (millions)</td>
<td>199.7</td>
<td>1,545.5</td>
<td>3,767</td>
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<tr>
<td>Surface area (thousand sq. km)</td>
<td>796</td>
<td>5,131</td>
<td>31,923</td>
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<tr>
<td>Urban population (% of total population)</td>
<td>22.2</td>
<td>1.5</td>
<td>1.2</td>
</tr>
<tr>
<td>GNI (Atlas method, US$ billions)</td>
<td>198.8</td>
<td>1,534.4</td>
<td>7,682</td>
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<tr>
<td>GNI per capita (Atlas method, US$)</td>
<td>1,000</td>
<td>993</td>
<td>2,039</td>
</tr>
<tr>
<td>GNI per capita (PPP, international $)</td>
<td>2,690</td>
<td>2,775</td>
<td>4,302</td>
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<tr>
<td>GDP growth (%)</td>
<td>3.6</td>
<td>4.8</td>
<td>7.5</td>
</tr>
<tr>
<td>GDP per capita growth (%)</td>
<td>1.4</td>
<td>3.3</td>
<td>6.3</td>
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</tbody>
</table>

(most recent estimate, 2005–2008)

Net Aid Flows

(US$ millions)

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<th>1980</th>
<th>1990</th>
<th>2000</th>
<th>2009</th>
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<tr>
<td>Net ODA and official aid</td>
<td>1,181</td>
<td>1,127</td>
<td>700</td>
<td>1,539</td>
</tr>
<tr>
<td>Top 3 donors (in 2007):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>42</td>
<td>167</td>
<td>88</td>
<td>351</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>44</td>
<td>84</td>
<td>24</td>
<td>260</td>
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<tr>
<td>Germany</td>
<td>26</td>
<td>124</td>
<td>2</td>
<td>89</td>
</tr>
<tr>
<td>Aid (% of GNI)</td>
<td>4.5</td>
<td>2.7</td>
<td>1</td>
<td>0.6</td>
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<tr>
<td>Aid per capita (US$)</td>
<td>14</td>
<td>10</td>
<td>5</td>
<td>9</td>
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</table>

Long-Term Economic Trends

<table>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Consumer prices (annual % change)</td>
<td>10.6</td>
<td>4.8</td>
<td>20.8</td>
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<tr>
<td>GDP implicit deflator (annual % change)</td>
<td>9.1</td>
<td>6.6</td>
<td>24.9</td>
<td>23.0</td>
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<tr>
<td>Exchange rate (annual average, local per US$)</td>
<td>9.9</td>
<td>21.4</td>
<td>51.7</td>
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<td>Terms of trade index (2000 = 100)</td>
<td>103</td>
<td>130</td>
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<td>Population, mid-year (millions)</td>
<td>82.7</td>
<td>108.0</td>
<td>138.1</td>
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<td>GDP (US$ millions)</td>
<td>23,690</td>
<td>40,900</td>
<td>73,952</td>
<td>161,990</td>
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<tr>
<td>(% of GDP)</td>
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<tr>
<td>Agriculture</td>
<td>29.5</td>
<td>26.0</td>
<td>25.9</td>
<td>21.6</td>
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<tr>
<td>Industry</td>
<td>24.9</td>
<td>25.3</td>
<td>23.3</td>
<td>24.3</td>
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<tr>
<td>Manufacturing</td>
<td>15.9</td>
<td>17.4</td>
<td>14.7</td>
<td>17.1</td>
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<tr>
<td>Services</td>
<td>45.8</td>
<td>48.8</td>
<td>50.7</td>
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<tr>
<td>Household final consumption expenditure</td>
<td>83.1</td>
<td>73.8</td>
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<td>15.1</td>
<td>8.6</td>
<td>8.1</td>
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<td>Gross capital formation</td>
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<td>13.6</td>
<td>16.5</td>
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<tr>
<td>Imports of goods and services</td>
<td>24.1</td>
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<td>20.4</td>
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<tr>
<td>Gross savings</td>
<td>24.1</td>
<td>22.3</td>
<td>20.1</td>
<td>21.0</td>
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Note: Figures in tables are for years other than those specified. 2008 data are preliminary. ... indicates data are not available.
s. Aid data are for 2008.

Development Economics, Development Data Group (DECDG).
### Balance of Payments and Trade

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<td>(US$ millions)</td>
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<td>Total merchandise exports (fob)</td>
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<td>19,121</td>
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<td>Total merchandise imports ( cif)</td>
<td>9,602</td>
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<td>Net trade in goods and services</td>
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<td>Current account balance</td>
<td>-217</td>
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<tr>
<td>as a % of GDP</td>
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<tr>
<td>Workers' remittances and compensation of employees (receipts)</td>
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<td>8,717</td>
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<tr>
<td>Reserves, including gold</td>
<td>1,510</td>
<td>9,365</td>
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</table>

### Central Government Finance

(%) of GDP
- Current revenue (including grants): 13.7
- Tax revenue: 10.2
- Current expenditure: 16.7
- Overall surplus/deficit: -6.6
- Highest marginal tax rate (%): Individual, 20

### External Debt and Resource Flows

(US$ millions)
- Total debt outstanding and disbursed: 32,722
- Debt service: 2,866
- Debt relief (HIPC, MDRI): --
- Total debt (% of GDP): 44.3
- Total debt service (% of exports): 26.7
- Foreign direct investment (net inflows): 308
- Portfolio equity (net inflows): 35

### Governance indicators, 2000 and 2009

- Voice and accountability
- Political stability
- Regulatory quality
- Rule of law
- Control of corruption

### Technology and Infrastructure

- Paved roads (% of total): 56.0
- Fixed line and mobile phone subscribers (per 100 people): 2
- High technology exports (% of manufactured exports): 0.4

### Environment

- Agricultural land (% of land area): 35
- Forest area (% of land area): 2.7
- Terrestrial protected areas (% of surface area): 9.0
- Freshwater resources per capita (cu. meters): 380
- Freshwater withdrawal (billion cubic meters): 159.4
- CO2 emissions per capita (mt): 0.77
- GDP per unit of energy use (2005 PPP $ per kg of oil equivalent): 4.2
- Energy use per capita (kg of oil equivalent): 457

### World Bank Group portfolio

(US$ millions)
- IBRD Total debt outstanding and disbursed: 3,090
- Disbursements: 159
- Principal repayments: 227
- Interest payments: 182
- IDA Total debt outstanding and disbursed: 3,828
- Disbursements: 141
- Total debt service: 93
- IFC (fiscal year) Total disbursed and outstanding portfolio: 718
- Disbursements for IFC own account: 140
- Disturbance for IFC own account: 85
- Portfolio sales, prepayments and repayments for IFC own account: 52
- MIGA Gross exposure: 111
- New guarantees: 0

Note: Figures in italics are for years other than those specified. 2009 data are preliminary. -- indicates data are not available. -- indicates observation is not applicable.

Development Economics, Development Data Group (DECDG).

2/20/11
Millennium Development Goals

Pakistan

With selected targets to achieve between 1990 and 2015 (estimates closest to data shown; n=2 years)

<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Goal 1:</td>
<td>Halve the rates for extreme poverty and malnutrition</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Poverty headcount ratio at $1.95 a day (PPP, % of population)</td>
<td>64.7</td>
<td>48.1</td>
<td>29.1</td>
<td>22.6</td>
</tr>
<tr>
<td></td>
<td>Poverty headcount ratio at national poverty line (% of population)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Share of income or consumption to the poorest quintile (%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prevalence of malnutrition (% of children under 5)</td>
<td>26.0</td>
<td>21.3</td>
<td>19.7</td>
<td>9.1</td>
</tr>
</tbody>
</table>

Goal 2: Ensure that children are able to complete primary schooling

<table>
<thead>
<tr>
<th>Objective</th>
<th>2005</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary school enrolment (net, %)</td>
<td>57</td>
<td>66</td>
</tr>
<tr>
<td>Primary completion rate (% of relevant age group)</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Secondary school enrolment (gross, %)</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td>Youth literacy rate (% of people aged 15-24)</td>
<td></td>
<td>55</td>
</tr>
</tbody>
</table>

Goal 3: Eliminate gender disparity in education and empower women

<table>
<thead>
<tr>
<th>Objective</th>
<th>2005</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender disparity in primary and secondary education (%)</td>
<td>49</td>
<td>56</td>
</tr>
<tr>
<td>Women employed in the nonagricultural sector (% of nonagricultural employment)</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Proportion of seats held by women in national parliament (%)</td>
<td>10</td>
<td>2</td>
</tr>
</tbody>
</table>

Goal 4: Reduce under-5 mortality by two-thirds

<table>
<thead>
<tr>
<th>Objective</th>
<th>2005</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-5 mortality rate (per 1,000)</td>
<td>130</td>
<td>121</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>101</td>
<td>94</td>
</tr>
<tr>
<td>Measles immunization (proportion of one-year-olds immunized, %)</td>
<td>50</td>
<td>47</td>
</tr>
</tbody>
</table>

Goal 5: Reduce maternal mortality by three-fourths

<table>
<thead>
<tr>
<th>Objective</th>
<th>2005</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal mortality ratio (modeled estimate, per 100,000 live births)</td>
<td>190</td>
<td>18</td>
</tr>
<tr>
<td>Births attended by skilled health staff (% of total)</td>
<td>190</td>
<td>18</td>
</tr>
<tr>
<td>Contraceptive prevalence (% of women ages 15-49)</td>
<td>15</td>
<td>18</td>
</tr>
</tbody>
</table>

Goal 6: Halt and begin to reverse the spread of HIV/AIDS and other major diseases

<table>
<thead>
<tr>
<th>Objective</th>
<th>2005</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of HIV (% of population ages 15-49)</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Incidence of tuberculosis (per 100,000 people)</td>
<td>230</td>
<td>220</td>
</tr>
<tr>
<td>Tuberculosis case detection rate (% of all forms)</td>
<td>59</td>
<td>4</td>
</tr>
</tbody>
</table>

Goal 7: Halve the proportion of people without sustainable access to basic needs

<table>
<thead>
<tr>
<th>Objective</th>
<th>2005</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to an improved water source (% of population)</td>
<td>88</td>
<td>87</td>
</tr>
<tr>
<td>Access to an improved sanitation facility (% of population)</td>
<td>28</td>
<td>30</td>
</tr>
<tr>
<td>Forest area (% of total land area)</td>
<td>3.3</td>
<td>3.0</td>
</tr>
<tr>
<td>Total trees per hectare (%)</td>
<td>3.0</td>
<td>2.7</td>
</tr>
<tr>
<td>CO2 emissions (metric tons per capita)</td>
<td>0.6</td>
<td>0.7</td>
</tr>
<tr>
<td>GDP per unit of energy (2005 PPP $ per kg of oil equivalent)</td>
<td>4.2</td>
<td>4.4</td>
</tr>
</tbody>
</table>

Goal 8: Develop a global partnership for development

<table>
<thead>
<tr>
<th>Objective</th>
<th>2005</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone mainlines (per 100 people)</td>
<td>0.8</td>
<td>1.7</td>
</tr>
<tr>
<td>Mobile phone subscribers (per 100 people)</td>
<td>0.0</td>
<td>0.2</td>
</tr>
<tr>
<td>Internet users (per 100 people)</td>
<td>0.0</td>
<td>1.4</td>
</tr>
<tr>
<td>Personal computers (per 100 people)</td>
<td>0.1</td>
<td>0.4</td>
</tr>
</tbody>
</table>

Note: Figures in italics are for years other than those specified. ... indicates data are not available.

Development Economics, Development Data Group (DE/CCG).

2/25/11
Annex 14: Maps

PAKISTAN: Revitalizing Health Services in Khyber Pakhtunkhwa Project