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Strategic Review of DFID support to the Health and Population Sector in Pakistan and Recommendations for Future Support

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20 December 2010

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Abbreviations and acronyms

ADB	Asian Development Bank
AusAID	Australian Agency for International Development
CMW	Community Midwife
CPR	Contraceptive Prevalence Rate
CYP	Couple Years of Protection
DFID	Department for International Development
DH	District Hospital
FLCF	First Level (health) Care Facility
FP	Family Planning
FRA	Fiduciary Risk Assessment
GBS	General Budget Support
GoP	Government of Pakistan
H&P	Health and Population
KPK	Khyber Pakhtunkhwa (province)
LHW	Lady Health Worker
MDG	Millennium Development Goal
MMR	Maternal Mortality Rate
MNCH	Maternal, Neonatal and Child Health
NGO	Non Governmental Organization
NMR	Neonatal Mortality rate
NFC	National Finance Commission
PFM	Public Finance Management
PHC	Primary Health Care
PPHI	People´s Primary Health Care Initiative
PPP	Public Private Partnership
PW	Population Welfare
RBA	Results-based Aid
RBF	Results-based Funding
RHC	Rural Health Centre
RMNH	Reproductive, Maternal and Neonatal Health
SBS	Sector Budget Support
SRH	Sexual and Reproductive Health
SWAp	Sector-wide Approach
TH	Tehsil-level Hospital
USAID	United States Agency for International Development

Executive Summary

This report.
The objective of this strategic review is to produce evidence-based options and recommendations for DFID's strategy for engagement in Pakistan's health and population (H&P) sector over the next 3-5 years.

The main body of the report contains: (a) a brief review of DFID support to the H&P sectors in recent years; (b) an analysis of the current health sector context and donor landscape in Pakistan; and (c) a comparative analysis of options for DFID's future strategy, taking into account DFID corporate priorities, policies, country plan and capacity, in particular DFID's focus on reproductive, maternal and newborn health (RMNH).

In this final draft the reviewers have made every effort to accommodate feed back received from DFID on the first draft, and we have also submitted separately a new Public Finance Management assessment (Annex 8) to support our review. The reviewers had little time to discuss issues and options fully with the DFID health team in Islamabad, and our visit was too short and our knowledge of Pakistan too limited for us to venture beyond what we have submitted in this revised report. Our aim is to contribute to internal discussion by the DFID health team in Pakistan and beyond with evidence-based suggestions.

The Past.
Looking back DFID has implemented quite successful health programmes – in more recent years largely through supporting national programmes. This approach has been adopted because national programmes were the best available channel to support key services for poor people on a country wide scale. Whilst this approach has delivered results there have been significant missed opportunities. The programmes –including the national MNCH programme that DFID is supporting are input-driven, rigid (in terms of adapting to local needs) and poorly integrated with other programmes and services. Although it may be necessary, such support does not give a sufficient basis for achieving sustained improvements in the required outcomes. Governance is the key issue preventing greater progress in health (as indeed in other sectors). Although approaches have generally been technically sound, involvement on key political and institutional structures has been limited.

The Present.
There is a clear framework for future DFID involvement in health in Pakistan, which, alongside Afghanistan, is now seen as DFID's top priority (although in Pakistan, education is seen as the flagship programme). Should DFID decide to continue its involvement in health (as we recommend) such support will need to have a clear focus. In terms of geographical focus the key provinces are Punjab and KPK. RMNH (and malaria[1]) are key DFID priorities although any investments might be expected to have broader systems impact, by demonstrating, for instance, how to help provincial governments guarantee PHC delivery in the scenario post 18th Constitutional Amendment. There should be a strong emphasis on results and value for money. The DFID office is growing and restructuring but constraints remain – notably the security situation, as the resulting rapid turnover of staff creates challenges to sustained engagement. Any strategies therefore need to be feasible and designed to

[1] We have not paid much attention to malaria but note that (a) malaria has increased in flooded areas of Pakistan and (b) a recent Lancet study suggests that in India malaria deaths may be 13 times higher than reported by routine systems. In any case, support to malaria is probably better delivered through the Global Fund, where DFID is a key partner at Board level.

minimise DFID management requirements. Ongoing reforms – such as the National Finance Commission (NFC) award and the 18th Constitutional Amendment, whilst introducing considerable uncertainty, also offer potential opportunities for DFID to work in new and more effective ways.

The Future.
Looking forward is particularly challenging given the short-term challenges currently being faced. Main challenges include the impact of floods in human, infrastructure and fiscal terms and the outcome of key governance reforms – notably devolution – which remains unclear. This uncertainty means DFID will need to adopt a flexible approach and be prepared to amend its strategies as circumstances change, without losing focus on the ultimate outcomes.

Options.
We considered four broad options and discuss these in the body of the report.

Options (and Rationale)
A. Do nothing in Health & Population: H&P is too unstructured and risky a sector. DFIDP involvement would require a level of engagement that is problematic given staffing and security constraints. DFIDP focus would remain on education, PFM and governance.
B. Continue with what DFIDP is doing: continue to fund the national MNCH programme as is. It is delivering some results.
C. Re-orientate what DFID funds within the MNCH programme: resume funding to provinces as per original plan but in Punjab and KPK use the programme to focus on key districts, key services, key reforms. Use this experience to design new support programme (as in option D) better aligned with new realities and DFID departmental priorities from 2011-12.
D - stop support to MNCH programme and design new programme in Punjab and KPK

We do not recommend options A and B because we fear they would negatively affect both the changes of Pakistan improving on MDGs 4 and 5 and the status of DFID as a key, strategic health partner. In the short term we recommend option C, but recognise that the feasibility of this option needs to be tested in the coming months following engagement with provincial governments. Ideally, Option C should help DFID move towards option D, but if Option C proves unfeasible then we recommend DFID to design a new programme of support with high focus on RMNH outputs and outcomes.

What?
We suggest approaches which will work **with** - rather than just **through** - Government so as to enable other stakeholders to complement and strengthen government services. For example, national/international NGOs might be contracted in certain districts by the provincial governments to help the latter deliver more and better sexual and reproductive health (SRH) services through the PHC network. Where PHC is already contracted out (as in the PPHI model) the contractee/service provider should be encouraged to follow the same principle and contract in or out certain services (like SRH) so as to ensure synergy between SRH and MNCH services and outputs. The picture right now is that the PHC network misses most opportunities to deliver SRH, and the same can be said about missed opportunities among SRH providers to link their patients with available MNCH services.

The main **themes** that we recommend for support would include:

- **supporting the transition between emergency support and sustainable health programmes** in flood-affected districts. These are also amongst the poorest and most vulnerable districts. This vulnerability will persist, and while working in these districts will surely represent a challenge we feel that DFID might be able to use the experience of working through NGOs in these areas during the emergency response to the August 2010 floods.

- **supporting the transition from centralised vertical programmes to more effective locally-led more integrated services**. The aim is to protect the quality and quantity of PHC services during the devolution process and to strengthen subsequent performance. The aim would be to support a narrow range of essential reforms already under consideration or being implemented, and include building capacity to ensure that authorities get value for money from innovative approaches including public private partnerships (PPP) through improved oversight and monitoring of services delivered by public and private providers.

In practice, the first theme is subsumed under the second. Key criteria for the former would include need for emergency support/degree of flood damage and interest on the part of the district and provider organisations.

These themes both imply targeted interventions in targeted districts for targeted service outputs contributing to RMNH outcomes. Ideally we would recommend both of the above, but need to look at operational strategies and implications for DFID. Our preferred approach is to combine contracting in and contracting out of services and interventions, seeking synergies between supply and demand, state and NGO sectors, Population Welfare with Primary Health Care services, community-based with facility-based services, all with a tight focus on RMNH outputs and outcomes. This would be in selected districts offering good potential for increasing RMNH service delivery, using a demonstration, learning-by-doing approach to implementing devolution and protecting the poor in poorer districts.

Even within the 2 themes there are various levels of possible engagement by DFID, as we have reflected in Table 1 in the main report. We think that Table 1 might be useful for DFID to define its “level of ambition” in terms of which RMNH results it would set its programme to achieve, and at what costs both in terms of finance as in the form of DFID staff time. In essence, DFID may decide not to attempt impact at all levels and to limit itself to certain service outputs, either as a permanent strategy or as an entry strategy to learn by doing and to engage with the health side of the provincial governments.

How?

Despite substantial fiduciary risks DFID should continue to try and make maximum use of national systems, even in cases where alternative service providers to government may be used, because the basic elements for PPP are already in place and it is in the interest of the Pakistan health sector to strengthen existing channels. Efforts have been made to strengthen PFM systems, which are now largely in place. The issue now is more about whether the systems are adhered to. The situation will require continuous, close monitoring. DFID should investigate channels for providing earmarked budget support to channel support for the two themes – notably provincial conditional grants earmarked for health (as established under an early ADB project in Punjab) and tied grants for districts.

Should such support prove successful and the process of developing sound strategic plans move forward successfully less earmarked forms of support such as provincial sector budget support or even provincial budget support may become viable options

Performance could be judged against a relatively short set of key indicators such as key service outputs and/or specific reform milestones relating to bottlenecks in the system which prevent further progress - such as progress in building a regulatory framework; and capacity for contracting in or out to allow oversight; identifying and financing a basic service package; strengthening PFM; and adopting effective service delivery strategies. These performance indicators and milestones should become the basis for a quid pro quo arrangement leading to a provincial "work programme" between DFID and the governments of Punjab and KPK.

We expect this arrangement to be quite attractive to provincial governments given the uncertainty surrounding future funding of PHC in the provinces. We also expect it to work well for DFID as this approach would enable increased focus on RMNH outcomes and the establishment of strong, pragmatic relationships between DFID and the two chosen provincial governments. The approach should be open to encourage other donors to join in and work jointly with DFID in supporting a common set of outputs and milestones, in a way similar to a provincial SWAp but using a simplified monitoring framework with high focus on results. We would not overrule the involvement of the Federal MOH in these provincial work programmes as a guarantor that essential health care continues to be provided within provinces post devolution – this would help strengthen its regulatory and oversight roles consistent with a federal state.

Possibilities for results based financing should be considered but with the proviso that care is taken with the choice of results (which ideally should be broad and focus on a package of key services rather than specific services which runs the risk of distortion) and the availability of credible data.

Why?
The proposed approach focuses on improving access to key services, especially for the vulnerable in target areas; and on encouraging the adoption of innovative but evidence-based models including public private partnerships, and support for joint demand/supply models. It is also aimed at protecting access to essential curative and RMNH care for the poor - in an uncertain reform environment, there is a real risk that funding for key programmes will be interrupted during the devolution process. DFID should aim to use its advisory capacity, financial aid and technical assistance to help support a managed transition.

While there is little evidence that other donors are prepared to step in or lead – in fact most look to DFID as a leader in the field- there is general support from the main stakeholders (other donors, provincial governments and NGOs met by the reviewers) for the two approaches outlined above. The approach contributes to key DFID priorities in healthy as in other sectors (see table below) and has important synergies with the education sector. For instance, it is unlikely that education would achieve desirable results where health care – particularly that related to maternal, neonatal and child health - is unavailable.

Key Departmental Priorities	Theme 1: Transition from Emergency to Development	Theme 2: Centralised to effect local ownership
Impact and results Value for Money	Aim is to ensure increased use of essential (and highly cost effective) services and service outputs. Funding linked to delivery of outputs	Aim is to ensure increased use of essential – and highly cost effective – services and service outputs. Support to be linked to service improvement and achievement key milestones (in turn link to bottlenecks preventing more rapid progress). Aim is to maintain service delivery during devolution process and make sure national vertical programmes are not simply replaced by vertical provincial programmes.
Evidence base	Some (increasing) evidence of effectiveness of models. Results of SCF experience on Batagram just published. PPHI evaluation due shortly	Previous positive experience under NHF/MNCH (based in annual reports and country evaluation)
Accountability and engagement	Approaches will promote provincial and district management and stronger links with NGOs & Civil Society	Building regulatory capacity and oversight function would be a key component of any support
Innovation and ideas	Innovative approaches already being implemented (and encouraged further)	Innovative approaches already being implemented (and encouraged further)
Private sector	Direct engagement with NGOs through contracting model/indirectly and increasingly with civil society through oversight	Building regulatory capacity/oversight function key component
Role of Women	Likely to be major beneficiaries of better access to services	Likely to be major beneficiaries of better access to services
Wealth Creation	Wealth protection (better health services prevent catastrophic costs associated with ill health)	Wealth protection (better health services prevent catastrophic costs associated with ill health)
Afghanistan, Pakistan, Conflict and Stabilisation	Programme would aim to demonstrate the state can help deliver services which benefit the population – especially marginalised groups	Programme would aim to demonstrate the state can help deliver services which benefit the population – especially marginalised groups
Climate change	Higher contraceptive prevalence rate can contribute to alleviation of population pressure	Higher contraceptive prevalence rate can contribute to alleviation of population pressure
	Direct Effect	Indirect Effect

Implications for DFID

The approach would require sustained presence and engagement by DFID advisers at provincial levels to focus on political and institutional levers. While funding would be channelled through provincial governments the operational and monitoring focus should be on districts. Funding through certain national NGOs (Greenstar, MSI) should not be discarded, particularly in areas like Sexual and Reproductive Health (SRH) where they would add value. However, it would be important for these NGOs to access DFID funding through the provincial government wherever PPP arrangements so enable or, at least, for these NGOs to work within the framework defined between DFID and the provincial government.

We recognise important limitations to DFID engagement linked to the delicate security situation which may constrain DFID advisers/staff from engaging at all levels. Given these constraints and the size and complexity of the provinces, a small team in DFID cannot achieve enough sustained engagement on its own. DFID will therefore need to consider contracting in external support (providing technical competence, understanding of sector management issues) on an ongoing basis, this depending largely on the scale and scope of interventions that DFID selects for supporting RMNH outputs in each province (see Table 1 in main report mapping possible interventions). Contracting in additional support may not free advisers time in the early stages but it would contribute to longer term, sustained engagement at the organisational, management and systems levels. It would also free DFID advisers time to engage at the political and institutional levels (DFID Health team/HMG Integrated Delivery).

1 Introduction

The assignment and our approach to it

The DFID Human Development Resource Centre was asked by DFID to find consultants to undertake a strategic review of DFID´s support to the health and Population (H&P) sector in Pakistan. Full TOR for the health strategy review are included as Annex 1, and these will not be repeated here. A full list of acronyms and abbreviations has been included as Annex 2,

Two international consultants and one national consultant[2] were tasked with the strategy review and worked in Pakistan between the 11th and the 23rd October. They held meetings with DFID and a wide range of stakeholders in the capital Islamabad. They also visited Lahore, the capital of Punjab, one of two provinces where DFID aims to focus its development efforts over the next few years. The other selected province, Khyber Pakhtunkhwa (KPK) and its capital Peshawar could not be visited by the consultants due to security reasons, so instead a group of stakeholders from that province were kind enough to come to Islamabad to meet the consultants.

The consultants were supported by two research assistants[3] who undertook desk reviews of: (a) the health donor landscape in Pakistan and the harmonization and alignment issues relating to it; and (b) governance issues linked to the health sector in Pakistan, particularly in the context or recent policy changes such as devolution and the National Commission Awards 2010. These desk reviews form an integral part of this assignment and have been submitted separately as stand-alone reports that will be referenced as Annex 6 and 7 respectively.

The first draft report on the strategic review was submitted to DFID on 31st October 2010. In addition to the report and to the two desk reviews mentioned earlier (annexes 6 and 7) the consultants also submitted to DFID the Meeting Notes from our visit (Annex 4) and some rough Health Sector Notes (Annex 5).

Feedback from DFID was received on 30th November 2010. DFID asked the reviewers to, among other things, be more specific on the proposed way forward. We have made every effort to do this in this final report, and we have also submitted a new Public Finance Management report (Annex 8) to support our review.

However, we had too little time to discuss fully the issues and options with the DFID health team in Islamabad, and our visit was too short and our knowledge of Pakistan too limited for us to venture beyond what we have submitted in this revised report.

[2] Javier Martinez, Team Leader, health systems and aid effectiveness analysis; Mark Pearson. health financing and aid instruments analysis; Sher Shah Khan, public finance management and fiduciary risk assessment.
[3] Yasmin Hadi and Farrukh Moríani wrote the donor landscape and the health sector governance desk reviews, respectively. Our gratitude for their excellent work.

Specific objectives and report structure

The specific objectives of the strategic review were:

1. To produce evidence-based options and recommendations for DFID's strategy for engagement in Pakistan's health and population sector over the next 3-5 years.
2. The work is expected to include:
   I. a review of DFID support to the health and population sectors from the mid-90's to 2010. This will document DFID's role (programming and policy engagement) and outline the results (policy and programming) and value for money to date;
   II. analysis of the current health sector context and donor landscape in Pakistan, including (but not limited to); Government of Pakistan and donors' policies and plans, National Finance Commission (NFC) award, constitutional changes, the future of devolution, fiscal situation & constraints, security challenges, state-building and developmental deficits (and role of social sector service delivery);
   III. a comparative analysis of options for DFID's future strategy – taking into account DFID corporate priorities, policies, country plan and capacity, in particular DFID's focus on reproductive, maternal and newborn health (RMNH).

This report will adopt a similar structure to the one suggested in the second specific objective i.e. we will briefly look at DFID´s recent involvement in Pakistan's Health and Population (H&P) sector focussing on issues and lessons emerging from such involvement. A brief discussion of present day issues affecting Pakistan's H&P sector will follow to then analyse areas and options for DFID involvement.

Please note that the aim of this report is to contribute to internal discussion by the DFID health team in Pakistan and beyond with evidence-based suggestions. The report should not be seen as a scoping or pre-design mission for defining DFID´s health portfolio in Pakistan.

2 DFIDP support to the health & population sector

Brief overview

For a country ranking 132 in the world by level of income (GDP p.c. $2,496, HDI 2007) Pakistan has some of the worst health indicators in the world, and the worst in Asia. It has, for instance:

- One of the highest levels of maternal deaths in the world (approximately 15,000 a year).
- The fifth highest under-five child deaths (400,000 children a year).
- Serious malnutrition with 38% of children under five (9 million) underweight.
- 250,000-300,000 new cases of TB every year.
- Poor access to water and sanitation. Diarrhoea is the main killer of children.
- Poor reproductive health. Women average 4 births during their reproductive life (the second highest fertility rate in South Asia after Afghanistan).
- Low contraceptive use (only 30% of married couples use contraception).
- Very low HIV prevalence in the general population (<0.1%) but high rates in populations most-at-risk especially injecting drug users and male sex workers.
- Rising levels of non–communicable diseases and disability (including high blood pressure, heart disease, cancers, diabetes and injuries).

Health care in Pakistan has long been seriously affected by issues of accessibility, coverage, equity, quality and sustainability. Various attempts at reform have failed to improve service delivery, as evidenced by the consistently poor health indicators and the failure to meet the majority of the MDGs[4]. Although there are several factors contributing to the poor outcomes in the health sector—including high population growth rate, under-financing of the sector and inconsistent policies—the failure to improve health services largely reflects institutional weaknesses and a failure to establish appropriate governance structures.

Pakistan has one of the most complex and fragmented national health systems in the world. Federal, provincial and district levels compete for resources amidst a very weak policy and institutional framework that is constantly eroded by political interference and patronage. Population welfare services and health services continue to be managed by two separate ministries that have maintained their verticality down to the service delivery outlets. This results in poor delivery of Family Planning (FP) services in the PHC network as well as in few referrals from Family Welfare Centres (where FP services are delivered) to the PHC network. This results in huge missed opportunities for service users and in considerable duplication and waste of scarce resources.

The PHC network is large but poorly managed, staffed and resourced. It is also very supply-driven, with weak links with the community where demand generation activities are in their infancy, in part because of limited NGO presence when compared to neighbours like India or Bangladesh.

Some lessons from DFIDP past support

The highly dysfunctional policy and institutional environment in health described above is compounded by (and at times due to) the security situation (ethnic and religious conflicts and war zone areas) affecting many areas of Pakistan, which prevent the normal delivery of essential services like health or education and limit the

[4] Pakistan MDG Report, Planning Commission of Pakistan 2010

impact of interventions from those who wish to help, including government, donors, service providers, NGOs or community groups. These elements also seriously affect the chances of all donors – including DFID - to directly engage with the right institutional actors and counterparts and to build a medium term horizon in sector work. The point is that without minimum levels of peace and security health and education services cannot be provided, and therefore any future health strategy by DFID should focus, in the first instance, on areas where the minimum conditions exist for health aid to be delivered and used.

DFID's health development support in Pakistan over the past two decades has combined 'programme' or budget support, financial aid (backed up by technical cooperation), 'project' support mainly through civil society organisations and multilaterals. The former includes the Social Action Programme (SAP, 1993-2001), the National Health and Population Facility (NHF, 2003-10), and currently the national Maternal, Neonatal and Child Health Programme (MNCH, 2008-13). Project support has been more narrowly focused – limited to a specific locality, or focussed on addressing a specific issue (e.g. HIV & AIDS, Polio eradication, contraceptive social marketing, consumer protection etc).

Health has also been a component of some of DFID's multi-sectoral and humanitarian support, including Poverty Reduction Budget Support (PRBS-I, 2005-08 & PRBS-II, 2009-13), Punjab Devolved Social Services Programme (PDSSP, 2005-10), Earthquake (2005-09), Provincial Reform Programme (PRP, 2006-10) in NWFP and, more recently (2010) humanitarian support during and after the worst floods in the recent history of Pakistan.

Internal and external reviews of DFID´s health portfolio in recent years highlight several issues and lessons worth considering in the context of this strategic review, such as:

a. DFID's support to the H&P sector to date has been both highly strategic and opportunistic, based on the correct assumption that the Pakistan health system, with all its weaknesses remains the best option to target essential health care to poor Pakistanis, particularly rural women and children who share the worst health indicators both nationally and internationally. DFID´s health aid has used different entry points and strategies, different aid and financial instruments and has been delivered through both public and private institutional actors.

b. DFID health support and reputation to date ranks high among other donors, government and NGOs, all of whom consider DFID a leader in this sector. Health also featured very favourably in DFID Pakistan Country Evaluation in 2008 where it was the sector with the best ratings weighted by funds committed (97% of commitments were rated 1 or 2). By contrast, the challenge of tackling governance is evident from the fact that this sector has higher risk ratings and lower performance scores compared to other sectors. This is important information in this strategic review because most of the ills of the health sector and problems to make Pakistan a more stable and prosperous state relate to poor governance at both political and institutional levels, while the Pakistani public administration is quite well developed and could work much better without interference. Can DFID improve its contribution to improved governance in the health sector, and how?

c. According to the same evaluation health support has had had significant benefits both on key primary health indicators and on policy. For example, health sector budget allocation and disbursement has improved (at least until 2008), rising from £233m in 2002/03 to £400m in 2006/07, although

the health budget consistently accounts for less than 0.75% of GDP, compared to the PRSP target of 0.92%. DFIDP's health sub-sector budget support has had marked influence in several areas including on TB control and detection, on developing TB and HIV/AIDS strategic plans, and increasing the coverage of the Lady Health Worker (LHW) programme with more integration of family planning. Specific and positive impacts have been achieved through DFIDPs' health programmes, such as child mortality and birth attendance figures, contraceptive use and disease incidence and detection

d. The 2008 evaluation provided an interesting assessment in relation to financing instruments for health. For example, it concluded that the foreseen (in 2008) substantial increase in DFIDP spending should, where budget support is concerned, be limited to the sub-sector level rather than to sector or general budget support, "since this approach has been shown to be the most likely to improve policy influence and attribution to key poverty impacts". In fact, "though growing budget support has brought DFIDP recognition and some influence, there is little evidence that it has made the Government move any faster on the poverty agenda than it otherwise would have done. Health sub-sector budget support, on the other hand, shows strong and attributable results, while technical cooperation has been effective.

The current DFID health programme

DFID current support for the MNCH programme was originally seen as part of a broader strategy of providing budget support at both provincial and federal levels to address a range of broader institutional reforms, from the bottom and from the top. The fact that this institutional reforms component was not ultimately supported has left the overall programme with an unbalanced feel – narrowly focused on an individual programme which, whilst delivering reasonable and important results, plays only a limited role in promoting maternal and neonatal health outcomes and limits the potential to achieve further benefits e.g. through integration of different programmes.

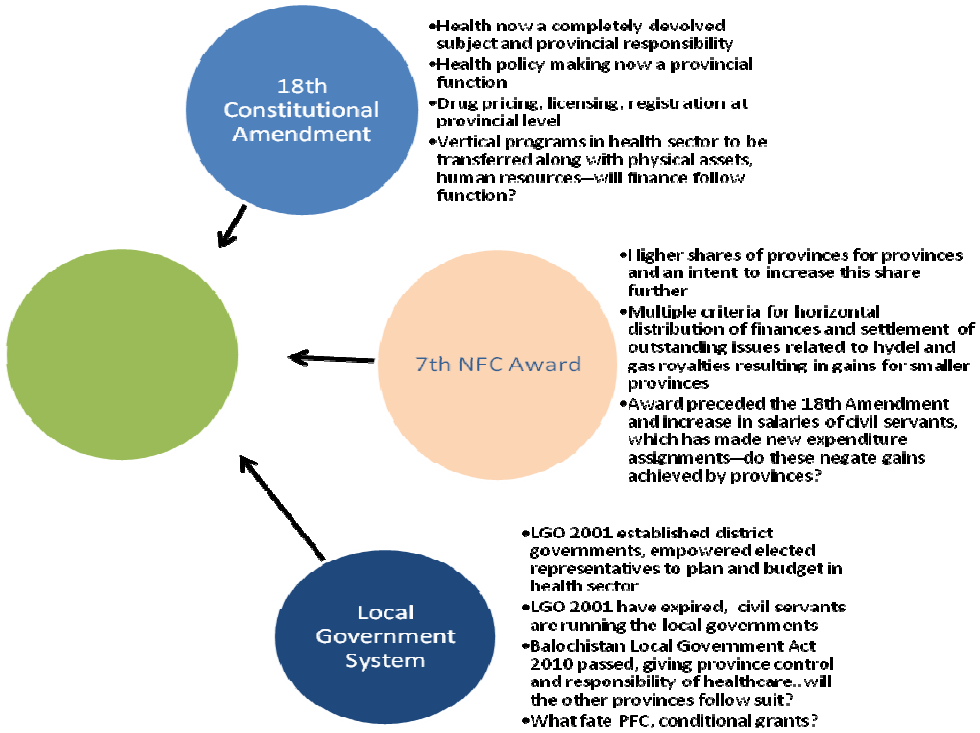
In any case 2010 has brought about several important changes that require DFID to reposition itself and its aid programme: the 18th Constitutional Amendment, devolving powers to the Provinces; the Finance Commission Awards, which have shifted resource allocation between federal and provincial levels in favour of the latter; the slow growth of the Pakistani economy which has led to spending cuts in several sectors, including health; and, lastly, the outcome of the UK Parliamentary elections which have brought in a new coalition government with new policies and priorities for UK aid. These issues are reviewed next.

3 The environment for DFID H&P support

The Context

DFID support for H&P needs to be tailored to the current circumstances and be made flexible enough to respond to emerging developments – both positive and negative. There is considerable uncertainty over the degree of political will to address poor health outcomes and inequalities, and regarding the extent to which key financing and institutional reforms currently underway will promote or constrain progress in improving health outcomes.

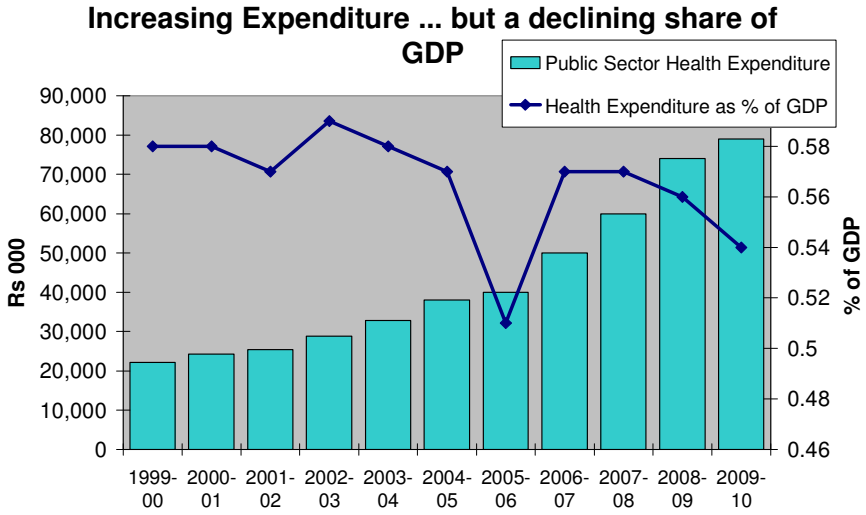
Figure 1 – The context where health and population operates



Degree of Political Will to Improve Health Outcomes and Address Inequalities

There is widespread awareness at the political level of the need for healthcare reforms and for improvements in service delivery, particularly in the rural areas that form the bulk of their constituencies. In fact, their party positions reflect a fairly well developed understanding of issues and in some cases, quite specific and appropriate policy responses (see **Annex 7)**. There are also some shared perspectives on health sector governance (such as improving coverage, targeting). However, much of that potential has never been realised, with policies remaining unimplemented by being systematically ignored or bypassed in practice. The reasons for this are complex but could be summarised in a combination of weak institutions and poor governance.

Although financial allocations for the sector have increased in the budgets, these remain at pitifully low levels and fall short of any desirable levels of financing. Rather than lack of will the issue is more the content and consistency of sector reforms. This would suggest a case for sustained high level engagement to help build momentum for reform and focused technical assistance to provide support in key areas and to help address specific bottlenecks.



Ongoing Institutional Reforms

Recent key reforms offer significant opportunities for ensuring a more effective response to existing health threats. In practice, the future progress of the reforms is uncertain and there are significant risks. We map out possible scenarios below

The 18th Amendment and the 7th NFC Award have several implications for the provinces in terms of adequacy of fiscal space for the health sector. If responsibility for maintenance of physical assets and absorption of human resources, including those from the numerous vertical programmes in the sector, is transferred from the federal government without requisite finances, these could create considerable fiscal imbalances and a wide variation in the allocation of resources for health at the provincial level.

18th Constitutional Amendment

Prior to the recent Constitution amendments the provision of health care and the management of the health services was a shared responsibility of the federal, provincial and local governments This led to various functional overlaps and contributed to complicated institutional arrangements for service delivery.

The 18th Amendment, amongst other things, aimed to address such issues by clearly defining the relative role of the federal and provincial governments in the stewardship and delivery of services. 30th June 2011 has been set as the deadline for completing the implementation of the 18th Amendment.

Whilst it is clear that responsibility for service delivery will be fully devolved to provinces – especially those which do not focus on infectious diseases and raise inter-provincial issues - the case for re-assigning all the remaining functions to the provinces is not obvious. These relate particularly to issues such as drug registration where there is a clear case for an ongoing federal lead, or to regulation of service

providers where the issues are common among provinces. Such issues will need to be reviewed by the constitutional Implementation Committee and discussed with the federal and provincial governments before any final assignment is made.

The crucial issue here is whether the right responsibilities are devolved to the right level. The Prime Minister has recently appointed members to the Implementation Committee of the 18th Amendment in anticipation of numerous policy and budgetary complications that could arise. Thinking on many of the issues continues to evolve.

For instance:

- it is not clear what responsibilities will be devolved when – there does not seem to exist a calendar for a planned transition – this is obviously risky in a devolution process by the government may be waiting for the deliberations of the implementation committee to reveal its plans;
- many technical staff from vertical programmes are said to be leaving their posts and looking for greener pastures, although this remains anecdotal rather than firm evidence;
- provinces (especially Punjab) clearly indicated to the review team that they will only accept the transfer of national vertical programmes from the federal to the provincial level if these include additional funding, which in the case of programmes like the MNCH does not appear likely;
- it is generally accepted that the Ministry of Population Welfare will cease to exist and that its services will be merged with those delivered from the PHC network, but there is no indication yet of how would that change take place or whether/if the Family Welfare Centres will be dismantled;

National Finance Commission

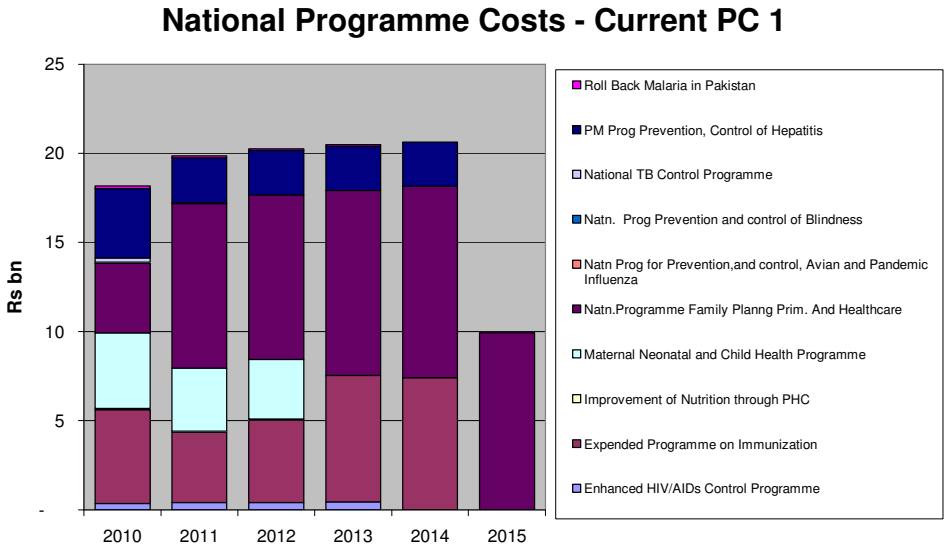
The recent NFC award is a significant achievement. It reflects an agreed, transparent resource allocation process which transfers a greater share of available resources to the provinces and does so in a relatively pro poor way[5]. As a result provincial budgetary outlays in 2010-11 have been much larger than in previous years. This has however, had only limited impact on fiscal space at the provincial level as a major portion of the additional resources have been allocated to finance the federally-mandated increases in public servant salaries (of over 50% in 2010-11). Nonetheless, provincial allocations for health have still grown significantly especially allocations for development expenditures. For more background on the NFC award see annex 7.

Whether transfers have grown sufficiently to allow provinces to take on the (as yet not fully defined responsibilities) is not clear. The revenue base of the provinces is weak – with low and inefficient tax collection and heavily reliance on federal transfers (which are often delivered in an unpredictable manner due to weaknesses in the fund flow mechanisms). Punjab is facing particularly pressing fiscal problems.

As yet there has been no explicit and conclusive debate in parliament or in the parliamentary committees whether and how provinces would meet their new legislative, policy and expenditure responsibilities out of their own resources, which are significantly enhanced by the new NFC or whether the Federal government will

[5] the formula is based less on population than it used to e with a higher weighting for poverty indices and remoteness although theire is a weighting for revenue mobilisaiton which would tend to favour better off provinces

make additional transfer of funds. There issues are expected to be resolved through discussion during the transition period. What is clear is that the provinces expect additional resources from the federal government to accompany the devolution of functions especially in the case of the vertical programmes.



The amounts involved are large. The current expected cost of the national programmes to 2015 is substantial – of the order of Rs 110bn[6].

The crucial issue is to ensure a balance and narrow any gaps between expenditure assignments and revenue assignments needs. Programmes need to be adequately funded through this transition period without major interruptions (alongside any other measures to improve their performance). This may require additional funding from the federal level (though the fiscal space to do this is limited), funding from additional NFC resources at the provincial level or reallocating provincial funds to health programmes.

Conditional grants have been widely used in countries implementing decentralisation to ensure that the achievement of national priorities in different sectors can still be enforced in a system where service delivery responsibility is devolved to lower levels. Such approaches are a part of the financing framework in some provinces in Pakistan and may be a useful means of channelling donor support. Conditional grants use national systems, can be transparent (when formula based) and are not subject to political manipulation and can, potentially, establish the provincial health departments' oversight role. DFID might want to consider providing support to a number of priority districts under such a mechanism.

Local Government Reform

Devolution reforms of 2000, resulting in the Local Government Ordinance (LGO) 2001 devolved the political power, reassignment of functions and responsibilities and decentralization of administrative and financial powers (for primary and secondary health services) from Province to local governments—from bureaucrats to elected representatives (the Nazims (Mayors)). The aim was to improve results through local

[6] This is likely to be an underestimate as the PC1 for some of the programmes ends before 2015. Their extension would add to costs

decisions based on local needs and improved public accountabilities through closer interaction with stakeholders.

In practice, the results were variable due an unwillingness of provinces to cede power and their dominant position in terms of funding district activities (including the fact that provinces have made little effort to raise funds locally as well as corruption at the district level. Nevertheless successes were also reported, including in developing local level capacities for planning and implementation; mobilization of political dialogue in District assemblies over sector priorities; women's enhanced participation in the political process[7]; and the establishment of Provincial Finance Commissions to allocate resources in an equitable and transparent manner. Within the health sector there has been progress in building district level capacity as illustrated by the development of fairly comprehensive Annual Sector Plans[8] and improved monitoring systems,

The LGO 2001 recently expired and the districts are now under the administrative control of the District Coordination Officers (who are either provincial or federal government employees). Three of the four provincial governments are still contemplating the new structure, scope, mandates and powers of local governments. Balochistan introduced the Balochistan Local Government Act 2010 in May 2010.which recentralises by abolishing the District Governments and placing the reins of health sector planning, budgeting, implementation and oversight firmly back in the hands of the provincial Health Department. There is a risk the other three provinces will adopt similar approaches which runs the risk of vertical federal programmes being replaced by vertical provincial programmes.

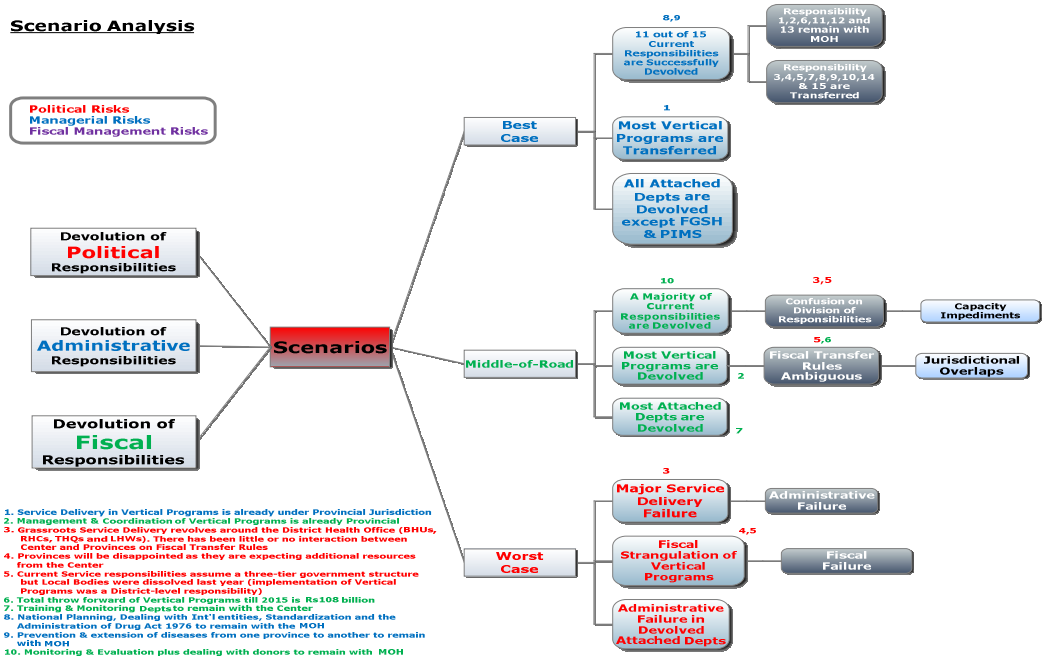
Potential scenarios to be faced

The chart below maps out a number of scenarios in relation to progress in terms of the devolution of authority and funding. Progress and the instruments used would depends heavily on progress in terms of these scenarios (to which financial management capacity/fiduciary risk might also be added.

[7] 33% of seats were reserved for women in all local governments and several women were elected Mayors in Districts in Sindh and Punjab

[8] These were introduced under the ADB funded Devolved Social Services Programs in Sindh, Punjab and Balochistan

Figure 2 – Scenarios linked to the devolution process



Implications of scenarios for choice of aid instruments

If one were fairly confident that the programmes most relevant to maternal and neonatal outcomes were to be devolved appropriately, and adequately funded, then broader sector budget support or even provincial budget support might be suitable. This could be done through a conditional grant, especially if current provincial sector strategic planning processes/PFM continue to strengthen. In such cases funds might be disbursed against key programme outputs (e.g. coverage rates for key services) or, if necessary, milestones related to reforms necessary to improve programme effectiveness. In the worst case situation DFID might hope to address issues of financial shortfalls in selected programmes through heavily earmarked support, subject to clear agreement on milestones relating to efforts to improve both the institutional framework and programme effectiveness.

Public Financial Management

Pakistan is nearing the completion of a number of PFM reform initiatives. A recent Public Expenditure and Financial Accountability (*PEFA) Assessment of Federal Government* of June 2010, as a follow up to completing PEFA for the four Provincial Governments sets the baseline assessment of the current status of the PFM system and outlines some of the progress made. Major achievements include development of capacity and systems to:

- prepare reliable financial statements for audit within 6 months of year-end;
- present certified accounts (meeting IPSAS cash-flow reporting standards) and audit reports to the president (or provincial assemblies) within 12 months of year-end;
- prepare monthly budget execution reports to ministries and central agencies within 15 days of month-end;

- implement a system which generates quarterly fiscal reports for macro-economic review and analysis by the Ministry of Finance and international community; and

- the roll-out of a medium-term budget framework to all federal ministries other than Defence Services.

Fiduciary risks in the public system remain substantial. As basic systems are now in place ongoing shortcomings should increasingly reflect the willingness, rather than the ability, of government actors to deliver sound PFM results. It also has to be noted that fiduciary risks also exist in the NGO sector though these have been less well documented. More details on PFM are included in a separate annex.

Openness to Public Private Partnerships

Although not a reform as such it is important to note that the Pakistan health system (and other sectors too) has been contracting out delivery of PHC services to private contractors known as Rural Support Programmes under the banner of the so called "People´s Primary Health care Initiative" or PPHI. While not everyone considers Rural Support Programmes as true "private providers" because or their links with and dependence of government funding the fact remains that PPHI represents an interesting entry point for innovation and experimentation with alternative service providers, as compared to the traditional government managed model.

The PPHI door has already been used on several occasions to contract out PHC services in earthquake affected districts of Pakistan, as in the case of Batagram (KPK) where SCF US were tasked with running the PHC network for three years. While results of these initiatives in terms of increased access and quality of PHC services are not yet known it is already clear that the schemes need a much stronger institutional framework where contractual arrangements are monitored (they seldom are now) and where performance management of service providers – public and private - is effectively undertaken (this is in its infancy right now). Yet PPHI offers an open door to innovation and to improved accountability of service providers which, if used properly, could achieve a significant change in the PHC landscape. A national Third Party Evaluation of the PPHI is currently underway managed by the TRF.

Public Private Partnerships offer the potential for DFID and other donors to use results based funding approaches (although there is no reason why they could not also be used within the public system). However, these should be led and owned by Government rather than driven by DFID. It is also important that due attention is giving to the choice of results to be rewarded. Ideally, these should relate to progress in the delivery of a wide range of services – ideally a locally developed essential service package - rather than a narrow set of specific services even if these are DFID priorities. A narrow focus can create distortions as providers focus only on delivering rewarded services at the expense of others which may serve to fragment, rather than strengthen, health services.

Impact of the floods

Pakistan suffered some of the worst floods in history in August 2010. At the time of writing this report the Disaster Needs Assessment being undertaken by the World Bank and the Asian Development Bank was not yet available to these consultants, so

the following bullet points should be taken as tentative and based on our discussions.[9]

- The reconstruction bill for health infrastructure in the flooded areas appears to be relatively modest ($40 million country-wide was quoted). This is possibly because the flooded districts are also the poorer districts in each province, where less service provision and hence health infrastructure was available in the first place.

- Members of provincial governments met by the consultants expressed high demand for and interest in ensuring a planned transition from emergency health delivery to longer term health systems building in the flooded areas. These views were backed by several NGOs, by the World Bank and by DFID´s Humanitarian Assistance team.

- In addition to humanitarian considerations there seems to be a strong case for investing in health in flooded areas because: (a) floods are likely to recur in the future, so better preparedness could save future lives; (b) generally speaking poverty levels are high and health indicators are worse in these areas, making them targets for longer term development assistance; (c) DFIDP, other donors and a few NGOs have already invested in these areas for emergency health services, so there is a case for both maximising the impact of investments already made and for helping the provincial and district administrations increase their focus on these areas.

- Since future investments in flooded areas through B and AD loans are likely (yet unconfirmed) DFID health support in these areas might help the case for re-building better and delivering better health services that are adapted to the higher vulnerability of the population living in these areas.

Summary of health and population challenges in Pakistan

In the light of the issues highlighted in previous chapters the following is a summary of challenges faced by the health and population sector in Pakistan in the immediate future:

- Financing for public health programmes remains uncertain from either government budget or external assistance;

- Will provinces foot the public health bill and focus on PHC? There is a risk of interruption/delaying of fund flows for essential health care;

- Poor focus and resource targeting on essential care, on quality and on the poor by the public health system

- Left on its own the traditional divide between health and population welfare services will continue and may not result in needed changes in the service delivery strategies – this will perpetuate the missed opportunities of delivering an essential package of H&P essential services through the PHC network;

- High verticality of public health programmes goes right down to service delivery points and prevents an integrated delivery of services. The national MNCH Programme contributes to only a few MNCH service inputs and

[9] Main views originate from DFID´s team for Humanitarian Assistance and from the World Bank. These perceptions were confirmed in our meetings with provincial stakeholders.

outputs - without complementarity from other programmes (LHWs, EPI, etc) through improved integration it will not achieve expected RMNH outcomes;

- The role of districts administrations in health care delivery are in a legal vacuum, with clear signs of recentralisation in various provinces (Punjab) that might undermine delivery of health and education services. Poor regulation and the lack of performance management of service providers is a key issue across the board limiting the scope of progress and innovation brought about by existing approaches to contracting PHC delivery;

- While a few bilateral donors have been supporting the GoP in H&P sector for many years the effectiveness of aid has been constrained by weak policy and institutional environment, poor alignment of donors (resulting in limited leverage) and insufficient emphasis on a SMALL number of KEY, essential reforms.

4. The proposed way forward

Focus on RMNH results – scope of various options

If DFID is to contribute to improved RNMH results in Pakistan it needs to support better access to relevant services. DFID current support to the MNCH programme is based on the belief that national vertical programmes represented in the pre-devolution scenario a convenient mechanism to encourage access to the right types of services. If we look at the table below it is clear that the MNCH programme, in its current form, would have, at best, a modest role in achieving RMNH results, and a much diminished one if opportunities to improve its effectiveness and to impact on other services are missed, as is the case to date.

Table 1 below is an attempt to illustrate what RMNH results might mean in practice, and to link these results to different RMNH service outputs. Service outputs have been classified in an incremental manner, i.e. starting with increased access to FP services and moving incrementally to a more holistic package of RMNH services. The table shows some simple yet important pointers for DFID potential involvement such as the following:

- **Demand or supply side or both?** There is the option of working only on the demand side, only on the supply side or at both levels. While the latter option might be the preferred one in terms of range and quality of RMNH results we are not necessarily recommending DFID to go for that option unless it feels it has the operational capacity to oversee work at both levels by, in this case, the provincial governments. In other words the supply + demand option implies a much higher degree of engagement by DFID (and its implementing agents, if applicable) and a much stronger implementation capacity on the part of provincial governments. Where capacity of either is an issue there is the option of reducing the scale of the interventions to a few "demonstration districts" in order to learn by doing, but this would also have an impact on the speed and scale of RMNH results that would be achieved.

- **FP, SRH, MNCH or all?**[10] As in the case above we are not necessarily recommending DFID to attempt to reach all types of services, from the more simple FP to the more complex MNCH unless it feels that it and the implementing agents (provincial government, district administrations, PHC service providers) have the capacity and willingness to do so. Where such is not the case DFID might chose to focus its work mainly or only on the FP side (increasing access to safe contraception), in which case it might either rely mainly on non state providers (national/international specialist NGOs) or chose to also support provision of FP services through the government health system, or both. In each case the needs for engagement and implementation capacity would be different as would be different the range of RMNH results that would be obtained.

In sum, Table 1 below is just a way for DFID to map its level of ambition vis a vis needs for engagement and implementation capacity, and to link it to likely range of RMNH results that would be achieved in each case.

[10] For the purposes of this report we are considering that FP services would focus mainly on contraception while SRH would add other services to FP, such as screening and curative care for sexually transmitted diseases. In this sense it would be necessary to define what the "R" in RMNH would imply in each case.

Table 1 – Scope and scale of services and interventions to achieve RMNH Results

	Main outputs achieved	Impact on H&P outcomes (CYPR, TFR, MMR, NMR) & on the poor over 4 years	Approaches & Implementation Strategies	Costs, cost-effectiveness and sustainability	Observations
A0	Increased access to FP **commodities** through commercial channels	Modest impact on CPR & CYP in short term and TFR in medium term. Impact subject to non state providers being able to reach rural areas. Very modest impact on MMR/NMR to be expected. Impact on the poor subject to ability of providers to work rural and target subsidies (vouchers?).	Social marketing of contraceptives combined with subsidies by provider outlets.	Costs are moderate (Pakistan considered to be amongst lowest cost per CYP in the world). Could be sustainable but expanding to poor would require subsidies raising sustainability concerns	Unlikely this would address the 30% "unmet" demand for CYPs without additional efforts on demand.
A1	Increased access to FP **services** and commodities **outside** the PHC network	Modest impact on CYP-CPR- TFR because many rural poor may not be reached. Negligible impact on MMR/NMR in short term; Poverty impact limited - many non state providers are based in urban & semi urban areas	Hire large NGOs to work with smaller, local ones (including perhaps LHWs) for demand generation & advocacy (might include LHWs) and supply through Population Welfare (PW) & NGO outlets.	Costs are high as it requires active search for couples and network of PW & NGO services remains small. Not sustainable without external funding (long term subsidies) in rural areas. Good intervention for learning by doing and extend lessons throughout Pakistan.	Main concern is it does not address the missed opportunities of targeting services through PHC network. Slow expansion likely as NGO capacity is limited.
A2	Increased access to FP services and commodities **within** the PHC network	Modest to substantial impact on CYP-CPR-TFR; modest on MMR/NMR in short term but could be significant in long term). Good on poverty focus.	Focus could be on both demand side (LHWs, NGOs) and supply side (PHC OUTLETS network, esp. LHVs) for higher impact. Limited reach in areas where utilization of PHC Outlets remains low, so worth initial focus on better used PHC Outlets.	Costs are moderate. Cost-effectiveness high where PHC already deliver services. Sustainability high.	Addresses the missed opportunities. Limitation is poor links between LHW and PHC network to link demand and supply in PHC network,[11] Rapid expansion likely using existing contracting out arrangements like PPHI. Would make contracting out more performance based in PHC outlets.

[11] They should develop in parallel to avoid demand generation where supply capacity is low or none.

A3	A0 + A1 + A2	Substantial impact on CYP-CPR-TFR; modest on MMR/NMR in short term but good in medium term. Excellent on poverty focus..	A1 + A2. Would require a basic PPP arrangement at district & provincial level and targeted TA for districts to monitor results. Needs for DFID engagement would be modest on al the "A" inputs even if these are combined.	Costs are moderate to high, but sustainability is good. Good intervention for piloting a systematic, holistic approach to delivering SRH/FP in Pakistan.	A1 + A2. Much more systems building that A1 or A2 in isolation as it would develop district capacity in PW services.
B1	Increased access to ANC, PNC and delivery services **through PHC network**	Modest on CYP-CPR-TFR; modest on MMR/NMR. Good on poverty focus..	Combination of demand (by LHWs, CMWs, NGOs) & supply side (PHC Outlets) interventions using vouchers & performance incentives to providers	Costs are moderate to high but sustainability is good.	Main limitation is poor impact on MMR and NMR due to weak referral services between PHC network and referral facilities, limiting chance of delivering ENMOC.
B2	Increased access to ENMOC and SRH services in selected RHCs and Tehsil Hospitals	Negligible to modest on CYP-CPR-TFR; Modest to substantial on MMR & NMR. Good poverty focus if rural districts are selected.	Combination of demand side incentives by NGOs (could use LHWs) for safe delivery and supply side incentives to providers using contracting out arrangements (PHC OUTLETS) and private sector (subsidised emergency transport).	Costs are moderate to high depending on scale. Good on sustainability. This is probably the only means to achieve substantial reduction of MMR and NMR in rural Pakistan.	Concept is to ensure every district has a minimum network of fully staffed and equipped ENMOC facilities and a hub for transport and emergency communications enabling fast geographic access. May require reallocating PHC doctors (shifts) to RHCs, & train them on ENMOC
B3	B1 + B2	Modest on CYP-CPR-TFR. Substantial on MMR, NMR due to internal synergies. Excellent on poverty focus through targeting poorer districts or districts with large supply gaps.	B1 + B2 would require DFID to contract in additional capacity to manage inputs at provincial level. Need for DFID engagement at political and institutional levels would be much higher in B when compared to A.	B1 + B2. Cost high but also very cost effective and sustainable.	Only means to achieve sustainable MMR and NMR outcomes in the medium to long term in rural areas. Could be highly innovative (similar to MNCH in Bangladesh)

C	Combinations of A and B	Synergies would increase impact substantially on all RMNH indicators.	Combining A and B requires considerable capacity building to province (targeting VPs), districts (oversight of contracts and service delivery) and providers (less of an issue). Such capacity building (not just TA) needs long term engagement, by DFID and by contracted TA agents working in the provinces and districts.		This approach would be the "gold standard" in terms of maximising RMNH outcomes, but we are aware that it has important implications in terms of cost (financial aid plus TA through contracted in health firms to help with implementation and in terms of need for DFID engagement. Therefore, if the approach finally selected by DFID combines A, B & C options it may require an incremental approach, beginning small and learning by doing.

Definition of scales. Negligible = impact insignificant, & not measurable. Modest = small yet measurable impact. Substantial = significant and measurable impact. Sustainability means that costs can be transferred over time and/or it builds on existing role or comparative advantage of service providers. Terminology: PHC OUTLETS; RHC; TH; LHW; LHV (Abbreviations will be added in the next draft).

What could DFID do? Options for DFID engagement in H&P

The following tables map out a series of possible options for future engagement by DFID in the health and population sector and set out their respective advantages and disadvantages.

Broad Options	Pros and Cons
A. Do nothing in Health & Population Argument: H&P is too unstructured and risky a sector. DFIDP involvement would require a level of engagement that is problematic given staffing and security constraints. DFIDP focus would remain on education, PFM and governance.	This option is rejected on the following grounds: • hard to defend in one of DFID´s top priority countries. Left to GoP RMNH outcomes unlikely to improve. There are opportunities for DFID to continue to make a difference in the current transition. • GoP and other donors see DFID as leader in health and expect it to "lead the pack" for improved alignment of health investments around key services and key reforms for RMNH. Other donors unlikely to take the space if DFIDP left. • DFIDP health aid to date seen internally and externally as influential, systems building, adapting to landscape, and valued by government, donors, NGOs and communities.
B. Continue with what DFIDP is doing Argument: continue to fund the national MNCH programme as is.	This option is possible but not favoured because: • We do not see current support to national MNCH programme alone, and certainly in its present form, as sufficient means to achieve RMNH outcomes: it is too input based, generic (the vertical nature of the programme imposes uniform approaches countrywide rather that locally relevant measures) and is not focused on poorer districts. Service integration and reforms agenda in original MNCH plan have not progressed. • In its current form programme does not help concentration of efforts on 2 selected provinces • Current financing deadlock is affecting DFID's reputation, yet risk will continue and national stewardship remains very weak.
C. Re-orientate what you are funding within MNCH programme Argument: resume funding to provinces as per original plan but in Punjab and KPK use the programme to focus on key districts, key services, key reforms. Use this experience to design new support programme (as in option D) better aligned with new realities and DFID departmental priorities from 2011-12.	**This option is our recommended one, although we are unsure whether the necessary reorientation in Punjab and KPK would be possible without major MNCH programme re-design.** • This option gives DFID and GoP time to address a number of concerns linked to the present programme while beginning to work in a different way in the selected provinces. • This option is compatible (and could be made more so) with the existing health BAR offer by modifying the proposed interventions along the lines of our recommended approach (if DFID accepts it – see later). • There is no need to resume funding everywhere or to support federal level positions – DFID could suggest a set of steps that would lead to resumption of funding and could make these conditional on achievable changes to programme rationale and management. • This would offer a good entry point for DFIDP to bridge the funding gap for essential services in provinces while focusing attention of provinces on results linked to RMNH services and outcomes. It would also enable DFIDP exert some leverage on the two provincial governments for key reforms to be pursued.

D - stop support to MNCH programme and design new programme in Punjab and KPK	This option might be perceived as too drastic by the GOP and other stakeholders. We would favour this option only if Option C proves unfeasible. • This option allows DFID to make a fresh start in the two provinces (and could still allow for some federal support to specific reforms); • It would require considerable re-design and a substantial change in the current BAR offer at the level of outcomes, outputs and proposed interventions.

What should DFID do? DFID´s new approach in greater detail

We propose approaches which will work *with* but not always necessarily *through* Government:

- **to support the transition between emergency support to sustainable health programmes** in flood affected districts. These are also amongst the poorest and most and must vulnerable districts – vulnerability will persist.

- t**o support the transition from centralised vertical programmes to more effective locally led more integrated services**. The aim is to protect the quality and quantity of health services during the devolution process and to strengthen subsequent performance. The aim will be to support a range of reforms already under consideration/implementation including build capacity to ensure authorities get value for money from innovative approaches including public private partnerships.

These two themes are discussed in more detail in the tables below. A key aim is to work with the provincial governments and avoid their becoming a new centralising force for development efforts. The role of districts will be crucial.

Key themes – supporting the transitions in PFP and Punjab

<table>
<tr><th colspan="2">Theme 1. From Emergency to Development in poorer, flooded districts</th></tr>
<tr><th>Justification – why this approach?</th><th>What elements might be included?</th></tr>
<tr><td rowspan="2">a) Poorest and vulnerable districts coincide
b) Focus on few selected districts to enable learning by doing of provincial governments and concentration of efforts
c) These districts currently get very little from gov't – fertile ground for unrest, hence opportunity to get some essential services going with DFID support
d) Good value – building on previous investments
e) Reasonably cheap: limited reconstruction, and equipping. Use contracting for staffing and service delivery strategies. Good value for money
f) Visible gains and results – DFID supporting reconstruction helps win "hearts and minds"
g) No obvious alternative – major donors not bridging this gap
h) Floods and disasters will recur – prepare – no one there to deal with it
i) Need to help districts stay in driving seat for local development – won't work otherwise – Close involvement in planning – ensure complementarity between Govt/NGO
j) Emphasise government key role in performance management. In KPK we got clear message that this is where it will happen
k) Scope for innovation using reasonably well proven models of contracting (out and in) similar to PPHI – this does not mean supporting PPHI but using this entry point to achieve performance and accountability for results
l) Work with range of stakeholders e.g. NGO to complement work of Govt - use and learn from contracting experience in Pakistan, including: PPHI; CMIPHC and National Commission for Human Development in Punjab; SCF US in Batagram; AKHS in Sindh and elsewhere. District to be focal point for bringing together key actors.
m) Very positive feedback from provincial governments, donors (WB, AusAID), NGOs (SCF, MSI, Greenstar): value in this approach</td><td>• Build capacity of district administrations to assume responsibilities for a basic health package;
• Help them adapt to the vulnerability of these areas to future floods by defining "programme of minimums rather than ideal programme".
• Strong emphasis on integration of VPs (EPI/LHW/RMNH) and PW/H services and focus on RMNH related results, initially higher access to service delivery
• Focus on essential referral services esp. RHCs, Tehsil/District hospitals in strategic geographical areas
• Use contracting out and in for alternative service providers on both supply and demand side
• Support provincial government to fund and develop systems (performance management, oversight) in these areas. Assess leadership gaps and build strong provincial engagement /stewardship
• Focus on results – monitoring arrangements – narrow focus will help - service outputs EPI, FP, ANC, essential curative care staffing</td></tr>
<tr><td>How? See later the approach in more detail
• Begin by assessing capacity in Govt/DFID to proceed in both provinces simultaneously – begin by assessing needs and demand– first needs assessment/mapping – prioritisation – key areas, services, providers???
• Provincial government to allow sufficient flexibility for District Health Management Team (DHMT): salary and non salary; mix inputs from vertical programmes; etc. There are precedents in PPHI and Batagram models.
• DFID would target additional resources needed for essential health package, incrementally, quid pro quo with provincial government over time for sustainability
• Additional costs would be the extra management costs (known to be modest from Batagram model); limited rehab/commodity and logistics support to integrate; incentives to LHWs for higher mobility (explore modalities of Results Based Financing (RBF) – managing for results.
• Financing Instruments – make best use of existing ones; DFID top up support to Account IV through national systems. (Alternatively DFID might want to consider the use of a challenge fund; use existing TA arrangements; Crown Agents in Punjab, TRF to support.
• Funds channelled through provinces, earmarked to districts

Needs considerable additional thinking but looks like worth doing to strengthen performance, accountability, value for money, focus on RMNH results and on poverty.</td></tr>
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<table>
<tr><th colspan="2">Theme 2. Financing and supporting transition from centralised planning model to provincial and district led programmes</th></tr>
<tr><th>Justification – why this approach?</th><th>What elements might be included?</th></tr>
<tr><td rowspan="2">

Programmes deliver but not as well as they might
Transition following 18th amendment is unclear: is there a plan? Risk of impact on key services needed by poor people.
Provinces unable/unwilling to take up VPs and PHC – possible overemphasis on curative care and bigger hospitals (esp. Punjab – fat cows)
Opportunity for targeting financial support against agreed milestones to ensure essential package
Concerns about funding interruptions (responsibilities without transfers) – create incentives
Need for provinces to establish capacity fairly quickly – regulation, performance management, M&E - currently reactive
Wont be resolved immediately – even if decisions made – substantial longer term support required
Receptiveness – KPK already thinking along these lines – but danger political establishment not paying enough attention
New roles required – best practice/evidence based – suggests need for TA so as not to reinvent the wheel (regulation, contracting, performance management, contracting)
Provinces want DFID to back them – both provinces. Appreciation for current TA (CA/TRF/TAMA)
Promising openings Health Care Commission Punjab), Health Regulatory Authority (KPK)
Demand at all levels for more strategic use of donor $ and technical cooperation – much beyond “donor coordination”, and much more around alignment

</td><td>

DFID funds a partnership deal – linked to clear work programme and milestones with the provincial government.
Focus on a manageable set of work areas rather than on a broad health sector strategy – main areas to be broken down into measurement milestones. These would be the results to measure the quality of the engagement, to complement RMNH results at service delivery points.
Examples of key work areas:

financing, (e.g. KPK developing notion of essential package/integrating programmes – funding to follow package – complement under emergency
simplifying financial management systems – direct yet safe handling of $ at district/provincial
adopting effective, integrated service delivery strategies from the district and below
regulatory framework for professionals and accreditation of health facilities
Strengthen capacity for oversight of contracting arrangements in districts and provinces
Building performance management capacity in provinces and districts for public and private providers to deliver essential package with quality – use DHIS as monitoring tool
Bridge the complete divide between health and population welfare– won’t be bridged on its own – e.g. health services don’t provide FP services. Eg MSI working with Govt to develop effective service delivery strategies. Reduce missed opportunities
support for medium term plans (existing home grown strategies being developed (paper strategies) IHP+ link

</td></tr>
<tr><td>How? See later the approach in more detail</td></tr>
<tr><td></td><td>

provincial level sector budget support – linked to clear work programme and milestones. Use existing conditional grant mechanism
Small number of key donors to back the DFID partnership deal for increased leverage and alignment. USAID, AusAID and World Bank likely to endorse this approach.
Need for greater engagement at political and institutional levels of provincial Government to ensure responsibilities are taken up, helping them define clear set of milestones in prioritised areas.
TA (current good and high quality – how to) will need to continue but DFID will need additional pairs of hands almost “embedded” in provincial administrations to oversee and support change. Better to separate TA from this institutional development role, even if both should complement each other.

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We also believe that the approach needs to:

- have a focus on high level results and RMNH outputs and outcomes to achieve systems building and systems change;
- ensure the DFID programme targets the political, institutional, administration and service delivery levels, through combinations of strategies within HMG departments, with other donors and bringing in additional support to enable DFID to engage more and better at institutional and political levels and that sufficient focussed engagement takes place at each level;

Focus on provincial and district levels

Key DFID efforts at provincial level should focus on:

1) **Helping to define provincial health sector priorities**. To help provincial governments develop essential health priority policies and interventions, and help them move step by step to improve stewardship through learning by doing. This means that instead of requiring governments to produce good looking but unfeasible comprehensive health sector strategic plans the focus should be on a limited number of minimum key results to be delivered over a 3-5 years period, with clear milestones for provincial governments and donors to be held mutually accountable. Examples of areas where we feel efforts should concentrate include:

   a) Defining the responsibilities of the provincial governments vis a vis health policy, financing, stewardship (regulation, accreditation, etc) and performance monitoring of service providers.

   b) Focussing attention on improving the performance monitoring of PHC service providers to maximise the potential of existing contracting out arrangements (i.e. PPHI). Such focus could deliver several interconnected outputs:

      i) greater focus on results, including RMNH results;

      ii) make the HMIS/DHIS a live tool to monitor service delivery;

      iii) enable increased targeting of resources (service overheads, commodities, incentives, etcetera) to service providers who can make use of these (based on evidence of results) thus rewarding effort and innovation, whether on supply or demand side interventions;

      iv) enable increased focus on poor service providers to target additional support and capacity building efforts.

   c) Ensuring districts remain the main hubs to monitor and coordinate the delivery of essential services. While status of district governments is unclear district administrations remain in place and the district remains the best option to focus and coordinate development efforts.

2) **Aligning with, and supporting, provincial priorities**. Donors (including DFID) to use the above efforts to achieve greater alignment with prioritised national and provincial health policies and strategies, and to better coordinate their efforts in support of these. Steps to move in that direction would include:

a) Defining and approaching key health financiers in Punjab and KPK to persuade them of the benefits of working together for higher leverage, accountability and results.[12] Other related measures might include

   i) Defining a simple code of conduct for these donors to engage with government.

   ii) Nominating a donor to become the main interlocutor with government in each province and for a defined (2 years?) period of time.

b) Giving clear indication to provincial governments that if focus is placed on delivering essential services such as RMNH donor support to help them achieve that aim in a flexible, transparent and accountable manner (including SBS) will be forthcoming. There will be a need to persuade provincial governments of the need to identify a small rage of key interlocutors for H&P to engage with the main financiers.

c) Working swiftly with provincial governments to define the health sector priorities and to identify ways (TC, SBS, etc) to finance these. DFID should consider the benefits of focusing their support on the following:

   i) Supporting the two transitions, from emergency health aid to health sector building and from federal to provincial stewardship;

   ii) Targeting financial aid (SBS, whatever) to specific districts, ensuring each of these districts receives attention from the provincial government in terms of defining needs and service delivery strategies to achieve measurable RMNH results (see later what we mean by results). Ideally these should use promising national mechanisms such as conditional grants and/or Provincial Finance Commission formula;

   iii) Targeting technical support – people capable of helping the government develop systems through close engagement over a long period of time- to provinces and districts for the above to be achieved;

   iv) Exploring the possibility of re-engineering existing GBS support to the national MNCH programme into provincial sub sector (or earmarked) budget support aimed at promoting more integrated delivery of both health and population services in each selected district (earmarked to district and to PHC level, but not within these).

   v) Once the main health financiers and governments have established the main working arrangements and agendas it would be the right time to increase the involvement of other health sector stakeholders in something like the existing “health cluster groups” to enable wider discussion and information exchange leading to improved coordination of efforts in each province. Key stakeholders to bring in would be the UN, the Global Fund and GAVI, and representatives from key NGOs and service providers.

3) **Develop longer term engagement and financing modalities with provincial governments**. The immediate priority for DFID and other donors would be to adapt existing aid instruments and flows to serve the steps and milestones outlined above. This will be essential to:

[12] By main financiers we mean DFID, USAID, World Bank, AusAID and, if feasible, European Commission.

a) gain leverage with provincial governments and help them focus attention on PHC and focus on results;

b) to learn by doing and achieve RMNH results as soon as possible, while at the same time help provinces fund and integrate vertical programmes in their PHC network and to merge health and population welfare services.

In the medium term though (say, from 2012-13 in the case of DFID) the focus should be on moving towards a programme approach in each province, as the only means for HMG to target its broader health and development priorities.

How would the proposed approach fit in KPK and Punjab

Punajb and KPK pose different challenges. The following is a summary of issues identified by the review team, which would of course require closer assessment should DFID decide to proceed in the suggested direction.

Khyber Pakhtunkhwa (KPK) Province

- KPK has a well developed sector strategy - though perhaps not yet with a clear focus on the few priorities which could, and should, be taken forward quickly.
- There is an openness to new approaches – for example to contract in and out in settings where government cannot reach (evidence is emerging from experience in Batagram district).
- KPK officials seem keen on DFID support for transition from emergency aid to the development of sustainable district health systems and recognise that there will be more emergencies.
- They are also keen on donor support to keep health high in provincial government's agenda. The presence of provincial counterpart funding for the MNCH programmes suggests at least some degree of commitment.
- Key institution and systems building needs include regulation & performance management of service providers (a Health Regulatory Authority has recently been established); integration of vertical programmes in service delivery, and of FP & Health services.
- There is huge potential for rapid increase in RH and MNH services - provincial government keen on district role.
- The World Bank and AusAID on board for stronger alignment - USAID position is currently unclear but verbal statements suggest endorsement of this approach.
- KPK also offers particular opportunities to build on links between health work and the wider HMG integrated delivery approach.

Punjab Province

- In Punjab there is no clear health sector strategy - the one we saw seems to suggest everything should be done – there is little prioritisation.
- There is leadership from a dynamic Health Secretary but it is not clear that the direction is sound.
- There is also openness to new approaches but high emphasis in regulating private sector (a Health Care Commission was just been established) but there will also be a need to monitor performance of public facilities.
- Punjab is keen on DFID help through Sector Budget Support. Given the fiscal situation the provincial government is likely to struggle to take on costs of national programmes without further support.
- The relationship between the province and federal government in health is tricky.
- There are concerns about possible recentralisation of district powers and there is limited willingness for NGO involvement in areas where the provincial government cannot reach.
- Punjab remains a key province – it has traditionally led in many health matters, but there is a clear need for donor alignment around key priorities.

Rationale for the Proposed Approach

The overall rationale for the approach we propose is that:

- it focuses on improving access to key services – and highly cost effective services - especially for the vulnerable in target areas,
- encourages the adoption of innovative, evidence based models including public private partnerships,
- supports and protects access in uncertain reform environment,
- there is little evidence other donors are prepared to step in, interest/support from key stakeholders (other donors, Govt, NGOs).
- it is likely to be generally welcomed by most key stakeholders
- contribution to DFID corporate priorities

How would the new approach help DFID meet Departmental priorities?

The following table sets out how the proposed approach will support stated Ministerial priorities as well as priorities set out in the DFID Structural Reform Plan

Table 2 – How the proposed approach would meet DFID priorities

Key Departmental Priorities	Theme 1: Emergency to Development	Theme 2: Centralised to effect local ownership
Impact and results/Value for Money	Aim is to ensure increased use of essential – and highly cost effective - services/service outputs. Funding linked to delivery of outputs	Aim is to ensure increased use of essential – and highly cost effective -services/service outputs. Support to be linked to service improvement and achievement key milestones (in turn link to bottlenecks preventing more rapid progress. Aim is to maintain service delivery during devolution process and make sure national vertical programmes are not simply replaced by vertical provincial programmes.
Evidence base	Some (increasing) evidence of effectiveness of models. Results of SCF experience on Batagram just published. PPHI evaluation due shortly	Previous positive experience under NHF/MNCH (based in annual reports and country evaluation)
Accountability and engagement	Approaches will promote provincial and district management and stronger links with NGOs/CS	Building regulatory capacity/oversight function would be a key component of any support
Innovation and ideas	Innovative approaches already being implemented (and encouraged further)	Innovative approaches already being implemented (and encouraged further)
Private sector	Direct engagement with NGOs through contracting	Building regulatory capacity/oversight function key

Key Departmental Priorities	Theme 1: Emergency to Development	Theme 2: Centralised to effect local ownership
	model/indirectly and increasingly with civil society through oversight	component
Role of Women	Likely to be major beneficiaries of better access to services	Likely to be major beneficiaries of better access to services
Wealth Creation	Wealth protection (better health services prevent catastrophic costs associated with ill health)	Wealth protection (better health services prevent catastrophic costs associated with ill health)
Afghanistan, Pakistan, Conflict and Stabilisation	Programme would aim to demonstrate the state can help deliver services which benefit the population – especially marginalised groups	Programme would aim to demonstrate the state can help deliver services which benefit the population – especially marginalised groups
Climate change	Higher contraceptive prevalence rate can contribute to alleviation of population pressure	Higher contraceptive prevalence rate can contribute to alleviation of population pressure
	Direct effect	Indirect effect

What are the implications for DFID?

Although much depends on the level of ambition that DFID sets for its health programme (see Table 1 above) DFID's approach in the new scenario of devolution would require sustained presence and engagement by DFID advisers at provincial levels to focus on political and institutional levers. While funding would be channelled through provincial governments the operational and monitoring focus should be on districts.

Funding through certain national NGOs (Greenstar, MSI) should not be discarded, particularly in areas like Sexual and Reproductive Health (SRH) where they would add value. However, it would be important for these NGOs to access DFID funding through the provincial government wherever PPP arrangements so enable or, at least, for these NGOs to work within the framework defined between DFID and the provincial government.

We recognise important limitations to DFID engagement linked to the delicate security situation, which may constrain DFID advisers and staff from engaging at all levels. Given these constraints and the size and complexity of the provinces, a small team in DFID cannot achieve enough sustained engagement on its own. DFID will therefore need to consider contracting in external support (providing technical competence, understanding of sector management issues) on an ongoing basis. This will depend largely on the scale and scope of interventions that DFID selects (again see Table 1). Contracting in additional support may not free advisers time in the early stages but it would contribute to longer term, sustained engagement at the organisational, management and systems levels. It would also free DFID advisers time to engage at the political and institutional levels (DFID Health team/HMG Integrated Delivery).

END OF FINAL REPORT

Annex 1 Terms of reference

UK's Department for International Development, Pakistan

Terms of Reference

Strategic Review of DFID support to the Health and Population Sector and Development of Recommendations for Future Support

Objective

1. To produce evidence-based options and recommendations for DFID's strategy for engagement in Pakistan's health and population sector over the next 3-5 years.

2. The work will include:

i) a review of DFID support to the health and population sectors from mid 90's to 2010. This will document DFID's role (programming and policy engagement) and outline the results (policy and programming) and value for money to date;

ii) analysis of the current health sector context and donor landscape in Pakistan, including (but not limited to); Government of Pakistan and donors' policies/ plans, National Finance Commission (NFC) award, constitutional changes, the future of devolution, fiscal situation & constraints, security challenges, state-building and developmental deficits; NGO and private sector capacity in health service delivery; the health and health systems impact of the floods;

iii) a comparative analysis of options for DFID's future strategy – taking into account DFID corporate priorities, policies, country plan and capacity in particular DFID's focus on reproductive, maternal and newborn health (RMNH) and the use of government systems for budget support to the health sector[13]

The recipients:

3. DFID Pakistan

Expected Outputs

4. The following outputs are expected from this consultant:

- Brief notes on the various meetings/ consultations and the background analysis to generate evidence for 2 i), ii) and iii)..
- A draft report of maximum 20 pages (not including annexed analysis) by 29th October 2010.. This must include options (along with pros and cons) for DFID's strategy for future work in the health sector in Pakistan and a recommendation. The consultants may be required to present and discuss the draft with relevant DFID staff. (Meeting/s with DFID in advance of writing the draft report is also required - see paras 9 and 10)

[13] There will be a concurrent consultancy to make a fiduciary risk assessment (FRA) in the health sector and assess the feasibility of budget support in the health sector. The review should draw on the findings of that work to make its assessment.

- A final report of up to 20 pages (not including annexed analysis) including a way forward for DFID in health. The final report is to be delivered approximately 1- 2 weeks after receiving DFID's feedback (exact deadline to be finalised at time of reviewing draft report).

Scope of work

5. The consultants will work with DFID, public bodies at federal and provincial levels, development partners, civil society organisations and any other relevant parties or individuals to develop a paper that:

- Outlines UK government and DFID's current regional and country level roles and commitments: for improving health, HIV, population and nutrition status; delivering improved healthcare and related services especially for women, children and vulnerable people; disaster risk reduction and emergency preparedness; the health sector's contribution to state building and peace building especially in the context of border areas; taking into account findings of the health portfolio review; and briefly describes how DFID's health policies, strategies and priorities add value to this;
- Outlines health development partners' roles, priorities and investments in the health sector;
- Outlines DFID's role representing European Union (EU) to support the health sector;
- Outlines the likely impact of the current floods emergency on health and health systems;
- Reviews and describes briefly how DFID has worked with others previously to meet the objectives and comparative advantages of the organisation;
- Briefly describes the actions that DFID is undertaking or should undertake to fulfil the objectives, also justifying why to invest in health rather than other areas;
- Reviews analytically the current major issues and challenges faced by the health sector, and the health policy[14] and financing choices that need to be made, including (but not limited to): Government of Pakistan and donors' policies/ plans, National Finance Commission (NFC) award, constitutional changes, the future of devolution, fiscal situation & constraints, security challenges, fiduciary risk issues, state-building and developmental deficits (and role of social sector service delivery).
- Recommends how DFID could maximise value for money by supporting the health sector, also suggesting alternate option/s with justification, pros and cons;
- Reviews and updates the objectives for DFID's support to the health sector and provides recommendations for future decision making processes;
- Recommends complementary support/activities that could be provided by other DFID & HMG teams (Basic Services, Income Growth, Policy and FCO) collectively to better fulfil our obligations to the country (with special emphasis on multi-sectoral investment);
- Describes ways of working for DFID to support better engagement with and by other bilateral, multilateral organisations on one side and improved operations with and between public and NGO or private health providers on the other side.

6. The paper is expected to analyse current processes and ways of working and to highlight whether DFID has fulfilled its obligations, along with recommendations /indication of what further work needs to be done.

Methodology

7. The consultants will take account of emerging and new UK government policies, strategies and programmes of support as evident in the Bilateral, Multilateral and Humanitarian Aid Reviews (BAR, MAR and HAR), to develop the paper. In particular the consultant will take account of the new

[14] In particular the 2010 National Health Policy and the 2010 National Population Policy

focus on reproductive, maternal and newborn health (RMNH). The consultant(s) will also take account of documents related to DFID's different health / multi-sectoral / humanitarian projects in the country.

8. The consultants will also take account of wider analytical work in Pakistan, for example on education, gender, governance, political economy and social exclusion.

9. In order for the consultants to fully understand and appreciate the roles, responsibilities and strategies of the various partners, meetings with development partners, federal & provincial governments and civil society organisations will form an integral part of this consultancy. Meetings with senior government officials will also be important to generate evidence on the current issues and challenges.

10. The consultants will also need to understand current DFID, development partners and public sector resources that support the health and population sector. The consultants should also understand inputs available to the devolved administrations.

11. Once the consultants have reviewed and analysed the information above, they should convene a small meeting with DFID top management and basic services group. DFID will consider whether there are one or two external experts that should be invited to join these discussions. Main purpose of the meeting is to review findings and conclusions and discuss key objectives and strategies for the future.

12. The consultants will subsequently produce a draft paper and in consultation with DFID will review and agree on the contents and changes for the final draft. The consultants will then work to produce a final document.

Timeframe

13. The work will take place between September and November 2010.

- Up to 25 days for each consultant - the health sector consultant and the health financing consultant. The lead could be identified once the two consultants have been selected.
- An additional up to 15 days for research support, especially in the context of governance.
- The two consultants will produce a costed work plan before contract is finalised

Reporting and Management

14. The consultants will report to Martin Dawson, Programme Manager, Basic Services group in DFID. Other contact and information points in DFID will be: John Grinyer, Economic Adviser; David Gray and Ali Azhar, Governance Advisers; Lizzie Smith (Regional Health Adviser)) and Raza Zaidi, Health Adviser, Philip Powell-Davies, Basic Services Adviser, Helen Appleton, Social Development Adviser, Richard Gregory, Results Adviser; Zoi Andrew Deputy Programme Manager and Nusrat Hammad, Programme Officer.

15. The consultants will be contracted by Technical Resource Facility (TRF, managed by HLSP consortium) on behalf of DFID. DFID and TRF will supply relevant documents from their records. The outputs should be submitted electronically to Zoi Andrew, DFID Deputy Programme Manager, DFID: z-andrew@dfid.gov.uk .

Consultants Specification

16. The work requires two development professionals with considerable knowledge, skills and experience in health financing, governance, monitoring and evaluating donor investments. Familiarity with DFID strategies and processes and with evaluating budget support programmes is desirable. Public health experience is not essential but knowledge of issues related to social sector service delivery and its institutional context, and of public financial management in developing countries, and preferably in Pakistan, is needed. Excellent report writing and presentation skills in English are essential.

17. The Team Leader will be responsible for producing final work plan for the consultancy, managing inputs of team members to produce a holistic review and plan; produce a summary of

review, options and recommendations for future direction. He will finalise arrangements with TRF for additional research support of 15 person days.

Background

18. The Department for International Development, (DFID)'s health development support in Pakistan over the past 2 decades has combined 'programme' or budget support, financial aid (backed up by technical cooperation), 'project' support mainly through civil society organisations and multilaterals. The former includes the Social Action Programme (SAP, 1993-2001), the National Health and Population Facility (NHF, 2003-10), and currently the Maternal and Newborn Health Programme (MNH, 2008-13). Project support has been more narrowly focused – limited to a specific locality, or to address a specific issue (e.g. HIV & AIDS, Polio eradication, contraceptive social marketing, consumer protection etc). The support demonstrates DFID's commitment to strengthen health systems.

19. Health has also been a component of some of DFID's multi-sectoral and humanitarian support, including Poverty Reduction Budget Support (PRBS-I, 2005-08 & PRBS-II, 2009-13), Punjab Devolved Social Services Programme (PDSSP, 2005-10), Earthquake (2005-09), Provincial Reform Programme (PRP, 2006-10) in NWFP etc.

20. In 2008, engagement with the Federal and Provincial Governments, civil society and other development partners began with a scoping mission and continued through a design phase for a new Health Sector Support Programme (HSSP) to respond to the new sector policy and consolidation of the Medium Term Budgetary Framework (MTBF, which has also received DFID TA support).

21. In March 2010, it was agreed that HSSP would not now be the right option for DFID given some of the following challenges and issues:

- Expected changes to federal and provincial functions and budgets following the National Finance Commission (NFC) Award;
- The constitutional amendment which abolishes the concurrent list and is thus expected to curtail health functions of the federal government significantly;
- An economy presently suffering from slow growth and characterised by inadequate revenue generation which in unison are negatively impacting on the Public Sector Development Programme (PSDP) compromising funding to priority health programmes at the federal level.
- The federal and provincial governments are yet to objectively address management of the expected/desired "transition" .
- Fiduciary risk and corruption related concerns;
- The delay in approval of new National Health Policy – and uncertainties about the *opportunities* this may or may not offer for strengthening sector coherence, planning, governance and monitoring;
- The consistently precarious security environment of the country, unsatisfactory law and order situation and state building deficit;
- Other donors' plans, especially those for on-budget assistance, (USAID, WB, ADB), but also other bilaterals and the EU. We work in close partnership with AusAID, who co-finance our Technical Assistance for Maternal and Newborn Health initiatives and they are keen to explore future opportunities for further collaboration with DFID in the Health sector.

22. Since the UK general election in May 2010, the new government has both strongly committed itself to Pakistan's development and to making significant progress on the MDGs, and in particular on reproductive, maternal and newborn health. An initial strategic review of DFID Pakistan's programmes has proposed that DFID will 'do more on maternal health and population – to help address the

appallingly high maternal mortality and Pakistan's unsustainable population growth. And to do this by working on demand and access to maternal and reproductive health services and increased use of contraception …' and 'do less' across the health portfolio … and encourage others to lead in other areas.

23. It is therefore a good time to take stock of health sector and determine the direction of future DFID development support for health for maximum results and value for money taking into account the changing wider context of DFID's support[15] and the new government's priorities.

24. The current main objectives of DFID's planned future health sector support are: i) Increased delivery of cost effective and quality health care services, especially to women, the poor and socially excluded; ii) Federal, provincial and district governments operating effectively to fulfil their health sector stewardship and management roles; and iii) enhanced responsiveness and accountability of different tiers of the government.

25. Based on analytical review, this consultancy should provide (a) a review of DFID's planned objectives for the sector; (b) a clear direction along with alternate option/s of how the re-affirmed or newly proposed objectives should be reached.

Security

26. The consultants will be responsible for ensuring their own safety and security. We recommend to consultants that they work within the framework of the British High Commission's (BHC) security advice and follow the DFID process for obtaining security clearance for all travel within Pakistan. DFID will advise on the process should the consultants agree to operate within the BHC's framework.

27. The BHC and DFID accepts no liability for injury, loss or damage arising in any respect of any statement contained within its security advice.

DFID Pakistan

Sept 15th 2010

[15] Including the impact on health and health systems of the current floods emergency

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