**PROJECT INFORMATION DOCUMENT (PID)**
**APPRAISAL STAGE**

Report No.: AB6532

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|---|---|
| **Project Name** | Revitalizing Health Services in Khyber Pakhtunkhwa Project |
| **Region** | South Asia |
| **Country** | Pakistan |
| **Sector** | Health (100%) |
| **Project ID** | P126426 |
| **Borrower(s)** | Government of Pakistan |
| **Implementing Agency** | Health Sector Reform Unit (HSRU), Department of Health, Government of Khyber Pakhtunkhwa (KP)<br>KP Secretariat, Khyber Road<br>Peshawar, Pakistan<br>Tel: (92-91) 9210878 Fax: (92-91)) 921-2068 |
| **Environmental Screening Category** | { }A {X }B { }C { }FI |
| **Date PID Prepared** | July 30, 2011 |
| **Estimated Date of Appraisal Completion** | July 30, 2011 |
| **Estimated Date of Regional Vice President Approval** | September 30, 2011 |

## I. Country Context

1. During the past few years Pakistan faced an emergency of historic proportions, caused by the still ongoing militancy crisis in Khyber Pakhtunkhwa (KP) and FATA, compounded by an earthquake, and floods. Over time, militant groups pushed further east across the settled districts of KP into Swat. In early 2009, the Government of Pakistan launched major military operations in the KP Province and FATA to root out the local pockets of militants. The offensive led to significant damage to physical infrastructure and services while creating a large number of internally displaced persons (IDPs). In 2009, approximately 3 million people were displaced in KP and FATA. About 7 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[1]. 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 return of major economic activity which is essential for building people stakes in sustainable peace.

2. **Sectoral Context:** Health indicators for KP have been improving but remain poor in comparison to some regional countries. The intra-provincial inequities in service provision and

[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

the resulting health status is of concern. Health facilities in KP suffer from lack of equipment, medicines and other essential supplies. The frequent and continuous emergencies / crisis 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 are 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 8 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 Standard Measurement Survey 2007-08).

3. In response to a severe impact on health service provision in KP, the Department of Health, GoKP, sought out the World Bank assistance to scale up the successful experience supported by the Japan Social Development Fund (JSDF) in its Batagram district on a public private partnership project entitled "Revitalizing and Improving Primary Healthcare Services". The project contracted out management of 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[2]; ii) improvement in core indicators -- childhood immunization increased from 10% to 76%, ANC visits from 33% to 63% and hospital based delivery from 33% to 50%[3]. The GoKP wants to replicate the innovative approach in other districts of KP to improve performance of the health sector.

## II. Project Development Objectives

4. 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. The project will be implemented in six crises affected districts of KP for a period of three years. The proposed operation will be financed through Multi Donor Trust Fund (MDTF) for Khyber Pakhtunkhwa, FATA and Balochistan on grant terms. It will support the implementation of the program with co-financing from the GoKP.

## III. Rationale for Bank Involvement

5. The PCNA provides the underpinning for long term peace building in KP and FATA. 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 of the PCNA are: (i) enhance responsiveness and

[2] Report on Health Facility Assessment. End line evaluation of JSDF project district Battagram, Khyber Pakhtunkhwa. Contech International Health Consultants. June 2010.
[3] Final Report. End line Household survey of the project "Revitalization of Primary Health Care in Battagram". Apex Consulting Pakistan. June 2010.

effectiveness of state to restore citizen trust; (ii) stimulate employment and livelihood opportunities; (iii) ensure provision of basic services; (iv) counter-radicalization and reconciliation. The Project builds on the third strategic objective of the PCNA. The proposed operation is in line with the Country Partnership Strategy for FY10-13 which in turn is aligned with MDGs, is linked to the Fourth Pillar: Improving Security and reducing the risk of conflict as well as to the third pillar encompassing human development. The project is in line with the objectives of the Post Crises Needs Assessment (PCNA) to improve the situation in the crises affected districts. 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 crisis affected areas. To date ten donors have contributed a total of US $130.0 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.

6. 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 and Pillar 4. Building Capacity and Institutional Strengthening.

## IV. Project Description

7. The Project development objective will be achieved by working through three major components:

**Component 1: (US$ 11.0 million) Revitalizing health care services.** 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. In the first year, management of all the facilities in the hubs will be outsourced to a private firm/non-governmental organization, through a competitive process. The selected firm/organization 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.

**Component 2: (US$1.0 million) Rehabilitation of Health Infrastructure** in the Districts. The health facilities damaged during the crisis will be rehabilitated to enable service delivery. The total number of health facilities damaged in these districts is 34, and only existing infrastructure will be rehabilitated, no new construction is envisaged. The list of facilities will be finalized based on the resources available in the Annual Development Plan, which will take up some of the reconstruction, and leftover facilities shall be financed through this grant.

**Component 3: (US$4.0 million) Establish and operationalise a robust monitoring and evaluation system at the district and provincial levels.** The component will support operationalizing monitoring and evaluation systems to guide project implementation at the district level and disseminate results. 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 achievement of results.

## V. Financing

| Source | ($m.) |
|---|---|
| Borrower/Recipient | 54 |
| MDTF | 16 |
| TOTAL | 70 |

## VI. Implementation

8. The project has been prepared by the Health Sector Reform Unit (HSRU) of the Department of Health (DoH), GoKP, and its implementation shall rest with the HSRU. HSRU was established in early 2002 and was the first reform unit to be established in Pakistan. The unit was established in the DoH 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.

9. 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.

10. **Project Management**: No separate Project Implementation Unit shall be established and the project shall be managed by the HSRU with strengthening through a Management Unit/ section. 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 special account and financial management.

11. **District Health Office:** The functions, responsibilities and structure of the district health office will be reviewed in consultation with the DoH 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.

12. **District level Implementation:** 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 environmental and social safeguards

and monitoring the implementation of the civil works. The EDOH shall also be providing supervisory support to the management firm as well as verifying 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.

13. **Health Services Contracts:** The management contractors 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.

## VII. Safeguard Policies

| Safeguard Policies Triggered by the Project | Yes | No |
|---|---|---|
| Environmental Assessment (OP/BP 4.01) | X | |
| Natural Habitats (OP/BP 4.04) | | X |
| Pest Management (OP 4.09) | | X |
| Physical Cultural Resources (OP/BP 4.11) | | X |
| Involuntary Resettlement (OP/BP 4.12) | | X |
| Indigenous Peoples (OP/BP 4.10) | | X |
| Forests (OP/BP 4.36) | | X |
| Safety of Dams (OP/BP 4.37) | | X |
| Projects in Disputed Areas (OP/BP 7.60)* | | X |
| Projects on International Waterways (OP/BP 7.50) | | X |

## VIII. Contact point at World Bank and Borrower

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* *By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas*

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**Implementing Agencies**
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