The Technical Resource Facility and related initiatives (TRF+)

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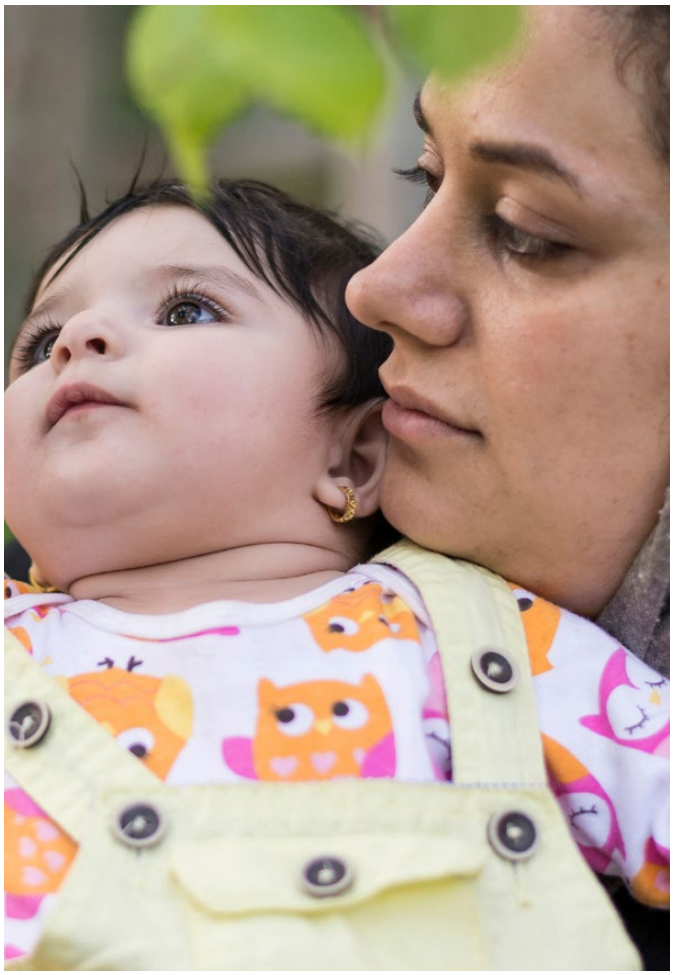
Public private partnership in health: the experience of Khyber Pakhtunkhwa



Summary

Public private partnerships in health have long been recognised in Khyber Pakhtunkhwa (KP) province for their potential in supporting the achievement of health goals. In the period 2007-16, three separate PPP initiatives were launched in the province, covering, between them, 23 out of the total of 25 districts.

More recently, the KP government has signalled renewed interest in PPPs. In 2018 a provincial Health Policy and Health Sector Strategy were approved that TRF+ provided support to, which both include PPP as a principal means of attaining the SDG goals. A new law mandates the KP Health Foundation to execute PPP projects in health. The three previous PPP initiatives were:

1. People's Primary Healthcare Initiative (PPHI), 2006-16
2. Revitalizing and Improving Primary Healthcare in Battagram District, 2008-11 (Battagram)
3. The Multi-Donor Trust Fund (MDTF) Revitalising Health Services in KP, 2012-15

The purpose of this paper is to compare these three models and their degrees of success, focusing on programme management, financing arrangements and political economy considerations, to distil key lessons which can inform future PPP initiatives.

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Key lessons

Capacity: For PPPs to work, their overseeing bodies need to have capacity to procure and manage contracts, with expertise in donor rules and procedures, drafting PPP contracts, project management and performance monitoring. It will be important for the KP Health Foundation to establish dedicated units for these functions, seeking technical assistance where necessary, and to put in place an institutional mechanism for DoH involvement.

Financing: The use of PC-1 as a financing instrument has been cited as a cause of delay given lengthy approval timeframes. The possibility of channeling donor funding through the KP Health Foundation, without recourse to a PC-1, should be explored. There is a room to review and simplify processes that guide payments, critical to which is the empowerment of a Project Management Unit (PMU) as the approving authority for payments.

Monitoring and Evaluation: In the Battagram project, the formation of a district committee for assessing progress against indicators proved to be useful not only for monitoring purposes but also for generating local political and community support. Reconstituting a similar body would make eminent sense and would make performance-related payments more straightforward.

Political economy: The experience of PPP in KP highlights the important role of political economy. Past failures to foster collaboration or undertake systematic efforts to engage and convince provincial/ district officials and service providers of the rationale for PPPs have impacted projects negatively. Due attention needs to be paid to such risks, and mitigation measures proposed in project planning.

Leadership: PPPs have been successful when backed by a strong political leader, whether at federal (in the case of PPHI) or provincial level (in the case of Battagram). The MDTF project unfortunately did not find a strong supporter within government. Sensitising the high-level political leadership could help to generate such support in future initiatives.

Trying alternative approaches: Experience from the PPHI and Battagram projects show that the autonomy given to a third-party supplier in developing its own budget, providing additional financial resources for systems building and innovations, and putting staff under their administrative control, was an essential requirement for the project's success. DoH needs to explore models where similar autonomy could be given to district health managers on a trial basis, backing them with technical assistance if required.

Introduction

Providing access to quality health services to people, particularly in rural areas, has always been a huge challenge for the government. Since devolution in 2011, provincial governments have been responsible for this. One of the ways they have tried to improve health services, and meet elusive targets including universal health coverage (UHC), is by resorting to public-private partnerships (PPP), contracting an outside agency to deliver specific services in return for defined payments. In this paper we analyse the experience of Khyber Pakhtunkhwa (KP) province where three distinct PPP initiatives have been implemented with varied degrees of success.

The importance of PPPs for the KP government is evident from the fact that during 2007-16, three separate PPP initiatives were launched covering, between them, 23 out of the total 25 districts. More recently, in 2018, the provincial government introduced a law that mandates the KP Health Foundation to execute PPP projects in health. The newly approved provincial Health Policy and Health Sector Strategy both include PPP as a principal means of attaining the SDG goals.

In order to inform future government efforts, in KP and elsewhere, this paper examines the factors responsible for producing varying results in the three PPP initiatives so that informed decisions could be taken while introducing new initiatives. The design, management, financing and procurement arrangements of each are discussed as they have a direct bearing on the results achieved. The political economy played a vital role in the projects' ownership by the government, and its influence on the project's dynamic also forms a part of the analysis.

Origin of PPP initiatives in Pakistan: In 2003, Punjab government's initiative to contract out the management of Basic Health Units (BHUs) in the remote district of Rahimyar Khan (RYK) led to a substantial improvement in people's access to basic health services. These first-tier public health facilities for primary healthcare were contracted to Punjab Rural Support Programme (PRSP), a quasi-government organization set up by the provincial government for rural development through community participation.

An assessment of the initiative carried out by the World Bank in 2005 showed that, after two years, the BHU utilisation rate climbed and was 54% higher than in a comparable district. Women and children under five, in particular, had benefited. The community reported that both the physical conditions of the facilities and the health services had improved considerably, and their out-of-pocket expenditure had reduced. The results indicated large efficiency gains as the overall budget for facilities did not change. Other measures of service quality and preventive care, however, did not improve and remained a challenge.[1]

The World Bank termed the RYK initiative as a bold reform and urged the government to build on it in a phased manner. To address the issues of quality and preventive care, it recommended that contracted NGOs should be made responsible for delivering a well-defined service delivery package. The assessment noted that one of the main factors behind success was the full autonomy given to the NGO in staff management and use of financial resources.

1. Partnering with NGOs to Strengthen Management: An External Evaluation of the Chief Minister's Initiative on Primary Health Care in Rahim Yar Khan District, Punjab, The World Bank, 2006

The RYK initiative led to the President's Primary Healthcare Initiative launched in 2005, which was re-named the People's Primary Healthcare Initiative (PPHI) following the change of government in 2008. The PPHI was designed to improve on the RYK model and be implemented in a selected number of districts in each province, starting with BHUs and gradually expanding to all other primary healthcare facilities.[2]

The PPHI was initially established in the Ministry of Industries and then transferred to the Cabinet Division of the federal government as a "special initiative" with sizeable annual grants to pay for the expenses relating to project management in the provinces and Special Areas; Punjab was an exception where the government opted to continue its partnership with PRSP with an expanded programme.[3] PPHI had a strong political backing at the federal level and their staff tightly controlled the programme, while the respective Rural Support Programmes (RSPs) who signed contracts with provincial governments, played merely a facilitative role for PPHI. The project management including control over funds remained in the hands of PPHI management.

KP's 3 models of PPP in KP: In KP, the first initiative was under the PPHI programme, which started with six districts in 2006 and had extended to 17 out of the total of 25 districts by the time it was terminated in 2016.

In six additional districts the provincial government introduced two successive PPP initiatives in cooperation with the World Bank, the first of which was launched in 2007 in a remote district of Battagram. The initiative captured the interest of provincial government and its partners as it proved to be a resounding success and, in many ways, surpassed the achievements recorded by the RYK initiative in Punjab. Encouraged by its success, the provincial government and World Bank decided to extend their cooperation and in 2012 introduced another PPP initiative, the MDTF supported "Revitalising Health Services in Khyber Pakhtunkhwa". This had some important changes to the model, and covered five additional districts, as well as continuing in Battagram. The provincial government, however, struggled with the implementation of the expanded project and it led to dismal results. The following sections present the experience of and lessons learned from these three initiatives.

2. The federal government issued a directive to the provincial governments for designation of districts where BHUs were to be run under the PPHI arrangement. The country being under the military rule and Health not being devolved as yet led the provinces to accept the directive.

3. Besides Punjab, PPHI was implemented in the provinces of Balochistan, Khyber Pakhtunkhwa (then called the North-West Frontier Province) and Sindh and the Special areas of Azad Jammu and Kashmir, Federally Administered Tribal Areas (now part of Khyber Pakhtunkhwa) and Gilgit-Baltistan.

People's Primary Healthcare Initiative (PPHI), 2006 – 2016

Key Features

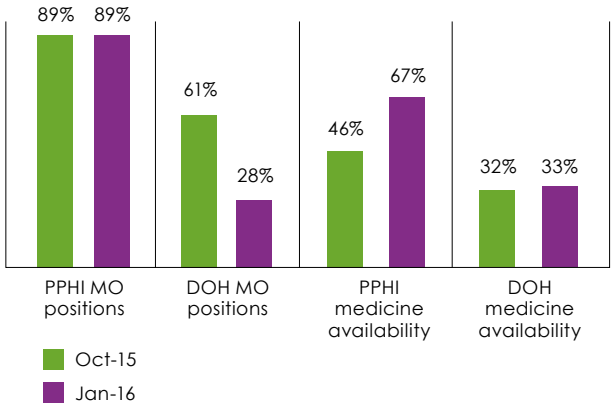
- 17 districts
- Managed by PPHI's Provincial Support Unit (PSU), who reported to central leadership of PPHI with little involvement of Provincial DoH
- Sarhad Rural Support Programme (SRSP) contracted for administrative delivery
- Two funding sources: federal funds for programme management and provincial funds for running of BHUs via SRSP
- Included management of all primary care facilities but not outreach (preventive) programmes
- M&E largely non-existent

The experience of PPHI managed BHUs was mixed at least in KP, as shown by an independent evaluation of the model in 2010.[4] As no baseline was established the evaluation relied on data from DHIS and PPHI, the quality of which was questionable, and included a sample survey of BHUs and interviews with clients to compare the performance of PPHI and government run BHUs. At the time the evaluation took place, PPHI had expanded to 14 districts.

In the BHUs surveyed, staffing levels were found to be much better in PPHI BHUs, with Medical Officers (MOs) posts filled in 67% of facilities, compared to 33% in government-run, and Lady Health visitors (LHVs) posts filled in 100% facilities compared to 75%. Availability of essential drugs and vaccines was also much better in PPHI run BHUs e.g. Amoxilin had 83% availability versus 42% in government BHUs. Importantly, PPHI added some new services that were not available at government run BHUs including Hepatitis-B tests, pregnancy tests, and haemoglobin for anemia tests.

According to the KP government's Independent Monitoring Unit (IMU) data, MO posting and availability of two weeks' supply of critical medicines was much better at PPHI managed BHUs compared to DoH run BHUs, in the period October 2015 to January 2016, as shown in the figure below.[5] This initiative was terminated in July 2016.

PPHI vs DOH - Medical officer and medicine availability at BHUS



4. Third-Party Evaluation of the PPHI in Pakistan, Technical Resource Facility, 2011
5. TRF+ Roadmap stock-take presentation for KP, February 2016

Project design and management: Being established under a federal government directive, PPHI lacked ownership by the provincial government from the beginning. The Sarhad Rural Support Programme (SRSP), like RSPs in other provinces, was designated by the federal PPHI to implement the project in the province and the provincial government did not play any role in its selection. An overall Memorandum of Understanding (MOU) for project execution was signed between the provincial government and SRSP, followed by specific contracts for delivery of services between the district administration and SRSP.

The project management was carried out by the PPHI's Provincial Support Unit (PSU), which oversaw the District Support Units (DSUs) in all districts where the project was implemented. PSU reported to the central leadership of PPHI at the Federal Support Unit. SRSP mainly played a facilitative role of issuing staff contracts and making payments as instructed by PSU.

The contracts under the PPHI initiative, while mentioning that primary healthcare related preventive, curative and promotional services were to be delivered, did not specify the services delivery package and targets against which progress could be assessed. The lack of specificity gave PPHI the freedom to introduce some new services that were not customarily provided at BHUs, causing friction with the DoH. A design flaw was that the preventive and promotional components could not be implemented under the project as, unlike the PPHI run BHU staff, the management of outreach programme staff remained with the DoH district managers. The contracts did not specify mechanisms for cooperation between PPHI teams and the DoH district management in this regard.

Performance monitoring and contract oversight by the government was largely non-existent. Despite one of the findings of the RYK initiative assessment being that the quality of services remained poor[6] even though access increased, neither DoH nor PPHI put in place any technical supervisory mechanism or service delivery benchmarks. Although the MOU and the contracts referred to supervision, the mechanisms to carry out these functions were not defined. There was no assessment of PPHI performance throughout its lifetime, even as more districts were added to their portfolio. While data from the routine monitoring system of DHIS was available, there is no evidence of DoH using it to monitor PPHI project performance ensuring public funds were being put to the intended use.

The absence of regular performance monitoring and technical supervision mechanisms even for the government run BHUs suggests that DoH may have lacked these capacities, which could be a main reason for failing to carry out these functions under the PPHI.

Although the overall objective of the PPHI was to reform district management of health services through a temporary outsourcing of health facilities, the contracts did not define the nature of these reforms. DoH also did not have any plans for instituting reforms in the health system. The project design, in fact, created disconnects between the health system and the outreach programmes and referral system which undermined integrated delivery.

The provincial and district government involvement in the project activities remained minimal with limited dialogue on how PPHI should link with other parts of the health system. The PPHI evaluation cited earlier reported that the relationships between the two entities "were found to be ineffective and often characterised by mutual distrust".[7] Throughout its life the project remained limited to improving services at BHUs in which it seems to have done well, but an opportunity was lost as it did not lead to reforms in the broader health system. Even the improvements in BHUs were not sustained after the project finished and the facilities were handed back to DoH in 2016.

6. In RYK evaluation, the quality of care was assessed through direct observation of provider-patient interactions, and focused on behaviour of provider to the patient, history taking, physical examination, diagnosis and management and counselling.

7. Third-Party Evaluation of the PPHI in Pakistan (p.78), Technical Resource Facility, 2011

Financing arrangements: The project was financed by two sources: Cabinet Division of the federal government provided funds for programme management by PSU and DSUs of PPHI as well as for repair and rehabilitation of the health facilities. The second source was from the provincial budget; on approval from DoH the district administration transferred the funds allocated in the budget for running of the allotted BHUs to SRSP. The funds were transferred as a single line item, and the specific allocations were made by PPHI. The funds flow from both sources was reported to be timely and did not cause any impediment in the project execution.

Substantial savings by PPHI management were reported during the project implementation. The savings were made despite offering additional services at BHUs for which additional staff had to be engaged and supplies procured. The PPHI evaluation cited earlier pointed out that this was due to the freedom given to PPHI BHUs to allocate funds according to their needs, conduct procurements swiftly, contract staff from the market after negotiating salaries and firing them promptly if they did not perform well and, importantly, retaining the underspent funds at the end of the financial year. The PPHI BHUs, therefore, had far greater authority in resource management than their government counterparts.

The role of political economy: The way PPHI was introduced and SRSP selected diminished the provincial government's support for the project from the beginning. The lack of coordination between PPHI management and provincial and district health authorities fueled mutual antagonisms: the DoH officials feeling that PPHI had encroached on their territory, while the PPHI management made no secret of their views that the facilities were contracted out to them because DoH had failed to improve health services. PPHI, therefore, persisted in their "do it alone" approach that increased antagonisms further. Health department built further pressure on PPHI by demanding an official audit of the provincial government funds given to the project. That led to the closure of PPHI in KP, as SRSP did not agree to this demand.

The saga underlines the importance of ownership of the initiative by provincial government. A better course might have been for the federal government to have played more of a catalyst role and help the provincial government introduce and manage this initiative.

Revitalising and Improving Primary Healthcare in Battagram District, 2008 – 2011

Key Features

- 1 district (Battagram)
- Tripartite collaboration between provincial government, World Bank and an international NGO
- Budgetary and administrative authority entrusted to the NGO, who was paid directly by World Bank
- Contract included management of all primary care facilities and outreach programmes
- Government and World Bank's funds dispersed separately with each party following its own rules
- Health Sector Reform Unit (HSRU) responsible for contract management and coordination
- Clear M&E arrangements, and performance-based incentives introduced

Battagram was one of the most challenging districts in KP due to its remoteness, poor health indicators and extensive damage to its health infrastructure following the massive earthquake of 2005. The selection of this district, therefore, showed a unique resolve on the part of government and the World Bank to showcase how a PPP model could be instrumental in dealing with such grave challenges to the delivery of health services.

Battagram was a rewarding experience for the people of the district, as all the project targets were met and even surpassed. Table 1 provides the achievement against the baseline on key health indicators over three years of the project and in 2017 as measured by the KP Health Survey.[8]

As the table shows, all the target indicators increased substantially during the project. Although most of these indicators have declined since the project finished in 2011, importantly, they remain well above the baseline most probably due to the systems and capacities built during the project. Facility based deliveries have registered a substantial increase even after the project finished.

Table 1: Progress on Battagram district indicators of mother and child health

Indicator	Baseline 2007/08	End Project 2010/11	KP Health Survey 2017
12-23 months children fully immunised	10%	76%	50%
ANC1 by skilled attendant	33%	63%	52%
Facility based deliveries	33%	50%	64%
Mothers receiving Tetanus protection	30%	63%	40%

Source for project data: Khan, A. et al, n.d., Health Systems Strengthening in District Battagram, Pakistan (2008-2011) – A case study, Save the Children UK

8. Khyber Pakhtunkhwa Health Survey 2017, Department of Health and Bureau of Statistics, Government of Khyber Pakhtunkhwa, 2017

Project design and management: The Battagram project demonstrated the success of a tripartite collaboration between provincial government, donor (the World Bank) and the contracted private party, an international NGO, Save the Children. Importantly, the NGO was selected mutually by the World Bank and the DoH due to its expertise in running community health projects in the province. A market-based selection process was not followed and perhaps was also not required as the World Bank directly contracted the NGO.

The NGO in turn signed MOUs with the provincial government and district administration for delivery of services and was responsible for delivery of a primary healthcare package that included both curative and preventive services. The management of all primary care facilities and outreach programmes, including budgetary and administrative authority, was entrusted to the NGO. Strengthening of referral services was also included for which an ambulance service was introduced, and the district government improved the secondary health facilities. The NGO followed a hub approach for service delivery that improved staff productivity; the approach involved a group of BHUs being managed by an RHC based administration. Performance based incentives were introduced for service delivery staff to improve their motivation and outputs. Much emphasis was placed on capacity building of health staff and administration, including strengthening of monitoring and reporting.

The responsibilities of the NGO and the District Health Office (DHO) were clearly defined, where the DHO looked after the secondary hospitals and the NGO managed the primary healthcare system. Their mutual collaboration ensured that the required care existed for patients referred by the primary healthcare system. The NGO also involved the DHO in staff selection and capacity building events, which forged a close cooperation between the two entities.

Monitoring arrangements were clearly defined. A monthly monitoring plan was put in place and monitoring was jointly carried out by the DHO and NGO teams that included visits to selected health facilities for assessing quality of care. A baseline of performance indicators for the NGO was established and targets defined, which were reflected in the NGO's work plan. Performance monitoring meetings at the district level, chaired by the district Nazim, were also attended by the World Bank, besides the DHO office and officials from Health Sector Reform Unit (HSRU) at DoH. The HSRU was responsible for overall contract management and coordination between the provincial and district administration and held quarterly review meetings, which were also attended by the World Bank.

Financing arrangements: Two streams of financing were available for the Battagram project: one by the district government and the other by the World Bank. The district government transferred the budget relating to primary healthcare facilities and programmes to the NGO in a lump sum and the latter allocated the funds received under various heads according to the project needs. The payments by the World Bank, using a grant from the Japan Social Development Fund, were made directly to the NGO for additional programme costs and its management fee, and were linked to the achievement of performance indicators. Payments from both streams were mostly timely and facilitated a seamless project execution.

The role of political economy: The project was fully backed by the provincial government, who were looking for donor assistance to ameliorate the suffering caused by the earthquake. The Bank's close involvement in the project minimised the usual risks associated with procurement, performance and productive utilisation of resources. The close cooperation forged between the government and NGO in the district ensured timely resolution of issues encountered during project execution. The project not only utilised almost all donor assistance but also surpassed the programme targets. It seems the Bank's close involvement in the project was one of the critical factors behind this success.

MDTF Supported Revitalising Health Services in Khyber Pakhtunkhwa, 2012 – 2015

Key Features

- 6 districts
- Replicated Battagram model, with contracted NGOs delivering a package of health services, but with NGOs selected competitively and contracted and paid by government
- Both the government's and the World Bank's funds disbursed via government's financing instrument of PC-1.
- Dedicated Project Management Unit (PMU) responsible for project management
- External M&E firm contracted, however no baseline due to delays

The exceptional success of the Battagram project led the provincial government and the World Bank to extend their collaboration for improving the accessibility of primary and secondary healthcare services in five more districts, while continuing the programme in Battagram. The other five districts were Buner, D.I. Khan, Dir Lower, Kohistan and Tor Ghar. All of these were remote districts with depressed health indicators and some of them faced security challenges. The five additional districts were thought to be a start, after which the "Battagram model" was to be gradually applied to all districts in the province.

The results of this initiative, however, were dramatically different to that in Battagram. Due to the late start of the project and other factors, some of the selected NGOs walked away so the project could not be implemented in D.I. Khan and Kohistan. The actual implementation of the project was reduced to one year from the original three years. Multiple difficulties faced by the project hindered improvements in the targeted health indicators. As the baseline survey could not be conducted, it is difficult to quantify the progress made by the project. However, the rapid decline in two key input indicators after the project closed underlines the project's potential.

Table 2: Medical Officers and medicines availability in project districts before and after project's closure

Project districts	MO posts filled at BHUs		BHUs with Medicine stocks	
	June 2015	January 2016	June 2015	January 2016
Battagram	81%	17%	49%	57%
Buner	88%	67%	61%	34%
Dir Lower	61%	13%	64%	36%

Source: IMU data presented at TRF+ Roadmap stock-take for KP, July 2015 & February 2016
(Data for Tor Ghar was not reported)

Clearly, the improvements brought about by the project could not be sustained once the facilities were handed over to the government after the project's closure in November 2015.

Project design and management: The project in large part replicated the design of the Battagram model in terms of contracting NGOs to deliver a package of health services in close coordination with the District Health Office. However, there were three important differences. First, the NGOs were to be selected through a market-based competition rather than the Bank pre-selecting and contracting them. Second, all payments to the NGOs were to be done by the government, including the Bank's part of the funding, through the government's financing instrument of PC-1. Third, a dedicated Project Management Unit was to replace HSRU for overall project management and its capacity was to be built accordingly. These changes made eminent sense for the provincial government to take full ownership of the initiative and to lay down an institutional base for future PPP initiatives, but ended up creating difficult challenges for the government.

The PC-1 approval process was time-consuming requiring several layers of government approvals at both provincial and federal levels and took nine months to complete. Another delay occurred in finalising the selection of NGOs for the project. The selection process was challenged that led to an official investigation, but which finally declared the selections as per rules. Another delay occurred when the senior PPHI management exerted pressure on the government to cancel the NGO selection process and hand over the project to them. The delays forced the World Bank to restructure the project three times, and at one stage to consider cancelling the project altogether. The restructuring led to cancelling of the project components for rehabilitation of health facilities and strengthening of M&E systems.[9]

After these delays, the service delivery contracts with NGOs were finally signed for five out of six districts in the later part of 2014. The NGO for the sixth district declined to sign the contract due to a short remaining implementation period of little over one year. Just as project activities started, the government bifurcated Kohistan district which led to a diluted district administration capacity and the NGO responsible for this district also decided to drop out.

The project faced further delays after its implementation started. A baseline of NGO performance indicators was to be developed by the M&E Cell, which was abolished by DoH. Instead, DoH decided to hire a private firm to carry out M&E activities. With persistent delays in the hiring process the firm came on board only a few months before the project closed. The data collection for baseline, therefore, did not take place and the indicator target setting on a realistic basis was not possible. Recourse to hiring an external M&E firm was against the spirit of the government's capacity building, which was one of the central aims of the project.

The PMU was not established as planned. DoH could not appoint the Project Director and some other staff due to many court cases that were filed against staff appointments. A part-time official took charge of this position but was not empowered to make decisions and give approvals. Importantly, one of the main reasons for delays was unfamiliarity of the PMU staff with the World Bank procurement rules and procedures.

These delays in funding forced the NGOs to curtail or delay their project activities. Due to this their progress reports were consistently delayed, which again delayed the next cycle of funds release. When, despite many reminders to the government, the situation did not improve, the World Bank decided not to seek extension to the project, which was closed in December 2015.

9. Implementation Completion and Results Report (TF-11062) … for Revitalizing Health Services in Khyber Pakhtunkhwa project, The World Bank, 2016

Financing arrangements: As in Battagram, this project also had both provincial and World Bank funding. The Bank's funding was a grant, drawn from the Multi-donor Trust. But unlike the Battagram project, where the government and the Bank's funds were dispersed separately with each party following its own rules, both the government's and Bank's funds were made part of the government's financing instrument of PC-1. However, for dispersing the Bank's funds the government was required to follow the Bank's rules of which they had little experience; it seems that no capacity building of the government in this regard was carried out.

As noted above, the approval of PC-1 took nine months, the time mainly being consumed in approvals at the federal level. Depending on the total amount involved, a PC-1 is approved by one of the three committees at provincial or federal level. The federal level approval, however, is required irrespective of the amount involved if the project is also to be financed by a donor, as was the case in this PC-1. The logic of federal government approval where donor financing is involved needs revisiting, especially after devolution. Whereas it makes sense in cases involving loans from foreign sources, the federal government being the guarantor of loan repayment, relaxation of this condition needs to be considered where the financing is a grant. The government's share of the total project cost was 74%, which reflected its strong commitment to the project. But this also meant that the project activities were largely dependent on timely availability of these funds, which proved to be one of the main bottlenecks.

Due to the absence of a fully functional and empowered PMU the payments to NGOs were processed through routine hierarchical channels where knowledge of the donor rules was lacking and the effect of late payments on the project's implementation was not given due consideration. The routine process was quite lengthy and reportedly involved 15 steps. It looks as if the provincial government was excessively defensive in avoiding fiduciary risks in making payments to NGOs.

Due to these delays and because the project was severely curtailed both in terms of its implementation period and scope, only 36% of the donor funds and 7% of the government funds could be utilized.[10]

The role of political economy: The insistence of PPHI senior management, with strong political backing, that the project be awarded to them and the NGO selection process be scrapped caused much delay and uncertainty. Interestingly, PPHI had submitted their expression of interest in response to an advertisement for NGO selection, which they withdrew for inexplicable reason. The Bank's refusal to accede to the PPHI demand neutralised this interference but only after it had caused considerable delay; contracts with NGOs were signed 14 months after their selection.

Appointment of qualified staff at PMU also proved to be a challenge. Political pressures were exerted for these appointments. The other hindrance was the court cases that suspended the process of some appointments in PMU.

These interferences and absence of an explicit support to the project by political leadership affected the pace of decision making by government officials as the project was not seen as a priority. There was no political or government leader to push the project forward. The proactiveness seen in Battagram project to address problems and handicaps so that the project schedules were met was absent in this project.

10. Implementation Completion Report (ICR) Review, Independent Evaluation Group, The World Bank, 2016

The Future

In implementing PPP, therefore, the KP government has had a good experience (Battagram), a mixed experience (PPHI) and a bad experience (the MDTF supported project). Since the closure of the last project, there hasn't been any PPP initiative of significance in the health sector in KP. However, the provincial government has introduced a new law, approved by the provincial assembly, that designates the KP Health Foundation as the lead organisation to manage PPPs in health. The Foundation's earlier functions were confined to providing small loans for establishment of clinics and individual medical practices in the private sector. Under the new law, the Foundation's main function will be to promote innovative approaches to healthcare delivery through PPP to improve healthcare coverage. The thrust of this final section is to discuss how this initiative could be successfully rolled out in light of the experience gained through the three PPP projects.

PPP is important for KP as it has been cited as one of the key means of achieving the newly introduced health policy[11] targets, as evidenced by the following excerpts from recent policy documents.

"Private sector including NGOs will be mainstreamed into the development process by harnessing their potential to deliver services. The government will further promote the role of the private sector in the delivery of health services, with attention to quality and patient safety and safeguarding the interests of the poor and marginalized." (Health Policy Outcomes and Policy Actions, No. 91, p.37)

"Private sector would be engaged as a partner in healthcare delivery through appropriate mechanisms for meeting national SDG targets including reporting on key indicators." (Health Policy Outcomes and Policy Actions, No. 16, p.29)

Capacity: KP Health Foundation lacks experience and expertise in managing PPP projects and this undertaking will be a big challenge for them. They need to have the capability to procure, contract and manage contracts for their timely implementation. They also need to involve the main stakeholder, i.e. DoH, in these processes so that issues of transparency, ownership and robustness do not arise.

Different expertise for these functions will be needed, e.g. procurement specialists who have expertise in Public Procurement Regulatory Authority (PPRA) and donor rules and procedures; legal experts with expertise of drafting PPP contracts with clearly defined roles and responsibilities; and project management experts who ensure that the project is being implemented as per contract and on schedule, and promptly address any issues that arise.

The experience of PPHI and the MDTF projects shows the importance of these capacities. The absence of performance indicators in the PPHI contract, for example, prevented DoH from conducting performance assessments and promoted mistrust between the two parties. The lack of knowledge of donor procurement procedures prolonged the process of payment to NGOs under the MDTF project.

It is important that the Foundation establishes dedicated units for performance of these functions and puts in place an institutional mechanism for DoH involvement. In establishing and building the capacity of these units, particularly in defining their roles and procedures, their staffing composition, and expertise specifications, technical assistance should be sought.

10. Implementation Completion Report (ICR) Review, Independent Evaluation Group, The World Bank, 2016

Financing: The use of PC-1 as the financing instrument was cited as a cause of delay in the MDTF project as its approval took nine months. Under the current procedures this is usually the time needed for a PC-1 to pass through all stages of review and approval at provincial and federal levels, although it could be made shorter by prioritising projects where timing is an issue and starting the PC-1 process ahead of the project. As earlier suggested the requirement for the federal government approval of PC-1 where donor funds are in the form of a grant should be reviewed, in order to empower the provinces in accordance with the spirit of devolution. In any case, the Economic Affairs Division of the federal government gives clearance to the donor financing before the latter disburses funds to a province.

We understand that for disbursing donor funds through the newly mandated Health Foundation, a PC-1 would not be required. If this is indeed the case, the flow of funds could be eased in a donor financed PPP project. The disbursement of the government's own share of funds did not come up as an issue in the PPHI and Battagram projects – in fact these flows were quite timely. The possibility of using the Foundation's channel for donor financing without recourse to a PC-1 should, therefore, be explored.

Protracted approval and payment procedures: In a contract where payments are linked to achievement of target indicators by suppliers, delays could occur if the achievement is not timely and/or not verified in time.

There is room to review and simplify the processes that guide payments, critical to which is the empowerment of PMU as approving authority for payments. These payments are recommended by the DHO after verifying progress, so approvals should be straight forward. The proposed institutional involvement of DoH with the Health Foundation will help to bring further transparency.

Monitoring and Evaluation: In the Battagram project, the formation of a district committee headed by district Nazim for assessing progress against indicators proved to be useful not only for monitoring purposes but also for generating local political and community support. Besides the DHO, representatives from other relevant government departments, HSRU and the World Bank participated in these meetings. A similar composition of district monitoring committee, replacing HSRU with the Health Foundation, would make eminent sense. The relevant donor representatives should be welcomed if they are willing to take part on a regular basis. The endorsement of the contracted party's achievement from such a representative committee should also make the related payment to private or NGO suppliers a straight-forward exercise.

Taking stock of political economy: The experience of PPP in KP highlights the important role of political economy. In project planning, due attention needs to be paid to such risks, and mitigation measures proposed to neutralise any negative impacts on the project.

The PPHI project, in particular, faced much opposition from all tiers of DoH, not only because of the manner it was introduced and the lack of collaborative approach, but also because no systematic efforts were undertaken to convince provincial and district officials, and service providers, of the rationale of the project and its utility to the health system and the people. Such an engagement could help address any apprehensions and reservations, which is necessary for generating goodwill towards the project. For such an exercise senior DoH officials will need to take the lead as without them it would be less credible. This is another reason why a close collaboration between the Foundation and DoH will be necessary.

Champion/leader for the project: PPHI was backed by a strong political leader and introduced throughout Pakistan. While it lasted, it showed good progress against the limited aim of improving health services in BHUs. It was closed after the animosity with DoH came to head and the federal government withdrew its support. For Battagram project, the strong backing from the provincial political leadership and the World Bank's proactive role in driving the project was critical in its success. In the MDTF project the Bank took a back seat, letting the government lead, which was the right course to take. But unfortunately, the project did not find a strong supporter within the government to steer it towards achieving its objectives. To generate such support, sensitising the high-level political leadership could help.

Trying alternative approaches: Experience from the PPHI and Battagram projects show that the autonomy given to the NGO in developing their own budgets, providing additional financial resources for systems building and innovations, in addition to putting staff under their administrative control, was an essential requirement for the project's success. DoH needs to explore other models where, for instance, similar autonomy is given to district health managers in selected districts on a trial basis, backing them with technical assistance if required.

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