TECHNICAL ASSISTANCE COMPLETION REPORT

Division: SASS

TA 3386-PAK: Health Sector Reform in North-West Frontier Province (NWFP)			Amount Approved: $500,000 Revised Amount: n/a	
Executing Agency: Provincial Health Department (PHD) NWFP	Source of Funding: TASF		Amount Undisbursed:[1] $66,154.46	Amount Utilized: $433,845.54
Date of Report Approval 29 December 1999	Signing 30 January 2001	Fielding of Consultants 30 August 2001	TA Completion Date Original: 30 Jun 2000 Account Closing Date: Original: 30 Jun 2000	Actual: 30 Apr 2003 Actual:[2]

Description

Despite major investments of the Government of North-West Frontier Province (NWFP) and the public, the health status of the people of NWFP, in particular the poor, women and children, remains very poor. Communicable diseases remain common and the burden of chronic diseases continues to increase. The Government noted that the extensive network of public health facilities has limited impact, as services are often unavailable or of poor quality due to governance problems and resource constraints. Similarly, the private sector is plagued by poor quality of services. In 1997, the Government of NWFP organized a task force to broaden stakeholder consultation and provide guidance to health sector reform (HSR). In line with the National Health Policy, NWFP decided to restructure the role of the Government in the health sector and undertake organizational and programmatic reforms. NWFP's aim was to develop a health system that provided effective care, in particular for the poor, women and children, and that would be managed in an efficient and transparent manner. ADB was asked to assist in the organizational reforms. In the first phase, priority was given to developing an overall plan for HSR, decentralization of powers to hospitals and districts, and shifting part of the patient loan of tertiary hospitals to the primary level and the private sector.

Objectives and Scope

The objective of the TA was to assist the Government of NWFP to strengthen its efforts in HSR to improve health sector performance in the province, with the ultimate goal of improving the health status of its people and achieving sustainable health sector development over the decade. The TA assisted NWFP's Provincial Health Department (PHD) in (i) strengthening the institutional capacity in HSR; (ii) conducting sector analysis and assessing progress in HSR; (iii) supporting the task force to develop a medium-term strategic plan for HSR; and (iv) developing detailed plans for hospital autonomy and the district health authorities in 4 districts. By the time the TA began, devolution had taken place and districts were formally separated from the PHD by the establishment of district governments. Major hospitals had been granted autonomy. The fourth workstream was therefore greatly facilitated by these developments and, on request of the PHD, became more demand driven.

The 16 studies under the second component covered sources and uses of health sector funds, institutional analysis, systems review and responsiveness survey, stakeholder analysis, financial and personnel management for decentralized governance, costing and financing health services, public-private partnership, monitoring HSR, and legal aspects of HSR. The study on sources and uses of funds was extended to a full provincial health accounts study, and studies were added on the quality of health services and public-private partnership, which were originally planned for a later phase.

The TA design was highly relevant for the problems of the health system in NWFP, including the recent devolution of social services to district governments, the increasing financial needs of tertiary hospitals to manage chronic diseases of the non-poor, and the emerging public-private partnership.

Evaluation of Inputs

Executing Agency. The consultants were provided ample accommodation, with easy access to the Minister and the Secretary, Health. PHD ownership and leadership of the reform agenda was strong. Competent counterpart staff worked with the consultants. However, staff transfers remained common. The other main issue was the delay in processing the TA. The input of the Executing Agency is rated as satisfactory.

Consultants. The team leader and his team did an excellent job. They worked hard throughout the TA, built up good relationship with NWFP, undertook consultations, proposed adjustments to the scope of work as required by the changing circumstances, mobilized additional support for reform, and provided timely and well written reports. TA administration by the UK office was satisfactory, although there was delay in finalizing payments. The home office

[1] About $27,000, inclusive of pending claims and statement of eligible costs, still to be disbursed to the consultant.
[2] Awaiting receipt of Certificate of Full Payment from the consultant and advice from Controller's Department.

time for international consultants was increased from 0.5 to 2.75 person-months and the field time from 11.5 to 12 person-months. The input of the consultants was rated as highly satisfactory.

ADB. The mission leader carried out inception, mid-term and tripartite review missions and made a presentation on health sector reform for the poor during the final conference. ADB's main problem concerned the recruitment of the legal consultant. The Executing Agency is satisfied with the inputs of ADB and consultants.

Evaluation of Outputs

The TA was considered highly effective and its impact sustainable. For a limited inputs in terms of person-months and funds, major reforms were agreed to that were formally approved, and will have lasting impact on the health system of NWFP. The output of the first component was the establishment of a permanent capacity for HSR in NWFP. The Government of NWFP formally approved the establishment of an HSR Unit in the Planning Cell of the PHD. However, high turnover of otherwise competent staff affected the capacity of the HSR Unit. The second component produced detailed working papers on the various aspects of HSR. These are being used to guide implementation of various reform activities. The Department for International Development (DFID), UK, financed the same consultants to provide training of all districts and major hospitals in administrative and financial matters under the devolved system. The third component produced the strategy for HSR, which was approved by the NWFP Cabinet in late 2003. The World Bank incorporated the HSR strategy as a condition for approval of the second phase of the NWFP Structural Adjustment Credit. Other donors also support the implementation of the strategy. The last component helped develop subsystems for autonomous tertiary hospitals and devolved district health services. The quality of these products was generally of high standard. The working papers and strategy were written in a clear and concise manner. The strategy was generally seen as a good compromise among the various stakeholders.

The TA was implemented in an efficient manner. Consultants worked hard and were productive. However, the TA experienced several delays. The provincial and federal government required almost one year to clear the TA. Consultants had to be evacuated after the events of 9/11. Security remained tense, and they had to be re-evacuated following further security concerns. Further delay occurred towards the end of the TA when a suitable legal consultant could not be found within ADB's rates. These delays required some adjustment to the evolving conditions in NWFP and probably also caused some loss in momentum and inefficiency. As discussed in the final tripartite meeting, the Executing Agency rated the outputs of the TA as satisfactory.

Overall Assessment and Rating

The TA is rated as successful. The TA has helped NWFP plan for HSR and devolve services from provincial level to districts and hospitals. Two major problems were the frequent turnover of otherwise competent counterparts, and the delays in TA implementation. The TA achieved more than the original scope in terms of systems analysis. There was considerable public opposition against reform before the TA started, but during the TA it was mainly the private practitioners and specialists that opposed reform plans. Through intensive dialogue with the various stakeholders, much of this could be diffused. Strong political leadership eventually helped obtain cabinet approval for the HSR strategy.

Major Lessons Learned

A major lesson is the need for flexibility when supporting major reforms that are linked to political decision making and have repercussions for many stakeholders. In this case, the persistence of the PHD eventually paid off. The presence of a champion to promote the reform process is also crucial. Capacity building of the public sector remains an unresolved challenge in the administrative realities of the public sector in Pakistan. Issues such as low pay and frequent turnover of planning staff continue to hinder the reform process. Federal authorities, and professional and political stakeholders, should be closely involved to ensure their commitment and realize reforms.

Recommendations and Follow-Up Actions

This TA supported the first phase of HSR. While the World Bank, DFID, the Government of Germany, and UN agencies have taken over some of the reform work, much needs to be done including passing private sector regulations, human resource development, strengthening quality control systems, and strengthening patient associations and local health boards. ADB plans to provide further assistance to the reform process through a proposed loan to support devolved social services currently included in the CSPU for 2006. The Government of NWFP will make the final reform plans accessible to the public.

Prepared by: Vincent de Wit Designation: Senior Health Specialist