Report Number : ICRR0020428

1. Project Data

Project ID P126426	Project Name PK: Revitalizing Health Services in KP
Country Pakistan	Practice Area(Lead) Health, Nutrition & Population

L/C/TF Number(s)	Closing Date (Original)	Total Project Cost (USD)
TF-11062	30-Jun-2015	70,000,000.00
Bank Approval Date	**Closing Date (Actual)**	
12-Apr-2012	12-Dec-2015	

	IBRD/IDA (USD)	Grants (USD)
Original Commitment	16,000,000.00	16,000,000.00
Revised Commitment	10,200,000.00	10,200,000.00
Actual	5,766,942.00	5,766,942.00

Sector(s)
Health(100%)

Theme(s)
Health system performance(70%):Population and reproductive health(20%):Nutrition and food security(10%)

Prepared by	Reviewed by	ICR Review Coordinator	Group
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2. Project Objectives and Components

a. Objectives

The objectives as stated in the Project Emergency Paper (p. 13) of March 26, 2012 and the Trust Fund Agreement (p. 4) of April 12, 2012 were "to improve the availability, accessibility and delivery of primary and secondary healthcare services at district level in the selected districts." The project was to be implemented entirely in Khyber Pakhtunkhwa Province (KP).

The scope of project activities and related target values of indicators were modified during a June 2014 restructuring. This validation therefore assesses the project before and after the restructuring, according to IEG/OPCS harmonized guidelines.

b. Were the project objectives/key associated outcome targets revised during implementation?

Yes

Did the Board approve the revised objectives/key associated outcome targets?

Yes

Date of Board Approval

10-Jun-2014

c. Components

The project consisted of three components:

Component 1: Revitalizing health care services (appraisal estimate US$11.0 million, actual US$5.0 million, 46% of appraisal estimate): This component was to finance: i) reorganizing primary health care centers into hubs; ii) supporting the delivery of a comprehensive package of health care services; iii) outsourcing the management of all facilities in the hubs to private firms/non-governmental organizations (NGOs), through a competitive process; and iv) improving district headquarter hospitals to foster optimal functioning as referral-level hospitals.

Component 2: Rehabilitation of health infrastructure (appraisal estimate US$1.0 million, no disbursement): This component was to finance the rehabilitation of health facilities damaged during the ongoing militancy crisis and 2010 floods, to allow for the delivery of health care services.

Component 3: Establish and operationalize a robust monitoring and evaluation system at the district and provincial levels (appraisal estimate US$4.0 million, actual US$0.72 million, 18% of appraisal estimate): This component was to finance: i) strengthening and operationalizing monitoring and evaluation (M&E) systems to assess project implementation at the district level and allow for the dissemination of results through a province-wide analysis; ii) supporting capacity building and operationalizing of a District Health Information System; and iii) supporting periodic third-party evaluation of the project in the selected districts, including baseline and end-line surveys to assess results.

d. Comments on Project Cost, Financing, Borrower Contribution, and Dates

Project Cost: According to the Financing Agreement (p.12), the project was estimated to cost US$16 million. During a project restructuring in June 2014 due to "a very slow startup and poor implementation" (ICR, p. 4), the project cost was reduced to US$10.2 million. Actual cost was US$5.77 million (36% of appraisal estimate and 56.6% of revised amount) resulting from a US$2.06 million cancellation of component 1, the complete cancellation of component 2 (US$1.0 million), and a US$2.7 million cancellation of component 3.

Financing: The project was one of nine projects to be financed by a Multi-Donor Trust Fund (MDTF) for Crisis-Affected Areas of US$16 million (reduced to US$10.2 million) and US$45 million of counterpart financing through the government's recurrent health budget. Actual disbursement of the MDTF was US$5.77 million (36% of appraisal estimate and 56.6% of revised amount).

Borrower Contribution: The government was to finance US$45 million. It actual contribution was US$3.31 million (7.3% of appraisal estimate) . The actual contribution is lower than planned as the government's financing was only used for running the government's health facilities under component 1 for the one-year contracting out period. The ICR did not include in its estimate for the actual contribution the regular budget the government provided to the health facilities for salaries of staff and operational expenditures.

Dates: The project was restructured three times:

On June 10, 2014 the project was restructured as follows: i) due to implementation delays, the financing for component 1 was decreased from US$11.0 million to US$8.2 million, and the implementation of Component 2 was dropped; ii) the financing for component 3 was decreased from US$4.0 million to US$1.26 million, as the operationalization of the District Health Information System did not take place due to the dissolution of the M&E cell; iii) the Health Sector Reform Unit (HSRU) in the Department of Health was replaced by a new Project Management Unit (PMU) under the direct administrative control of the Secretary of Health; and iv) the Results Framework was

revised by adding one Intermediate Outcome Indicator (health facility utilization rate by gender) and decreasing the target values for three out of the five Project Development Objective (PDO) indicators and three out of the eleven Intermediate Outcome Indicators;

On June 29, 2015 the project was restructured to extend the closing date from June 30, 2014 to October 31, 2015 to allow it to align with the closing date for the entire MDTF-1, which had been delayed.

On October 28, 2015 the project was restructured to extend the closing date from October 31, 2015 to December 12, 2015, as the extension of the MDTF-1 continued to be delayed.

3. Relevance of Objectives & Design

a. Relevance of Objectives

The project's objectives were highly relevant at project appraisal and project closing. At the time of project appraisal, Pakistan was in a state of emergency due to conflict and flooding. Approximately three million people were displaced in the province of KP, and only eight percent of parents of children with diarrhea visited public sector first-level care facilities and rural health centers, while 64 percent of parents visited private practitioners. The project's objective supported KP's post-crisis strategy as identified by the government and other development partners. One of the priority areas of the strategy was the provision of basic services. Furthermore, the project was in line with the second pillar of the Bank's Country Partnership Strategy (FY 2010-2013), which identified the need to improve the delivery of health, nutrition, and population services. The project's objective was still relevant at project closing. The Bank's current Partnership Strategy (FY 2015-2019) supports the agenda of the KP government to improve service delivery and management of health, nutrition, population, and sanitation services.

Rating	Revised Rating
High	High

b. Relevance of Design

The project's design was modestly relevant both before and after restructuring. It built on previous Bank-financed projects. The design included an approach to contracting out health service provision, which was innovative. However, the three dimensions of the PDO -- availability, accessibility, and delivery -- were not defined in the project preparation documents, making it necessary to reconstruct the linkages between planned activities and intended outcomes. This validation uses the definitions offered by the ICR (p. 14), which are in line with standard public health terminology. Availability of health services, defined as readiness in service provision on the supply side, was to be increased through the rehabilitation of health facilities. Accessibility of services, defined as financial affordability, physical accessibility, and acceptability (covering behavioral and cultural aspects), was to be increased through the reorganization of primary health centers into hubs, the provision of a basic package of comprehensive health services, and the focus on transforming district-level hospitals into referral centers. Delivery of services, defined as performance of services including end-users' perceptions, was to be increased through the contracting of responsibility for service delivery to private/NGO providers. The logical and plausible connection between these planned activities and intended outcomes was reasonable, but the chain of results relied on the existence of institutional capacity in contracting and provision of services that did not exist and for which the project did not plan. This situation did not change when the targets were revised at restructuring, and therefore the relevance of design under both the original and revised targets is rated Modest.

Rating	Revised Rating
Modest	Modest

4. Achievement of Objectives (Efficacy)

Objective 1

Objective
To improve the AVAILABILITY of primary and secondary healthcare services

Rationale
The ICR, and this review, define availability as readiness in service provision on the supply side.

Outputs:

- 1,365 health personnel were trained, surpassing the original/revised target of training 1,200 personnel.
- 126 health facilities were reconstructed, renovated and/or equipped, surpassing the original target of 20 health facilities.
- 52 health facilities were adequately refurbished (but did not receive new equipment), not achieving the original target of 100 facilities.
- One district headquarters hospital was refurbished, not achieving the target of three district headquarters hospitals.

Outcomes:

The ICR does not provide information on quality aspects of readiness of service provision on the supply side. In addition, the original targets on two of four indicators -- refurbishment of primary care facilities, and refurbishment of district-level secondary care facilities -- were not met. The ICR (Section 2) explains that implementation was hampered by lack of provision of promised counterpart funds, delays in government approvals, delays in concluding service contracts and implementation of those contracts, lack of contract management capacity, and communications issues among the various entities involved with implementation. Virtually nothing was accomplished over the project's first two years, and by the time implementation actually proceeded, the time for contracting out of services was short. Achievement of this objective under the original targets is therefore rated modest.

Rating
Modest

Revised Objective
To improve the AVAILABILITY of primary and secondary healthcare services (same objective, with changes in scope and in several key outcome targets).

Revised Rationale

- 126 health facilities were reconstructed, renovated and/or equipped, surpassing the revised target of 10 health facilities.
- 52 health facilities were adequately refurbished, achieving the revised target of 52 health facilities.

Achievement of service availability at the primary care level reached the revised targets, but there was no improvement in secondary care services (one of three targeted district headquarters hospitals refurbished), making achievement of the objective under the revised targets still modest.

Revised Rating
Modest

Objective 2

Objective
To improve the ACCESSIBILITY of primary and secondary healthcare services

Rationale
The ICR, and this review, define accessibility as financial affordability, physical accessibility, and acceptability (covering behavioral and cultural aspects).

Outputs:

- 3.82 million people were provided with access to a defined basic package of health, nutrition, and reproductive health services, surpassing the original target of 2.47 million (90% of the total population, which was 2.74 million). The ICR (p. 17) speculates that the provision of services to a number of people significantly higher than the population of the target provinces may be due to counting of repeat visits and of utilization of services by people living outside the districts. Given the outcomes noted below, it is not clear how "provided with access" was defined or measured.

Outcomes:

- The number of health facility visits per person per year remained essentially the same, at 0.50 visits in 2012 and 0.54 visits in 2015, not achieving the target of one visit per year.
- The ICR (Data Sheet) states that the average number of health facility visits in 2015, disaggregated by gender, was 0.54 visits by men and 0.63 visits by women. However, it is not clear how these figures are reconciled with the overall utilization rate of 0.54 visits per person per year.
- The attendance of deliveries by skilled health personnel increased from 24% in 2012 to 48% in 2015, surpassing the original target of 39%. The ICR (pp. 15-16) presents comparative data indicating that skilled birth attendance increased more in project districts than in other rural non-project districts over the same time period. However, as noted above, the project used data from the 2014-2015 Pakistan Social and Living Standard Measurement Survey, which does not differentiate use of public and private service providers, and which therefore raises questions about contribution of this project to the observed increase.
- The percentage of children with severe acute malnutrition who were provided with adequate nutrition services increased from zero at baseline to 16% in 2015, not reaching the original target of 50%. Due to delayed province-wide rollout of the nutrition program, this result covers only two of the province's districts.
- The contraceptive prevalence rate (modern methods) remained essentially the same, at 14.3% in 2012 and 15% in 2015, not achieving the original/revised target of 20%.
- The ICR reports uneven progress across project districts, with specific positive achievements noted for the Battagram district. The number of visits to the outpatient department in the Battagram district increased from 15,384 visits between July 2013 and June 2014 to 27,725 visits between July 2015 and February 2016. Over that same time period, the number of family planning clients increased from 749 to 1,128; the number of antenatal care visits increased from 846to 1,134; the number of pregnant women who were vaccinated with tetanus toxoid increased from 538 to 803; the number of newborns weighed increased from 0 to 296; and the number of fully immunized children below 15 months increased from 657 to 1,015. However, the Battagram district had the benefit of prior experience with contracting out health services; similar data are not reported for other project districts.

With essentially no progress on key measures of facility utilization and access to nutrition services, achievement of this objective under the original targets is rated Negligible.

Rating
Negligible

Revised Objective
To improve the ACCESSIBILITY of primary and secondary healthcare services (same objective, with changes in scope and in several key outcome targets).

Revised Rationale

- Health facility utilization remained the same, with the target unchanged (and not met).
- 3.82 million people were provided with access to a defined basic package of health, nutrition, and reproductive health services, not achieving the revised target of 3.96 million people.
- The percentage of children with severe acute malnutrition who were provided with adequate nutrition services increased from zero at baseline to 16% (in just two districts) in 2015, not reaching the revised target of 20% of all target districts.
- The attendance of deliveries by skilled health personnel increased from 24% in 2012 to 48% in 2015, surpassing the revised target of 30%. The ICR (pp. 15-16) presents comparative data indicating that skilled birth attendance increased more in project districts than in other rural non-project districts over the same time period. However, as noted above, the project used data from the 2014-2015 Pakistan Social and Living Standard Measurement Survey which does not differentiate use of public and private service providers, questioning the attribution of this result to the project.

Access to key services attributable to project interventions was essentially unchanged and did not meet revised targets, resulting in a rating of Negligible under those targets.

Revised Rating
Negligible

Objective 3

Objective
To improve the DELIVERY of primary and secondary healthcare services

Rationale
The ICR, and this review, define delivery as performance of services including end-users' perceptions.

Outputs:

- At project closing, 25% of funds to a consultant/NGO implementing contracting out were disbursed in a timely manner, not achieving the original target of 90%. Achievement was higher for some of the implementation period, with a timely disbursement of 75% of funds as of May 2015, but performance deteriorated toward the end of the project and did not meet the 90% original target.
- All hubs were established and assessed as fully functioning by the Department of Health (DoH), achieving the target of 100%.
- Two biannual meetings were held for the provincial steering committee, achieving the target of two meetings.
- Four districts contracted out for the management of services, not achieving the original target of six districts. The contractor for one district refused to sign the contract due to the short implementation time. Therefore, the project team decreased the target from six to five districts in the Implementation Status Report Number 8. Eventually, there were issues with another district and the contract was ended in one year. The project team decreased the target again to four districts in the Implementation Status Report Number 9.
- The number of health facilities that submitted monthly reports on time to the district increased from 50 facilities in 2012 to 90 facilities in 2015, achieving the target of 90 facilities.

Outcomes:

- 38% of the community was satisfied with the health care service delivery by the public sector in 2012, and this remained the same in 2016, not

achieving the original target of 53% or the revised target of 45% for community satisfaction.

The ICR provides no further information on performance of delivery of services, and contracting of service delivery was delayed and impacted by significant implementation challenges. Achievement of this objective under the original targets is rated modest.

Rating
Modest

Revised Objective
To improve the DELIVERY of primary and secondary healthcare services (same objective, with changes in scope and in several key outcome targets).

Revised Rationale

- 25% of funds to a consultant/NGO implementing contracting out were disbursed in a timely manner, not achieving the revised target of 100%.
- Four districts contracted out for the management of services, achieving the revised target, which was informally decreased in the Implementation Status Report Number 9 to four districts.
- Community satisfaction with health service delivery by the public sector did not increase from the baseline of 38% between 2012 and 2016, not achieving the revised target of 53%. Achievement of this objective under the revised targets therefore remains modest.

Revised Rating
Modest

5. Efficiency

Neither the Emergency Project Paper (EPP) nor the ICR provide an Economic Rate of Return or a Net Present Value due to lack of data. The EPP provides an overview of Pakistan's burden of diseases and the disability adjusted life years (DALYs) lost for several diseases and conditions that the project aimed to reduce in the areas of maternal and child health, nutrition, and communicable diseases such as tuberculosis. Also, the EPP provides a comparative analysis of DALYs lost due to these diseases among South Asian countries. This analysis shows that Pakistan's losses are among the highest in the region for both childhood and perinatal diseases, indicating that the project's areas of interventions were most critical to reduce Pakistan's burden of diseases. The EPP also provides an overview of direct and indirect benefits of the project. The direct benefits included the reduction of premature mortality, the extent to which averting diseases has a positive impact on an individual's chances to live a healthy and productive life, and savings of healthcare costs. Indirect benefits included a decrease in disability and death and associated costs.

Based on data from the literature, the ICR provides an overview of cost per DALY averted due to project interventions indicating that the project had a positive impact on maternal and child health status and on the reduction of prevalence of life-threatening communicable diseases, despite the relatively small size (US$5.13 million) of component one. The ICR also uses the concept of the value of statistical life to quantify the benefit of better health in monetary terms. The ICR assumes that the value of statistical life would be US$4,095 if it is five times higher than Pakistan's GDP per capita. Given that the project spent on average US$1.95 million per year, the project would only need to achieve an average of 476 additional years of life per year to break even. This would seem to be feasible if the project provided services to 3.82 million people.

However, even though the project addressed 42% of Pakistan's disease burden, there were major inefficiencies in project implementation (see Sections 9b and 11). Because the Department of Health had no experience in implementing Bank projects and managing a large contracting out initiative, the project faced several major procurement issues such as delays in the evaluation process, poor record maintenance, and inconsistency in requests for quotations. Most importantly, contractors had to follow a 15-step procedure within the health department in order to be reimbursed for the provision of health care services, leading to an almost two-year delay in procuring contractors

and releasing funds. Therefore, some contractors stopped providing services and others had to use their own funds to continue service provision. Due to these delays in contracting out of services (encompassing most of the project period), the project's funding was reduced by 36% in the June 2014 restructuring. The funds for components one and three were reduced by 80% and 30%, respectively, and component two was completely dropped. At project closing, only 36% of the project's original funding and only 57% of the reduced funding was disbursed. The project's efficiency is therefore rated Negligible.

Efficiency Rating
Negligible

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal		0	0 ☐Not Applicable
ICR Estimate		0	0 ☐Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

Under both the original and revised targets:

Relevance of objectives is rated High due to responsiveness to country conditions, government strategy, and Bank strategy. Relevance of design is rated Modest. While there was a logical and plausible connection between planned activities and intended outcomes, key activities relied on institutional capacity that was not present at preparation. Achievement of the objective to improve availability of primary and secondary health services is rated Modest, as some key original and revised targets were not met for rehabilitation of health facilities, particularly at the secondary level. Achievement of the objective to improve accessibility of primary and secondary health services is rated Negligible, as utilization rates for health facilities and use of modern methods of contraception did not change over the course of the project period, and access to basic nutrition services did not meet original or revised targets. Achievement of the objective to improve delivery of primary and secondary health services is rated Modest, as end-user satisfaction with services did not change (and therefore did not reach original or revised targets). Efficiency is rated Negligible, as extensive delays and implementation challenges resulted in cancellation of the majority of project financing. Taken together, these ratings are indicative of major shortcomings in the project's preparation and implementation under both the original and revised targets, and therefore an Outcome rating of Unsatisfactory.

a. Outcome Rating
Unsatisfactory

7. Rationale for Risk to Development Outcome Rating

This project served as a pilot for contracting out healthcare services and built political commitment within the KP government. The KP government decided to expand the contracting initiative to all KP districts from April 2016 for a period of 18 months, using the government's development budget. Even though the government of KP continues to be interested in the implementation of the contracting out model and the project supported the building of some capacity, remaining challenges such as complex procurement procedures and slow disbursement of

funds to contractors need to be addressed in order to move this model for healthcare service provision successfully forward. It will also be necessary to transfer practical knowledge and experience gained during the project on the contracting process to new implementing agencies, and there are no clear channels in place for that to happen.
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a. Risk to Development Outcome Rating
Substantial

8. Assessment of Bank Performance

a. Quality-at-Entry
The Bank team prepared this emergency project in only three months. The project design took into account the experience of two previous Bank health projects that had been implemented in Pakistan: the Battagram project, which aimed to revitalize and improve primary health care in Pakistan's Battagram District, and the People's Primary Health Care Initiative. Both of these prior projects had contracted out the delivery of health care services to NGOs/contractors. Also, the project took into account lessons from other local and global operations. The Bank identified several relevant risk factors during project preparation, including fragile security, insufficient capacity within the DoH, and weakness in the DoH's monitoring and evaluation (M&E). Mitigation measures included contracting out service delivery to local contractors, implementing a multilayered supervision mechanism including the use of an independent third party for data validation and periodic supervision, monitoring by district health offices, and community involvement. Also, under component 3 the project aimed to build M&E capacity within the DoH. However, even though mitigation efforts were well framed, the Bank underestimated the extent of the identified risks. For example, despite the Bank's effort to address challenges within the DoH, capacity was too weak and processes too complex and lengthy to be addressed during the project's short implementation period. Also, the project development objective (PDO) was rather complex, and none of the three areas of intervention were clearly defined or linked to the PDO indicators, which made tracking progress towards the achievement of the PDO challenging. Furthermore, several indicators in the Emergency Project Paper did not have targets.

Quality-at-Entry Rating
Moderately Unsatisfactory

b. Quality of supervision
The Bank team provided consistent support in various areas to the DoH despite a difficult post-crisis environment. The Bank also worked closely with senior officials within the KP government, as well as the country management unit and the MDTF Secretariat within the Bank, to raise implementation challenges. After the project did not achieve certain milestones, the Bank team recommended the restructuring of the project. However, the KP government did not agree to a restructuring until June 2014, one year before the original project closing date.

Bank supervision had some shortcomings. Bank management was not proactive in warning the government of a possible suspension or cancellation of the project due to its significant implementation delays. The Bank team did not revise the Results Framework after the June 2014 restructuring to reflect all modifications. Also, the Bank team used different targets for several indicators in the Implementation Status Reports than those stated in the Emergency Project Paper and changed some targets in the Implementation Status Reports without formally restructuring the project. Furthermore, the Bank did not intervene when the KP government did not release funds to contractors, and the contractors had to use their own funds to ensure the continuous provision of health care services, which was a violation of the contract between the government and the contractors. Also, the Bank did not ensure the project's compliance with safeguard policies (see Section 11a).

Quality of Supervision Rating
Moderately Unsatisfactory

Overall Bank Performance Rating
Moderately Unsatisfactory

9. Assessment of Borrower Performance

a. Government Performance

The commitment to the project by the government was mixed. The government showed initial strong interest by promising significant counterpart financing of US$45 million for the recurrent costs of running health facilities in the project districts. Also, the senior management of the KP government intervened to improve project implementation at important times. However, the government's complex internal approval process delayed the start of project implementation by nine months. The government did not use the implementation delay to take adequate measures such as addressing the limited capacity at the DoH, preparing an Operations Manual, or developing an Environmental and Social Management Plan (ESMP) in order to ensure successful implementation. Project implementation was significantly impacted by delays in budget relase to contractors and by seven changes of secretaries of health within a three-year period. In addition, even though project milestones were not being achieved, the KP government did not agree to restructure the project until June 2014, one year before the original closing date.

Government Performance Rating
Moderately Unsatisfactory

b. Implementing Agency Performance

The Health Sector Reform Unit (HSRU), and later an independent Project Management Unit (PMU) within the DoH, were responsible for the implementation of the project. However, the DoH had no experience with implementing Bank projects and managing a large contracting out initiative. Also, the DoH could not ensure the provision and continuity of key staff and timely decision making on a daily basis. Additional challenges included bottlenecks in the processing of government documents and differences in the interpretation of policies. Project implementation was also affected by high turnover of the project director/coordinator. Furthermore, contractors had to follow a 15-step procedure within the DoH in order to be reimbursed for the provision of health care services. All these issues led to an almost two-year initial delay in procuring contractors and releasing funds. Therefore, some contractors stopped providing services, and others had to use their own funds to continue service provision. The ICR (p. 11) reports ratings of Moderately Unsatisfactory for financial management and Unsatisfactory for procurement.

It was planned that the PMU would organize an inception meeting with all stakeholders after signing the contract for each district. However, these meetings never took place, and the contractors had to deal with challenges on their own. The monitoring and evaluation arrangements (M&E) were not adequate since the M&E cell was closed when the project became effective. The M&E cell was part of a poorly performing government initiative within the DoH. This project was aiming to improve its functionality but due to the delay in processing contracts, the M&E cell did not function and stood still for over a year, resulting in its closure.

Implementing Agency Performance Rating
Unsatisfactory

Overall Borrower Performance Rating
Unsatisfactory

10. M&E Design, Implementation, & Utilization

a. M&E Design

Originally, the Results Framework included five PDO indicators and 11 Intermediate Outcome Indicators. An Intermediate Outcome Indicator was added during the June 2014 restructuring of the project. All of the indicators were measurable in terms of numbers, timing, and location. However, a baseline value for PDO indicator 1, "people with access to a defined basic package of health, nutrition, and reproductive health services," was never defined.

The three dimensions of the PDO -- availability, accessibility, and delivery -- were not well-defined (i.e. not sufficiently specific and measurable), and were not clearly linked to the PDO indicators, which made measuring progress towards the PDO challenging. The project planned to use

data from project progress reports, the District Health Information System, provincial-level Multi-Indicator Cluster Surveys, and the Pakistan Social and Living Standards Measurement Survey.

To strengthen the already existing M&E system in the DoH, the project included several activities under component 3, including strengthening the M&E cell, establishing district health management teams to review progress on a quarterly basis at the district level, hiring an independent consulting firm for the collection of baseline, mid-term, and end-line data, strengthening the district health information system, and providing for external validation of the system's data, and conducting periodic supervision by a third-party consultant.

b. M&E Implementation

The project faced many challenges related to implementation of the M&E function. The M&E cell in the DoH was eliminated at the time the project became effective. The DoH hired an M&E firm to support the HSRU in the establishment of baselines and in monitoring project indicators on a quarterly basis. However, due to hiring delays, the firm could only start a few months before the project was closing. Monitoring progress towards achievement of objectives and revising indicator targets was challenging given the lack of baseline data. Also, the Multi-Indicators Cluster Survey did not take place during the implementation period. During the June 2014 restructuring, the Results Framework was adapted to reflect the downsizing of the project. However, several indicators were modified in Implementation Status Reports without formal restructuring of the project.

Three outcome indicators -- skilled birth attendance, modern contraceptive prevalence rate, and community satisfaction -- were not measured adequately due to the lack of an on-time population-based survey. Instead, the Pakistan Social and Living Standard Measurement Survey, which measured an average of four different districts, was used, raising questions about the attribution of these results to the project. Conducting a large population-based survey to obtain data for population-level indicators such as skilled birth attendance and contraceptive prevalence rate turned out to be too ambitious in the challenging post-crisis environment and did not take place during project implementation. The project team stated that given the very short implementation time, the use of administrative indicators showing the change of the volume of health services provided by the project, based on accessible administrative data rather than an extensive population survey, would have been more adequate.

c. M&E Utilization

Utilization of M&E project data to inform decision-making was limited. Some data from third-party surveys and the district health management teams was used to assess progress towards the project's objectives.

M&E Quality Rating

Negligible

11. Other Issues

a. Safeguards

The project was Environmental Category "B" and triggered the Bank's safeguard OP/BP 4.01 (Environmental Assessment). The government prepared an Environmental and Social Management Plan (ESMP), which was in accordance with local regulatory requirements and the Bank's safeguard policies and included plans and guidelines for health care waste management. The Bank also prepared an Environmental and Social Screening and Assessment Framework in accordance with OP/BP 8.0 for emergency operations. However, health care waste management was only partially implemented at the primary health care facilities, as none of the facilities was able to develop an adequate system to dispose infectious waste safely. The project prepared ESMP progress reports on an irregular basis. Also, due to security concerns, the project team was not able to visit project sites to monitor the implementation of safeguards during the initial years of project implementation. The ICR does not specifically state whether the project complied with the Bank's safeguard policies.

In regards to social safeguards, the Emergency Project Paper identified several demand-side and supply-side barriers to health services delivery and concluded that these barriers would be addressed by the project. However, compliance with social safeguards was not adequately measured, and progress was not included in Implementation Status Reports and Aides Memoire by the Bank team. Although a grievance redressal system was developed in all four districts that contracted out services, its implementation was substantially delayed.

b. Fiduciary Compliance

Financial Management:

Financial management was performed by an experienced team throughout project implementation. The project's financial management arrangements were adequate. Financial reports were submitted in a timely manner and found acceptable by the Bank. External audits were conducted by the Supreme Audit Institution, and internal audits were conducted by KPMG. No major internal control exceptions were identified. The external auditor's opinion was not qualified. The project experienced significant implementation delays, as the district officials responsible for the transfer of government funds to the contractors lacked understanding of fund flow mechanisms. This, coupled with delays in the release of counterpart funding, resulted in a rating of Moderately Unsatisfactory for Financial Management overall (ICR, p. 11). Contractors sometimes had to use their own funds to continue the provision of health care services.

Procurement:

The ICR (p. 11) reports a Procurement rating of Unsatisfactory. The project experienced delays in project implementation due to several procurement challenges. Each step in the procurement process took longer than planned due to the HSRU's limited experience in Bank operations. The Bank provided support to address these challenges. However, procurement only slightly improved when the project implementation function was moved from the HSRU to a new PMU. Even though five of six contracts were signed under the new PMU, procurement issues such as delays in the evaluation process, poor record maintenance, and inconsistency in requests for quotation persisted.

c. Unintended impacts (Positive or Negative)

None reported.

d. Other

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12. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Unsatisfactory	Unsatisfactory	---
Risk to Development Outcome	Modest	Substantial	Even though the government of KP continues to be interested in the implementation of the contracting out model and the project supported the building of some capacity, remaining challenges need to be addressed in order to move this model for health care service provision successfully forward.
Bank Performance	Moderately Satisfactory	Moderately Unsatisfactory	The Results Framework had several significant shortcomings. Also, the Bank did not intervene when contractors were not paid by the government and had to use their own funds to ensure the

			continuation of service provision.
Borrower Performance	Moderately Unsatisfactory	Unsatisfactory	Several implementation challenges due to lack of continuity of key staff in project management units, high turnover of project director/coordinator and complex procedures to release funds to contractors, produced significant delays that resulted in non-achievement of objectives.
Quality of ICR		High	---

Note
When insufficient information is provided by the Bank for IEG to arrive at a clear rating, IEG will downgrade the relevant ratings as warranted beginning July 1, 2006.
The "Reason for Disagreement/Comments" column could cross-reference other sections of the ICR Review, as appropriate.

13. Lessons

The ICR (p. 26) includes useful lessons learned, including the following:

- When a project is being implemented in a fragile, post-crisis environment, taking weak capacity and other implementation constraints into account when deciding on the project's scope and time frame for project implementation is key to success. In this project, an initial phase for capacity building in critical areas such as procurement, contracting out, and M&E would have been beneficial for successful project implementation.
- Conducting an in-depth political analysis and ensuring the buy-in of all stakeholders is critical for successful project implementation. In this project, the highest government level was committed to the implementation of the project; however, this commitment did not translate into action at the implementing agency level due to political complexity and loose enforcement of internal regulations, resulting in significant implementation delays.
- In a fragile, post-crisis environment, contracting out of healthcare services to NGOs/contractors, where traditional service provision does not work, can be effective. However, this project demonstrated the challenges related to this model when being implemented in a weak capacity environment. These challenges included delays in payments to contractors, lack of contract management capacity, and reporting delays by contractors.

14. Assessment Recommended?

No

15. Comments on Quality of ICR

The ICR is well written and evidence-based, providing a comprehensive overview of project preparation and implementation. It is candid and straightforward regarding the project's implementation challenges and shortcomings. The analysis is concise and consistent. The ICR makes sense of an unclear set of objectives, brings logic to the results framework, and incorporates additional data from outside the formal results framework to demonstrate achievement. Its discussions of attribution of observed results to the project's interventions are clear and nuanced. The ICR does not include a traditional economic analysis due to lack of data. The lessons learned are insightful and should provide important guidance to similar projects in fragile, conflict environments.

a. Quality of ICR Rating
High