Report and Recommendation of the President to the Board of Directors

INTERNAL

Project Number: 54297-001
September 2022

Proposed Results-Based Loan
Islamic Republic of Pakistan: Khyber Pakhtunkhwa Health Systems Strengthening Program

Asian Development Bank

CURRENCY EQUIVALENTS
(as of 10 August 2022)

Currency unit	–	Pakistan rupee/s (PRe/PRs)
PRe1.00	=	$0.0044
$1.00	=	PRs224.45

ABBREVIATIONS

ADB	–	Asian Development Bank
AGP	–	Auditor General of Pakistan
COVID-19	–	coronavirus disease
DLI	–	disbursement-linked indicator
DOH	–	Department of Health of Khyber Pakhtunkhwa
GDP	–	gross domestic product
HRH	–	human resources for health
IMU	–	independent monitoring unit
IVA	–	independent verification agency
JICA	–	Japan International Cooperation Agency
KPK	–	Khyber Pakhtunkhwa Province
PAP	–	program action plan
PforR	–	program-for-results
PHC	–	primary health care
PMIU	–	project management and implementation unit
RBL	–	results-based lending
RSHC	–	Revamping Secondary Health Care
SHC	–	secondary health care
SSP	–	Sehat Sahulat Program
TA	–	technical assistance
WHO	–	World Health Organization

NOTES

(i) The fiscal year (FY) of the Government of Pakistan ends on 30 June. “FY” before a calendar year denotes the year in which the fiscal year ends, e.g., FY2022 ends on 30 June 2022.

(ii) In this report, “$” refers to United States dollars.

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RESULTS BASED PROGRAM AT A GLANCE

1. Basic Data

Project Number: 54297-001

Project Name	Khyber Pakhtunkhwa Health Systems Strengthening Program
Country	Pakistan
Borrower	Islamic Republic of Pakistan
Country Economic Indicators	https://www.adb.org/Documents/LinkedDocs/?id=54297-001-CEI
Portfolio at a Glance	https://www.adb.org/Documents/LinkedDocs/?id=54297-001-PortAtaGlance
Department/Division	CWRD/CWSS
Executing Agency	Department of Health, Khyber Pakhtunkhwa

2. Sector

	Subsector(s)	ADB Financing ($ million)
✓ **Health**	Health sector development and reform	100.000
	Total	**100.000**

3. Operational Priorities

- ✓ OP1: Addressing remaining poverty and reducing inequalities
- ✓ OP2: Accelerating progress in gender equality
- ✓ OP3: Tackling climate change, building climate and disaster resilience, and enhancing environmental sustainability
- ✓ OP5: Promoting rural development and food security
- ✓ OP6: Strengthening governance and institutional capacity

Climate Change Information

GHG reductions (tons per annum)	0
Climate Change impact on the Project	Low

ADB Financing

Adaptation ($ million)	0.000
Mitigation ($ million)	5.300

Cofinancing

Adaptation ($ million)	0.000
Mitigation ($ million)	0.000

Sustainable Development Goals

SDG 1.5
SDG 3.8
SDG 5.1
SDG 10.4
SDG 12.2
SDG 13.a

Gender Equity and Mainstreaming

Effective gender mainstreaming (EGM) ✓

Poverty Targeting

General Intervention on Poverty ✓

4. Risk Categorization: Complex

5. Safeguard Categorization

Environment: B **Involuntary Resettlement:** B **Indigenous Peoples:** C

6. Financing

Modality and Sources	Amount ($ million)
ADB	**100.000**
Sovereign Results Based Lending (Concessional Loan): Ordinary capital resources	100.000
Cofinancing	**0.000**
None	0.000
Counterpart	**317.600**
Government	317.600
Total	**417.600**

Currency of ADB Financing: US Dollar

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on a proposed results-based loan (RBL) to the Islamic Republic of Pakistan for the Khyber Pakhtunkhwa Health Systems Strengthening Program.

2. The proposed RBL program supports the Revamping Secondary Health Care (RSHC)[1] program, a flagship and province-wide program of the Government of Khyber Pakhtunkhwa to improve secondary health care (SHC) services.[2] The RBL program aims to enhance the quality of SHC services in Khyber Pakhtunkhwa Province (KPK) by (i) ensuring the availability and implementation of clinical protocols, standards, and guidelines at secondary hospitals; (ii) modernizing hospital infrastructure and medical equipment; (iii) reinforcing the planning of human resources and health services; (iv) upgrading the management of the medicine supply chain; and (v) improving the efficacy of service delivery.[3]

II. THE PROGRAM

A. Strategic Context

3. **Overview**. Pakistan is a lower middle-income country with a per capita income (market prices) of $1,798 in 2022.[4] The coronavirus disease (COVID-19) adversely impacted the economy in 2020, prompting a revision of the gross domestic product (GDP) forecast from a pre-COVID-19 growth projection of 2.6% to a contraction of 0.9% in fiscal year (FY) 2020. For FY2021 and FY2022, GDP growth was estimated at respectively 5.74% and 5.97%. The GDP growth for FY2023 is forecast to be 3.5% due to impact of global supply chain disruptions and spillovers from the Russian invasion of Ukraine.[5]

4. KPK lies in northwestern Pakistan and had an estimated population of 35.5 million in 2017,[6] projected to have grown to 38.5 million in 2021.[7] It includes the former Federally Administered Tribal Areas, which were merged with KPK in 2018 and are denoted as the "merged districts," as opposed to the "settled districts." As in the rest of Pakistan, COVID-19 disrupted essential health services in KPK—e.g., immunizations, maternal and child health services, and treatment of noncommunicable diseases—particularly in the first half of 2020.[8] Pakistan, including parts of KPK, have experienced devastating floods in August 2022. The full extent of the damage in terms of loss of lives, housing, livestock, agriculture and infrastructure—including KPK's health

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[1] The program's full name in government documents is "Revamping of Non-Teaching District Head Quarter Hospitals in Khyber Pakhtunkhwa."

[2] Government of Khyber Pakhtunkhwa, Department of Health (DOH). 2022. *Project Concept Form for Revamping of Non-Teaching DHQ Hospitals in KP and Associated Results-Based Lending (RBL) from the Asian Development Bank*. Peshawar.

[3] The transaction technical assistance (TA) was approved on 5 October 2021. Asian Development Bank (ADB). 2021. *Technical Assistance to the Islamic Republic of Pakistan for Preparing the Khyber Pakhtunkhwa Health Systems Strengthening Program*. Manila.

[4] Pakistan Bureau of Statistics, National Accounts Tables Base 2015-16, Table 4, Accessed 16 August 2022.

[5] ADB. 2022. *Asian Development Outlook Update.* September. Manila. Negative spillovers include soaring inflation, widening current account deficit, declining foreign exchange reserves, rapid currency depreciation, widening fiscal deficit, and rising food insecurity and poverty. Moreover, downward revisions in Pakistan's credit ratings and lower market conditions have led to limited access to financial markets.

[6] Preliminary results from the 2017 census.

[7] Estimation by applying population growth rates for Pakistan for 2017 to 2021 from World Bank's Open data.

[8] Gavi, the Vaccine Alliance. 2020. *Gavi-COVID-19 -Situation -Report #-14*. Islamabad (28 July).

infrastructure—is yet unknown.[9] Early completion of the refurbishing of hospitals and health system strengthening may help take care of physically injured people and control the risk of infectious diseases spreading after flooding.

5. **Health**. In 2018, Pakistan ranked 154th out of 195 countries in terms of overall health system performance.[10] Health care had been devolved to the provinces in 2010, under the 18th Amendment of the Constitution, making the provinces responsible for health service delivery. The Khyber Pakhtunkhwa Health Sector Strategy 2010–2017[11] and the National Health Vision 2016–2025[12] inform the Khyber Pakhtunkhwa Health Policy 2018–2025,[13] which contains the goal of the Department of Health of Khyber Pakhtunkhwa (DOH) to strengthen the health system and provide quality health care services that are accessible, efficient, and equitable, especially for the poor and vulnerable. The health policy stresses the execution of a minimum health service delivery package at primary and secondary health facilities, prioritizes women's health, and focuses on renovating existing hospitals. The total budget of the provincial government for FY2022 was PRs1,118 billion, while the budget of the DOH was PRs142 billion, which is 12.7% of the total budget and shows the commitment to improve the health sector. Nonetheless, the health sector has been underinvested and health infrastructure is extremely limited. In 2020, the number of sanctioned beds in KPK was 0.54 per 1,000 inhabitants.[14]

6. KPK is facing tremendous challenges in the health sector. Its health outcomes need significant improvement to achieve the Sustainable Development Goals. The neonatal mortality rate is 41 per 1,000 live births, the infant mortality rate is 53 per 1,000 live births,[15] and the maternal mortality ratio is 165 per 100,000 live births.[16] The health indicators are worse in the merged districts (e.g., maternal mortality ratio of 261 per 100,000 live births in 2014).[17] Because of the lack of access to quality primary health care (PHC) and SHC services, people tend to bypass them and seek treatment directly at tertiary care hospitals. This overburdens tertiary services and limits the resources for those who really need them, and is costly both for the government and for the patients, who usually have to travel far.[18]

7. Clear guidance and rules for the medical and operational processes in the facilities are absent. The processes for clinical and managerial activities are not standardized, and quality

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[9] Pakistan 2022 Floods Response Plan: 01 Sep 2022 - 28 Feb 2023 (Issued 30 Aug 2022) - Pakistan | ReliefWeb. Accessed 30 August 2022.

[10] N. Fullman et al. 2018. Measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from the Global Burden of Disease Study 2016. *The Lancet.* Vol. 391(10136), pp. 2236–2271.

[11] DOH. 2010. *Khyber Pakhtunkhwa Health Sector Strategy 2010–2017*. Peshawar.

[12] Government of Pakistan. Ministry of National Health Services, Regulations and Coordination. 2016. *National Health Vision 2016–2025*. Islamabad.

[13] Government of Khyber Pakhtunkhwa, Department of Health of Khyber Pakhtunkhwa (DOH). 2018. *Khyber Pakhtunkhwa Health Policy (2018–2025)*. Peshawar.

[14] DOH. 2020. *PC-I for Revamping of Non-Teaching DHQ Hospitals in Khyber Pakhtunkhwa. ADP No. 2020-21: 200049*. Peshawar. The number of sanctioned beds is the statutory norm, but some hospitals have more, and others have fewer beds. In general, the number of sanctioned beds can be considered as an upper limit to the total number of hospitals beds in KPK, noting that the private sector barely offers inpatient services. While no global norm exists for the density of hospital beds in relation to the total population, it ranges from 1.0 per 1,000 inhabitants (Mexico) to 13.0 (Japan) and averages 5.0 in the member countries of the Organisation for Economic Co-operation and Development (OECD). The average for low and middle income countries is 0.8. Source: World Bank Open Data.

[15] National Institute of Population Studies. 2019. *Pakistan Demographic and Health Survey (2017–18).* Islamabad.

[16] National Institute of Population Studies. 2020. *Pakistan Maternal Mortality Survey 2019*. Islamabad. In comparison, the average infant mortality rate for OECD member countries is 3.1 per 1,000 live births and the average maternal mortality ratio is 6.3 per 100,000 live births. Source: World Bank Open Data.

[17] DOH. 2020. *Health Reform Blueprint – Discussion document*. Peshawar.

[18] ADB. 2019. *Khyber Pakhtunkhwa Health Sector Review – Hospital Care.* Manila.

assurance measures, clinical protocols, and clinical pathways or patient flow guidelines are often unavailable. Clinical cases are not formally reviewed. There is no external quality management benchmarking with hospitals of the same level. The infrastructure of many SHC facilities is inappropriate and often outdated: standard requirements for adequate spaces are not met; infection control is limited; services that should be interlinked and adjacent to each other are far apart; basic installations for utility services are inadequate, as is solid waste management; and hospitals are either too big or too small for the number of patients they receive, especially in the outpatient departments. Equipment has been neglected for many years, is often dysfunctional, and no longer guarantees patient and staff safety. Access to, and affordability of, essential medicines is low, both in PHC and SHC facilities.[19]

8. KPK is facing a shortage of health workers, having only 1.15 per 1,000 inhabitants, compared with 4.45 per 1,000 recommended by the World Health Organization (WHO).[20] Also, the development and deployment of human resources has been tilted toward doctors, neglecting others such as nurses.[21] KPK has only about 0.5 nurses and/or midwives per doctor, while the WHO recommendation is for 2.0 nurses and/or midwives per doctor (footnote 20). Other pressing issues in human resources for health (HRH) include poor distribution of human resources, [22] low retention rates, and low workplace satisfaction. Appointment is often based on seniority rather than merit; it is extremely difficult to attract staff to the remote districts; and staff absenteeism remains an issue. While the digitalization of human resources data is ongoing, much is still paper-based, and hospitals' information systems are not interlinked. In tackling these issues, the DOH has had some success with the contracting of clinical services (e.g., imaging, laboratory), nonclinical services (e.g., cleaning, catering, security, maintenance), and outsourcing of health facilities.[23] However, this is still relatively new, and more is needed. Also, hospitals should have greater financial autonomy in deciding how to use own revenues.[24]

9. While it is reported that about 65% of all medical students are female, they are underrepresented in the health workforce.[25] In 2015 in KPK, of general doctors registered with the Pakistan Medical and Dental Council, only 33.3% were women, and the proportion of female specialists was even lower at 21.8%. Of the nurses, however, only 5.2% were male. This gender imbalance is likely affecting access to the health care system—it was estimated in 2010 that about 30% of women and children were unable to gain access to health care because of socioeconomic and cultural barriers (footnote 11). The patriarchal mindset of society, workplace harassment, and hospitals' lack of basic facilities for working mothers are among the reported causes.[26]

10. SHC remains a neglected link in health care in KPK, receiving limited external support. While multiple development partners have long been active in PHC, most PHC facilities have no quality hospitals within easy reach to which they can refer their patients. SHC hospitals are the

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[19] World Bank. 2020. *Khyber Pakhtunkhwa Human Capital Investment Project*. Washington, DC.
[20] WHO. 2016. *Global strategy on human resources for health: Workforce 2030*. Geneva.
[21] DOH. 2020. *PC-I for Revamping of Non-Teaching DHQ Hospitals in Khyber Pakhtunkhwa. ADP No. 2020-21: 200049*. Peshawar.
[22] Whereas the term "human resources" includes management and hospital support staff such as cleaners and guards, "human resources for health (HRH)" is used to designate medical, paramedical, and technical staff.
[23] Public Private Partnership for Health – MERF (merf-pakistan.org).
[24] The level of autonomy a health care provider has affects how the provider can optimally adjust its mix of services to demand trends and to incentives from health care purchasers such as health insurers. WHO. 2017. *Aligning public financial management and health financing: sustaining progress toward universal health coverage*. Geneva.
[25] A.M. Hashmi et al. 2013. Gender discrimination among medical students in Pakistan: a cross-sectional survey. *Pakistan Journal of Medical Sciences.* Vol. 29(2):449. doi:10.12669/pjms.292.3256.
[26] Y. Iqbal, W. Khan, and M. Mooghal. 2022. Impediment to Leadership Opportunities for Female Doctors – Gender Disparity in Pakistani Healthcare System – Short report. *Advances in Medical Education and Practice.* pp. 213–215.

first place of referral and often the only nearby option for life-saving procedures, especially in rural areas. Therefore, improvements in SHC will have a significant impact on the health outcomes of KPK, yielding high returns such as reduced maternal and child mortality. Focused funding and support are needed to overcome the present shortcomings. Investing in SHC will also allow the Social Health Protection Initiative, commonly referred to as the Sehat Sahulat Program (SSP), to purchase quality health and hospital services for its members, while saving on expenses for costlier tertiary care services. KPK's health sector assessment provides more details.[27]

B. Program Rationale

11. **Revamping Secondary Health Care Program**. The provincial government, cognizant of the challenges, made improving the quality of PHC and SHC service delivery a central tenet of its health strategy (footnote 13). Quality of care concerns not only quality medical equipment and infrastructure, hygiene, maintenance, and availability of medicines, but also qualified and well-trained medical and support staff who all collaborate in an organized, conducive, accountable, evidence-based, and optimal manner. Stakeholders include the DOH; hospital managers; medical, technical, and support staff; medical associations; health insurances; and patients. The RSHC program aims to transform SHC by (i) upgrading the infrastructure of 33 SHC facilities; (ii) providing quality new equipment; (iii) ensuring posting and availability of medical, technical, and administrative staff; (iv) efficiently outsourcing certain services to the private sector;[28] (v) introducing and enhancing health management information systems, including electronic medical records; and (vi) introducing quality assurance regimes (footnote 2). The Minimum Health Services Delivery Package for Secondary Care Khyber Pakhtunkhwa will be implemented.[29]

12. **Alignment with ADB strategic priorities**. The RBL program is aligned with Strategy 2030 of the Asian Development Bank (ADB) and five of its seven operational priorities: operational priority 1—help developing member countries achieve universal health coverage (UHC) through improved quality and coverage of health care services; operational priority 2—improve women's access to infrastructure and services, and notably improve quality and access to women's and girls' health services; operational priority 3—boost resilience to climate change and disasters; operational priority 5—increase rural investment; and operational priority 6—strengthen governance and institutional capacity.[30] It is also aligned with ADB's country partnership strategy for Pakistan, 2021–2025, which emphasizes the crucial role of health in building resilience, and of strengthening human capital and social protection to enhance productivity and people's well-being.[31]

13. **Development partner coordination.** While other development partners—such as the World Bank; the United Kingdom's Foreign, Commonwealth & Development Office; WHO; Japan International Cooperation Agency (JICA); and the United States Agency for International Development[32]—focus on PHC, the RBL program will focus on SHC. It was designed in close coordination with the development partners to prevent duplications while promoting complementarity and collaboration. For instance, the disbursement-linked indicators (DLIs) of the

[27] Sector Assessment (Summary): Health (accessible from the list of linked documents in Appendix 2).
[28] Currently, for some of the hospitals, security and janitorial services and diagnostic and laboratory services were outsourced to the private sector. The DOH plans to do this for more hospitals. Even the outsourcing of complete hospitals is anticipated in outlying regions where the government has difficulty placing staff.
[29] DOH. 2019. *Minimum Health Services Delivery Package for Secondary Care Khyber Pakhtunkhwa.* Peshawar.
[30] ADB. 2018. *Strategy 2030: Achieving a Prosperous, Inclusive, Resilient, and Sustainable Asia and the Pacific.* Manila.
[31] ADB. 2020. *Country Partnership Strategy: Pakistan, 2021–2025—Lifting Growth, Building Resilience, Increasing Competitiveness*. Manila.
[32] United States Agency for International Development. Health (accessed 24 May 2022).

World Bank's program-for-results (PforR) financing for the Spending Effectively for Enhanced Development program target PHC.[33] Activities and goals relating to quality assurance and training of HRH are also coordinated (footnote 22), for instance with the Foreign, Commonwealth & Development Office, JICA, and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ). During implementation, ADB will have regular coordination meetings, at least twice a year, with partners such as the World Bank regarding its PforR activities, German development cooperation through KfW regarding its support to the SSP, and JICA regarding collaboration on HRH training and the referral system.

14. **Lessons**. The RBL program builds on (i) previous ADB health assistance in Pakistan since the 1980s, (ii) the assessment by ADB of KPK's health sector in 2017–2018 (footnote 18), and (iii) ADB's institutional experience and expertise in hospital reforms for quality improvement and health system development,[34] and is in response to a gap in development partner support for health system strengthening. Program processing should be in sync with the government budget planning cycle to ensure sustained government ownership,[35] which remains key to the success of ADB operations. ADB's experience with RBL shows that clear demarcation with the World Bank DLIs is required.[36] For hospital design, a comprehensive approach is key, taking into account international best practices, also when upgrading existing health infrastructure.[37] The World Bank notes that PforR is the most suitable financing modality to reinforce strong government ownership and results orientation, to sustain the implementation momentum (footnote 33), and to support the provincial government's push for UHC and associated reforms.[38]

15. **The results-based lending modality**. RBL is the most suitable modality to invest in measurable improvements in quality of care, an intricate ensemble of interacting components and multiple stakeholders.[39] Operational impact will be realized through ambitious but practical DLIs representing the multiple dimensions of quality of care and patient-centered care, which will motivate the government to achieve targets and ensure accountability for results, and in turn leads to a lasting impact of the gains in quality of care. The DOH has a proven record with the World Bank's PforR operations in PHC, and the government has shown strong ownership of its RSHC program in SHC. A well-established monitoring system is already in place for PHC and SHC through the independent monitoring unit (IMU) under the DOH. The RBL DLIs allow for further strengthening of the DOH's fiduciary management and financial management, while avoiding the creation of parallel systems.

C. Program Scope

16. The RBL program will support the government's RSHC agenda from fiscal year 2023 to fiscal year 2026: (i) enhanced coverage of and access to essential health services, especially for the poor and vulnerable; (ii) improved management of human resources; and (iii) improved

[33] World Bank. 2021. *Khyber Pakhtunkhwa – Spending Effectively for Enhanced Development*. Washington, DC.
[34] For example, ADB. 2017. Armenia: Social Sectors Reform Program. Manila; and ADB. 2020. Lao People's Democratic Republic: Improving the Quality of Health Care Project. Manila.
[35] ADB. 2021. *Completion Report: Preparing Health Sector Assessment in Pakistan*. Manila.
[36] ADB. Pakistan: Integrated Social Protection Development Program. Manila.
[37] ADB. 2011. Mongolia: Fifth Health Sector Development Project. Manila.
[38] World Bank. 2020. *Khyber Pakhtunkhwa Human Capital Investment Project*. Washington, DC; and World Bank. 2022. *National Health Support Program*. Washington, DC.
[39] In contrast, investment project financing is more appropriate for investment requirements, such as investments in infrastructure and equipment, while policy-based lending and sector development programs focus on policy reforms.

governance, regulation, and accountability (footnote 21). The difference between the broader government program and the RBL program is summarized in Table 1.[40]

Table 1: Program Scope

Item	Broader Government Program	Results-Based Lending Program
Outcome	1. Enhanced coverage of and access to essential health services, especially for the poor and vulnerable 2. Measurable reduction in the burden of disease, especially among vulnerable segments of the population 3. Improved human resource management 4. Improved governance, regulation, and accountability	Quality of care of secondary hospital services in Khyber Pakhtunkhwa enhanced
Key outputs	1. Infrastructure of secondary health care facilities is improved 2. Human resources are strengthened 3. Hospital equipment is upgraded 4. Hospital management information system is introduced 5. Services are contracted to the private sector 6. Services are standardized, and hospitals are accredited 7. Selected clinical services are subsidized	1. Clinical protocols, standards, and guidelines available and implemented at secondary hospitals 2. Hospital infrastructure and medical equipment modernized 3. Planning of human resources and health services reinforced 4. Management of medicine supply chain upgraded 5. Effectiveness of service delivery improved
Activity types	Revamping of infrastructure, upgrading of medical equipment, expansion of human resources, improving pharmaceutical supply chain, standardization of hospital protocols throughout the province, enhancing health management information system	Infrastructure upgraded according to international standards; medical equipment modernized and functional; training on gender-based violence provided, and counseling desks for reproductive health and mental health available; clinical pathways developed and implemented; quality committees established and operational; systems for procurement, financial management, and governance improved
Program expenditure	Estimated at PRs93.7 billion ($417.6 million)	Same
Main financiers and the respective financing amounts	Government of Khyber Pakhtunkhwa: PRs66.3 billion ($295.3 million) Government of Pakistan: PRs5.0 billion ($22.4 million) Asian Development Bank: $100 million	Same
Geographic coverage	Khyber Pakhtunkhwa Province	Khyber Pakhtunkhwa Province
Implementation period	Fiscal year (FY) 2022 to FY2026	FY2023–FY2026

Sources: Asian Development Bank; and Government of Khyber Pakhtunkhwa, Department of Health.

D. Program Results

17. The RBL program's impact will be accessible, equitable, and quality health care for all people of KPK to advance the community's well-being, productivity, and prosperity (footnote 13). The outcome will be: quality of care of secondary hospital services in KPK enhanced. The beneficiaries will be the estimated catchment population of 38.5 million (footnotes 6 and 7), and specifically those referred from PHC facilities to secondary hospitals, patients in need of

[40] The RBL program excludes high-value procurement contracts and any activities with major environmental or involuntary resettlement impacts categorized as A under ADB's Safeguard Policy Statement (2009). Also, ADB will not finance activities included in its Prohibited Investment Activities List as per the Safeguard Policy Statement.

emergency care, and women delivering in a hospital. Women will directly benefit from maternal and women's health services, and from jobs generated (such as nursing jobs). At the outcome level, two DLIs and one other indicator are used to track the achievement of results. DLI1 measures the improvement of SHC hospital services through the increase of (i) outpatient contacts and (ii) inpatient admissions. DLI2 tracks maternal care improvement (through the number of deliveries with skilled birth attendants).[41] The other indicator tracks the maternal mortality ratio.[42] The five outputs are described in paras. 18–22, and more details can be found in the design and monitoring framework.[43]

18. **Output 1: Clinical protocols, standards, and guidelines available and implemented at secondary hospitals**. This output concerns the quality of care relating to medical and operational practices. Medical processes will be improved by rolling out the government's program of standardized clinical protocols, and gender-sensitive clinical pathways will be developed and implemented.[44] Hospital-based quality committees—which discuss, analyze, and propose recommendations on health operational topics such as hospital hygiene and performed medical procedures—will be established and operationalized. As a measure of quality of care, the surgical site infection rate for selected interventions will be monitored.[45] DLI3, stipulating annual quality reports for gender-sensitive monitoring, feedback, and review mechanisms for key performance and quality indicators, can be seen as a composite indicator that tracks the various indicators under output 1.

19. **Output 2: Hospital infrastructure and medical equipment modernized**. The output supports the government's drive to use international best practices when upgrading the infrastructure and modernizing the equipment, especially for obstetrics so as to improve the maternal mortality ratio.[46] DLI4 is based on a carefully weighed checklist of ambitious but practical sub-indicators. DLI5 also brings best international practices to the management of equipment by requiring the essential equipment of key departments to be tagged, registered, and functioning, thereby improving their durability and the sustainability of the broader government program. Energy-efficient renovations and equipment will also be explored (para. 29), because Pakistan suffers power cuts and regularly applies loadshedding, and hospitals often use diesel-fueled generators for backup power supply.

20. **Output 3: Planning of human resources and health services reinforced**. The output supports the DOH's aim to reinforce, modernize, and reform the management of human resources in the health sector. The digitalization and operationalization of a human resources management information system is included as a performance indicator. To support the DOH's goal of

[41] Skilled birth attendance can help prevent maternal and neonatal deaths, and is part of Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all at all ages. Target 3.1 specifies that by 2030, the global maternal mortality ratio should be less than 70 deaths per 100,000 live births. There are two sub-indicators—3.1.1: Maternal mortality ratio; and 3.1.2: Proportion of births attended by skilled health personnel.

[42] The maternal mortality ratio, while an indicator of the overall quality of care of the health system, also depends on issues outside the scope of the program—e.g., nutrition and the security situation—and is difficult to estimate. It is therefore not linked to disbursement.

[43] The design and monitoring framework is in Appendix 1.

[44] Gender-sensitive clinical pathways refer to the protocols within the hospitals for treating patients clinically but also humanly. These patient-centered protocols also take into consideration women's rights and privacy. For example, the pathway will prescribe that consent must be clearly communicated and women's autonomy must be respected, and it should recommend that female staff provide services to female patients.

[45] To prevent the indicator resulting in a perverse incentive, where medical providers admit only low-risk patients—even if the patients should be treated at their level of care—the three selected tracer diagnoses or procedures represent primarily sterile interventions, where wound contamination can only be caused by the surgeon and/or other health workers involved and/or the instruments or linen used.

[46] Within the investment budget for the RSHC, civil works account for 42% and equipment for 33%.

reforming the use of human resources, one indicator concerns legal provisions for facility-specific contractual hiring of medical staff, while a second indicator is included for the internal recruitment of qualified health managers, promoting merit-based rather than seniority-based posting of hospital managers. DLI6 tracks the on-site availability in SHC program hospitals of qualified and gender-balanced HRH. DLI7 considers gender aspects under this output, such as training on gender-based violence and on the Protection Against Harassment of Women at Workplace Act 2010, the establishment of inquiry committees to investigate harassment complaints, and of counseling desks for reproductive health and mental health.

21. **Output 4: Management of medicine supply chain upgraded**. An indicator will monitor the refurbishing of hospital pharmacies and their equipping with information and communication technology and software. To ensure that the upgrades lead to tangible results for the patients, DLI8 will track the availability of essential medicines, vaccines, and supplies with a 1-month stock buffer. Another indicator will ensure that the procurement of medicines and consumables is compliant with the national competitive bidding regulations and procedures.

22. **Output 5: Effectiveness of service delivery improved**. This output supports the provincial government and the DOH in reforming hospital service management and increasing private sector engagement. DLI8, on active contracting of service providers, will track service contracts for clinical and nonclinical services. Non-disbursement-related indicators will monitor hospitals' financial autonomy, such as (i) greater autonomy to use its own revenues, and (ii) that by 2025, the hospital-generated revenues represent at least 25% of a hospital's total budget. DLI9, on fiduciary and financial management, concerns (i) the operationalization of the project management and implementation unit (PMIU) through the hiring of dedicated staff, (ii) updating and publishing of project procurement plans on the website of Khyber Pakhtunkhwa Public Procurement Regulatory Authority, and (iii) timely submission of financial and audit reports.

23. The DLIs and their disbursement allocations are summarized in Table 2. In a collaborative and iterative process with the DOH and the provincial government, ADB financing allocations considered the importance of each component to the outcome, i.e., quality of care improvement in SHC hospitals, and incentives for reforming medical practices and management—some of which may not have an intrinsic financial value. DLIs and the performance indicators provide ambitious yet achievable measures of progress toward outputs and outcome.

Table 2: Disbursement-Linked Indicators

Indicator [a]	**Disbursement Allocated** ($ million)	**Share of Total ADB Financing** (%)
Outcome: Quality of care of secondary hospital services in Khyber Pakhtunkhwa enhanced		
DLI 1: SHC hospital services improved	10.0	10.0
DLI 2: Maternal care ameliorated	5.0	5.0
Output 1: Clinical protocols, standards, and guidelines available and implemented at secondary hospitals		
DLI 3: Gender-sensitive quality assurance mechanisms established	15.0	15.0
Output 2: Hospital infrastructure and medical equipment modernized		
DLI 4: Infrastructure of SHC hospitals upgraded	15.0	15.0
DLI 5: Essential equipment tagged, registered, and functioning	10.0	10.0
Output 3: Planning of human resources and health services reinforced		
DLI 6: Qualified, gender-balanced human resources available	15.0	15.0
DLI 7: Gender issues adequately considered	10.0	10.0
Output 4: Management of medicine supply chain upgraded		
DLI 8: Essential medicines, vaccines, and supplies available	10.0	10.0
Output 5: Effectiveness of service delivery improved		
DLI 9: Contracting of clinical and nonclinical service providers	5.0	5.0
DLI 10: Fiduciary and financial management improved	5.0	5.0

Indicator [a]	Disbursement Allocated ($ million)	Share of Total ADB Financing (%)
Total	**100.0**	**100.0**

ADB = Asian Development Bank, DLI = disbursement-linked indicator, SHC = secondary health care.
[a] Full formulation is given in the design and monitoring framework.
Sources: ADB; and Government of Khyber Pakhtunkhwa, Department of Health.

24. The Auditor General of Pakistan (AGP) of the Government of Pakistan will be engaged as the independent verification agency (IVA) to verify RBL program results. The AGP, a well-respected and independent organization, is also the IVA for the Spending Effectively for Enhanced Development program, the World Bank's PforR operations in Khyber Pakhtunkhwa. The capacity of the AGP was strengthened through past ADB technical assistance (TA). The IMU will support the AGP in collecting the periodical and continuous data on the DLIs and other performance indicators, as described in Appendix 3, and will adapt its reporting tools accordingly. Although reporting to the Secretary of Health of the DOH, the IMU has the independent role of regularly evaluating the performance of the public health care facilities in KPK. The AGP will remain responsible for verifying the results, and may, to that end, hire expertise funded by the DOH. A memorandum of understanding between the DOH and the AGP will be formally signed following the approval of the RBL program. The AGP will also execute the financial audit of the RSHC program as per its constitutional role.

E. Value Added by ADB

25. ADB's participation through RBL will increase the impact of, and help sustain, the health reforms and quality-of-care gains started by the provincial government. The focus on quality of care, including infection prevention control in hospital care, will strengthen the resilience of the health system to future pandemics. ADB's RBL program and DLIs in SHC are complementary to the World Bank's PforR operations and DLIs in PHC, resulting in synergy that is further strengthened through collaboration with other development partners active in KPK. ADB's financing will allow the provincial government to focus on gender equity. ADB's contribution will also expand the involvement of the private sector in health care through contracting out the clinical and non-clinical services at the SHC hospitals.

F. Expenditure Framework and Financing Plan

26. **Program expenditures.** To implement the RSHC, the DOH has an investment estimated at PRs16.8 billion, while the recurrent budget for 33 hospitals under the RSHC is estimated at PRs76.9 billion, bringing the total estimated RSHC budget to PRs93.7 billion ($417.6 million). The government is committed to implementing the RSHC in FY2022–FY2026, and the program expenditures are estimated to be PRs93.7 billion (Table 3). The broad budget line items in the RBL program expenditure framework are recurrent expenditure and capital expenditure.

Table 3: Summary of Program Expenditure Framework, FY2022–FY2026
(in 2022 prices)

Item	Amount (PRs billion)	Amount ($ million)	Share of Total (%)
1. Civil works	7.0	33.1	7.4
2. Equipment	5.6	24.8	5.9
3. ICT and HMIS	0.4	1.7	0.4
4. Additional human resources	1.0	4.3	1.0
5. Outsourced, private sector-provided services	2.0	8.9	2.1

6. Capacity building, training, ISO certification	0.5	2.2	0.5
7. Subsidy for services	0.1	0.2	0.1
8. Project management and implementation unit	0.2	1.0	0.2
9. Contingencies	0.2	0.7	0.2
10. Recurrent budget (salaries, operations, medicines)	76.9	342.7	82.1
Total	**93.7**	**417.6**	**100.0**

ICT = information and communication technology, ISO = International Organization for Standardization, HMIS = health management information system.
Note: Numbers may not sum precisely because of rounding.
Sources: Asian Development Bank; and Government of Khyber Pakhtunkhwa, Department of Health.

27. **Program financing.** The government has requested a concessional loan of $100 million from ADB's ordinary capital resources to help finance the RSHC program. The loan will have a 25-year term, including a grace period of 5 years; an interest rate of 2.0% per year during the grace period and thereafter; and such other terms and conditions set forth in the draft loan and program agreements. The financing plan is summarized in Table 4.

Table 4: Program Financing Plan

Source	**Amount** ($ million)	**Share of Total** (%)
Government of Khyber Pakhtunkhwa	295.3	70.7
Government of Pakistan	22.4	5.4
Development partners		
Asian Development Bank		
Ordinary capital resources (concessional loan)	100.0	23.9
Total	**417.6**	**100.0**

Note: Numbers may not sum precisely because of rounding.
Sources: Asian Development Bank; and Government of Khyber Pakhtunkhwa, Department of Health.

28. The main source of financing will be the provincial government with 70.7%, while the federal government will finance 5.4% and ADB 23.9% of the total RSHC cost. Advance financing is proposed to be 25% of the loan amount, i.e., $25 million, to support some of the government program's initial investment costs, civil works ($33.1 million), equipment ($24.8 million), and medicines.

29. Climate change mitigation finance is estimated to cost $5.3 million, of which ADB will finance 100%. This is expected to comprise improved energy efficiency from upgraded hospital infrastructure and equipment under DLI4 and 5.[47] Although the RSHC mentions that backup solar energy and battery storage will be explored to ensure the continuous supply of electricity, no specific amount was reserved for these systems. None of the DLIs financed by ADB under the RBL program will involve procurement of solar photovoltaic equipment. During the RBL program's implementation, greenhouse gas reduction will be estimated and further climate change mitigation measures will be explored.

G. Capacity Development and Program Action Plan

30. The TA[48] will help establish the baseline values for the DLIs and other performance indicators, review medical waste practices, and elaborate the clinical pathways. Workshops on hospital design and equipment planning will be organized. Funding for a separate TA to support the government during RBL program implementation will be sought from the Japan Fund for Prosperous and Resilient Asia and the Pacific. The TA will further analyze what causes the

[47] Climate Change Assessment (accessible from the list of linked documents in Appendix 2).
[48] ADB. 2021. *Technical Assistance to the Islamic Republic of Pakistan for Preparing the Khyber Pakhtunkhwa Health Systems Strengthening Program*. Manila.

shortages of female medical staff and present possible solutions. ADB will provide training to DOH staff on ADB's loan disbursement procedures, including the Client Portal for Disbursement, and on financial reporting and auditing. Training on legal aspects and the code of conduct will be provided to inquiry committee members and other hospital staff. Training on public–private partnerships can be provided to DOH staff.

H. Implementation Arrangements

31. The DOH will be the executing agency for the RSHC, and the PMIU under the DOH will be the implementing agency.[49] The Infrastructure Development Authority of the Punjab, an autonomous agency under the Government of Punjab, was contracted for the infrastructural design of all RSHC program hospitals, and will be responsible for the civil works of the SHC hospitals under phases 1 and 2. The civil works for the hospitals under phases 3 and 4 will be the responsibility of the Communication and Works Department, which will bid out the civil works. The DOH will establish a RSHC program steering and coordinating committee chaired by the health secretary to provide overall guidance on program implementation. The implementation will take place from September 2022 to 30 June 2026. An independent verification arrangement system will be set up with the AGP as the IVA to verify RBL program results before disbursement is made by ADB. PMIU staff will be involved in implementing other development partners' activities and will be coordinating the inputs and outputs of various programs.

32. **Disbursement arrangements.** The loan proceeds will be disbursed in accordance with ADB's *Loan Disbursement Handbook* (2017, as amended from time to time). The DOH will submit a withdrawal application reporting on the achievement of DLIs and on compliance with other requirements, and disbursement will be made subject to verification by the IVA according to the verification protocols (Appendix 3, Table A3.3). Except for DLI9, disbursements will be made as specified in the verification protocols for early or late achievement. Disbursement of advance financing of up to 25% will be immediate upon effectiveness. The government will refund any advance financing amount outstanding within 6 months of RBL program completion, if the DLIs are not achieved on or before RBL program completion. The loan proceeds will be disbursed to the government's general account.

III. SUMMARY OF ASSESSMENTS

A. Program Technical Assessments

33. **Program soundness and results assessment.** Where the RSHC program is delivering the necessary improvements in infrastructure, equipment, numbers of staff, and the health system as a whole, the RBL program reinforces the structural improvements that are unlocked by these achievements. Quality of care depends on various components, including well-designed and maintained infrastructure, functional equipment, adherence to clinical pathways,[50] adequate and gender-appropriate HRH presence on site, and availability of medicines. The RBL program, by focusing on these parts, will improve the overall quality of care. Its design and implementation arrangements are sound, the results framework is well designed, the DLIs are a selection of critical indicators for achieving overall RBL program results, the monitoring and evaluation system is fully fit for the purpose, and the expenditure framework and financing plan are robust.

[49] Program Implementation Document (accessible from the list of documents in Appendix 2).

[50] The effectiveness of clinical pathways in improving the quality of care, and their efficiency in reducing length of stay and costs, has been proven in many scientific publications, e.g., Health Policy Series No. 53 of the European Observatory on Health Systems and Policies.

34. **Economic analysis.** This has been carried out in accordance with ADB's Guidelines for the Economic Analysis of Projects.[51] Through the quality improvements under the RBL program, patients will benefit from faster recovery, which reduces suffering and enables a faster return to work, and sustain less damage from less effective treatments. Better hospital facilities—e.g., more space, better hygiene practices, and functioning equipment—can prevent additional morbidity and reduce hospital infections and complications. The economic benefits are estimated in terms of a reduction in disability-adjusted life years for KPK, [52] multiplied by the per capita income over a period of 10 years. Based on this assumption, the project is expected to contribute to averting the productivity loss due to concerned health conditions by $734.5 million in present value. [53]

35. **Gender.** The RBL program is categorized as *effective gender mainstreaming*. At the outcome level, the RBL program includes (i) a DLI that supports safe child delivery in a hospital setting by increasing the number of deliveries by skilled birth attendants, and (ii) a performance indicator tracking the maternal mortality ratio in KPK. The program includes the implementation of, and adherence to, gender-sensitive clinical protocols and pathways for maternal care, gynecology and obstetrics, and other specialties, thus ensuring safe, patient-centered, and respectful health care (footnote 44). The RBL program will increase the number and percentage of trained women in nursing, and the number of medical staff and health technicians; and improve the gender-responsiveness of hospital infrastructure. The DLIs and performance indicators also ensure a focus on medical equipment for the obstetrics departments of hospitals. Finally, the RBL will ensure the training of staff on gender-based violence, gender-sensitive clinical protocols and pathways, the function of counseling desks for reproductive and mental health, and the role of inquiry committees in protecting women against harassment in the workplace. Six out of 10 DLIs promote women's empowerment.

36. **Poverty and social.** According to the Multidimensional Poverty Index, educational deprivation is the largest contributor to multidimensional poverty in Pakistan, followed by deprivation in living standards and health.[54] In 2018, 21.9% of Pakistan's population was living below the poverty line, while 3.6% lived below the international poverty line (i.e., below $1.90 purchasing power parity a day).[55] As per 2015 data, an additional 19.9% are vulnerable to slipping into poverty as a result of any shock. Chronic poverty leads to a lesser likelihood of seeking health care, while those who are transient poor—moving from below the poverty line to above and back—are likely to spend a larger share of their marginal income on health care than those who are never poor.[56] Since the RBL program is province-wide and many of the health services are covered by the SSP, the primary beneficiaries will be the lower-income groups, women, children, and other vulnerable groups in the population.

B. Program Systems Assessments

37. **Monitoring and evaluation system.** A well-established system for monitoring PHC and SHC is already in place through the IMU.[57] The IMU collects PHC and SHC data and submits periodical reports to the Secretary of Health. The data collection takes place at the health facilities through both announced and unannounced visits by IMU staff. The IMU has established a fierce

[51] ADB. 2017. Guidelines for the Economic Analysis of Projects. Manila.
[52] Institute of Health Metrics and Evaluation. 2019. Global Burden of Disease. Seattle.
[53] Program Soundness Assessment (accessible from the list of linked documents in Appendix 2).
[54] United Nations Development Programme. 2016. *Multidimensional Poverty in Pakistan*. Islamabad.
[55] ADB. 2022. *Basic Statistics, Asia and the Pacific (May 2022)*. Manila.
[56] A. Aftab et al. Examining the Impact of Chronic Poverty on Health Seeking Behavior for Children. Unpublished.
[57] Program Monitoring and Evaluation System Assessment (accessible from the list of linked documents in Appendix 2).

reputation for being independent of both the health care providers and the DOH, and being able to provide objective reports, including hard conclusions. However, since the IMU reports to the Secretary of Health, it cannot be considered fully independent, so the AGP will be contracted as the IVA. The IMU will provide periodical reports—at least once every 6 months—on the DLIs and other performance indicators and verify their realization, but the DOH may also request more frequent reporting.

38. **Fiduciary systems.** The financial management assessment concluded that the overall pre-mitigation financial management risk is *substantial*.[58] This is based on specific weaknesses: the DOH's current finance staff have limited prior experience in handling the funds flow and work of ADB programs; the DOH has no dedicated internal audit department, and its internal auditors are on deputation from the AGP;[59] the DOH's manual accounting and information systems are not functioning well, which can result in inaccurate and incomplete financial information, require lengthy spreadsheet monitoring, and lead to delays in overall reporting and monitoring. Program financial reporting is performed in an error-prone Excel application. A financial management action plan was prepared and incorporated in the program action plan (PAP),[60] which will help reduce the risks associated with the identified weaknesses.

39. The overall pre-mitigation procurement risk is rated *substantial*. This is because of a lack of dedicated PMIU staff; the risk of cost overruns in the RSHC program; and inefficient procurement processes, especially with regard to the issuing of purchase orders. The applicable DLIs and performance indicators will ensure that the procurement of medicines and consumables is compliant with national competitive bidding regulations and procedures. DLI10, on fiduciary and financial management, requires the (i) operationalization of the PMIU through the hiring of dedicated staff, (ii) updates and publication of program procurement plans on the website of Khyber Pakhtunkhwa Public Procurement Regulatory Authority, and (iii) timely submission of financial and audit reports. The systems are adequate and provide reasonable assurance that RBL financing will be used for the intended purposes. The Guidelines to Prevent or Mitigate Fraud, Corruption, and Other Prohibited Activities in Results-Based Lending for Programs were explained to and discussed with the provincial government.[61]

40. **Safeguard systems.** ADB's Safeguard Policy Statement (2009) was discussed with the provincial government and adherence to it agreed. The screening process during implementation will follow RBL policy and exclude activities with significant impacts from the program scope.[62]

41. **Environmental safeguards**. The RBL program is categorized *B for environmental safeguards*. The program components will be implemented within the designated boundary of the SHC hospitals. Limited impacts are envisaged during the civil works in terms of dust, noise, occupational health and safety risks, and waste streams. These impacts can be mitigated by implementing an environmental management plan. Impacts relating to inadequate disposal of medical waste may arise during operations but can be avoided or minimized by implementing a hospital waste management system. A program safeguard systems assessment (footnote 61)

[58] Program Fiduciary Systems Assessment (accessible from the list of linked documents in Appendix 2).
[59] Deputation is a government administrative policy whereby staff belonging to one department are appointed to another department for a specified period of time to perform functions under the new department. For the period of deputation, the staff does not have any reporting line with their original department, nor do they receive remuneration from their original department.
[60] Program Action Plan (accessible from the list of linked documents in Appendix 2).
[61] ADB. 2013. *Piloting Results-Based Lending for Programs.* Manila (Appendix 7). Appendix 1 to the Program Implementation Document (accessible from the list of linked documents in Appendix 2).
[62] Program Safeguard Systems Assessment (accessible from the list of linked documents in Appendix 2).

was prepared to comply with the Safeguard Policy Statement requirements and includes PAP measures relating to environmental safeguards. Some of the components of the RBL program may also require the preparation of initial environmental examination studies to comply with the national environmental regulations.

42. **Social safeguards**. The RBL program is categorized *B for involuntary resettlement* and *C for indigenous peoples* under the Safeguard Policy Statement. While no land acquisition is expected, economic displacement may occur, and livelihood restoration may be required in case of impacts on third parties involving personal and business income loss and/or loss of structures or other assets. In the absence of a specific law to protect indigenous peoples, the provincial government endorses the safeguard policies of ADB, which recognize the Kalash as the only indigenous peoples in Pakistan. There is no provision for land acquisition and therefore no adverse impacts on their land or territory. The RBL program will not negatively affect the dignity, human rights, livelihood systems, and culture of Kalash people, and they will benefit from the RBL program at the same level as other beneficiaries. The RBL program will include an action plan as part of the PAP to ensure that the Kalash people can benefit from the same level of services to be provided by the RBL program.

C. Sustainability

43. The RSHC and RBL programs are financially sustainable. More than 82% of the RSHC costs consist of four annual recurrent budgets for the 33 SHC hospitals under the program. As discussed in the financial analysis,[63] the provincial government has provided the annual budgets to the hospitals in the past and, after the end of the RBL program implementation period, will continue to allocate adequate budget to all hospitals to run their operations smoothly. The RSHC and RBL programs will incur marginal additional costs for the maintenance of new equipment and refurbished infrastructure, and the government needs to commit to the necessary budgetary allocations for such costs to ensure that the benefits of the RBL program are not lost.

D. Summary of Risk Assessment and Risk Management Plan

44. Major risks and mitigating measures, including assurances of independence, are summarized in Table 5 and described in detail in the risk assessment and risk management plan. The overall risk is rated *substantial*, but mitigating measures have been agreed with the provincial government, and the overall benefits and impact are expected to far outweigh the costs.[64]

Table 5: Summary of Integrated Risk Assessment and Mitigating Measures

Risks	Key Mitigating Measures
Results. Health consumption in program hospitals may be undermined by security concerns and/or COVID-19 flareups.	Hand sanitizers are part of the infrastructure indicators, and the clinical pathways will include infection prevention control measures, which will increase the population's trust in the hospitals. If the security concerns are worsened, DOH will request support from local law enforcement and other security agencies.
Fiduciary. The improvements in infrastructure and equipment, and additional human resources for health will lead to cost overruns.	The PC-1s have been approved. The agreed indicators—disbursement-linked indicators and other performance indicators—do not add additional charges to the budgets. In the event of an increased budget of revised PC-1s and/or cost

[63] Financial Analysis (accessible from the list of linked documents in Appendix 2).
[64] Risk Assessment and Risk Management Plan (accessible from the list of linked documents in Appendix 2).

Risks	Key Mitigating Measures
	overrun, the additional costs will be covered by the DOH budget.
PMIU is not fully functional.	The government has committed to establish a functional PMIU by December 2022.
Financial management. The DOH currently has internal auditors on deputation from the AGP. Once their assignment ends, the DOH needs to have a fully established internal audit department that can cover all ADB program activities. Insufficient authority and capacity of audit staff could reduce the effectiveness of financial management, cost control, and accountability, raising the risk of misuse of funds.	The internal audit department will be obligated to audit the ADB funds, and the detailed scope of this audit will be agreed with the DOH, including various aspects of ADB funding and audits of all program accounts. The DOH will recruit new internal auditors or arrange for new staff on deputation from AGP once the current arrangement with the AGP ends. ADB will support financial management and audit, including assistance in building capacity.
The AGP has various roles, such as being the independent verification agency for the disbursement-linked indicators, as well as preparing internal and external audits.	The AGP will assign independent teams for the IVA and auditing functions.
The DOH has no previous experience with the financial management and audit requirements of ADB programs.	Financial management staff for the PMIU will be engaged under ADB technical assistance to support the PMIU in all financial management activities. ADB will train PMIU accounting staff on its financial management and disbursement guidelines and policies.
Operating environment. The security situation in remote districts of Khyber Pakhtunkhwa may discourage contractors.	If the security situation worsens, support from local law enforcement and other security agencies will be requested for the duration of civil works in the merged districts (formerly Federally Administrated Tribal Areas).
Overall RBL program risk: Substantial	

ADB = Asian Development Bank, AGP = Auditor General of Pakistan, COVID-19 = coronavirus disease, DOH = Department of Health of Khyber Pakhtunkhwa, PMIU = project management and implementation unit, PC-1 = Planning Commission project appraisal form, RBL = results-based lending.
Source: Asian Development Bank.

IV. ASSURANCES

45. The government and the DOH have agreed with ADB on certain covenants for the RBL program, which are set forth in the loan agreement and program agreement.

V. RECOMMENDATION

46. I am satisfied that the proposed results-based loan would comply with the Articles of Agreement of the Asian Development Bank (ADB) and recommend that the Board approve the loan of $100,000,000 to the Islamic Republic of Pakistan for the Khyber Pakhtunkhwa Health Systems Strengthening Program, from ADB's ordinary capital resources, in concessional terms, with an interest charge at the rate of 2% per year during the grace period and thereafter; for a term of 25 years, including a grace period of 5 years; and such other terms and conditions as are substantially in accordance with those set forth in the draft loan agreement presented to the Board.

Masatsugu Asakawa
President

1 September 2022

DESIGN AND MONITORING FRAMEWORK

Impact the RBL Program is Aligned with:
Accessible, equitable, and quality health care for all people of Khyber Pakhtunkhwa to advance the community's well-being, productivity, and prosperity.[a]

Results Chain	Performance Indicators	Data Sources and Reporting Mechanisms	Risks and Critical Assumptions
Outcome Quality of care of secondary hospital services in Khyber Pakhtunkhwa enhanced	By 2027: **a. SHC hospital services improved** **a1. Outpatient contacts increased**. The number of patient contacts in outpatient departments of SHC facilities reaches at least 16,074,000 per annum. (2019 baseline: 12,060,000 per annum) (OP 1.1, OP 6.2) **(DLI 1)** **a2. Inpatient admissions augmented**. The number of patient admissions for inpatient care (including daycare) to SHC facilities reaches at least 662,000 per annum. (2019 baseline: 496,000 admissions per annum) (OP 1.1, OP 6.2) **(DLI 1)** **b. Maternal care ameliorated**. The number of deliveries managed at SHC facilities reaches at least 166,000 per annum. (2019 baseline: 124,000 hospital deliveries per annum) (OP 1.1, OP 6.2) **(DLI 2)** **c. Maternal mortality ratio reduced**. The maternal mortality ratio is reduced to 115 per 100,000 live births (2019 baseline: 165 maternal deaths per 100,000 live births) (OP 1.1, OP 2.1.4, OP 6.2)	Hospital annual activity / assessment reports by IMU	R: Security concerns because of unrest in neighboring Afghanistan further disrupt the health system after the coronavirus pandemic.
Outputs 1. Clinical protocols, standards, and guidelines available and implemented at secondary hospitals	By 2026: 1a. Standard, gender-sensitive clinical pathways are available for the 10 most frequent diagnoses and related diagnostic and therapeutic procedures [b] (2021 baseline: none available) (OP 1.1.2, OP 6.2.1) 1b. Quality committees are established and operational in at least 30 SHC facilities [c] (2021 baseline: no quality committees are established) 1c. Compliance with clinical pathways is satisfactory [d] (2021 baseline: not applicable) 1d. Surgical site infection rate has declined for selected interventions [e] (2021 baseline: to be established) 1e. At least 30 SHC hospitals submitted gender-sensitive performance and quality reports (2021 baseline: none available) **(DLI 3)**	1a.–1e. Published annual activity / quality reports; assessment reports by IMU	R: Resistance from medical associations to any change in status quo
2. Hospital infrastructure and medical equipment modernized	2a. All SHC hospital infrastructure upgraded to an average score of ≥ 9 and in compliance with ADB's Safeguard Policy Statement (2009) requirements. [f] (2021 baseline: infrastructure below benchmark level) (OP 1.1.2) **(DLI 4)** 2b. 85% of essential equipment in accident and emergency units, operating rooms, sterilization units, and obstetrical departments is tagged, registered, and functioning (2021 baseline: 0) (OP 1.1.2) **(DLI 5)**	2a. Assessment reports by IMU 2b. Hospital equipment inventory register; assessment reports by IMU	R: International trade and transport remain constrained, curtailing availability of imported equipment
3. Planning of human resources and health services reinforced	3a. HR management information system is in place and commissioned (2021 baseline: not commissioned) 3b. Legal provisions have been developed and approved for facility-specific contractual hiring of medical doctors / specialists	3a.–3c. DOH's annual report (HR chapter); official gazette of provincial	R: Civil unrest in Afghanistan affects (perceived) security in

Results Chain	Performance Indicators	Data Sources and Reporting Mechanisms	Risks and Critical Assumptions
	(2021 baseline: not approved) (OP 1.2) 3c. Sufficient qualified and gender-balanced human resources for health are available at all program hospitals 3c1. 90% of sanctioned doctor posts for SHC facilities are filled (2021 baseline: 77% of sanctioned doctor posts filled) (OP 2.2.3) **(DLI 6)** 3c2. Female doctors working at SHC facilities represent 40% of total doctors, and 20% in newly merged districts (2021 baseline: 33.3% share of female doctors) (OP 2.2.3) **(DLI 6)** 3c3. Absenteeism of doctors is reduced to less than 5%, and less than 10% in newly merged districts (2021 baseline: absenteeism of doctors at 13% of total number of posts filled in all SHC facilities) (OP 2.2.3) **(DLI 6)** 3d. Gender issues are adequately considered 3d1. At least 60% of staff working at SHC facilities, of which 30% are women, reporting improved knowledge on gender-based violence (2021 baselines: 0) (OP 2.2.3) **(DLI 7)** 3d2. At least 30 SHC facilities established a counseling desk each for reproductive and mental health (2021 baseline: desks / consultation rooms for psychosocial care available in 7 program hospitals) (OP 2.4.1) **(DLI 7)** 3d3. Inquiry committees in at least 28 SHC facilities established and operational [c] (2021 baseline: not applicable) **(DLI 7)** 3e. Human resources plan for internal recruitment of qualified health managers approved (2021 baseline: not approved)	government; assessment reports by IMU 3d1. DOH's HR planning / development report 3d2. Hospital activity reports; DOH's annual report 3d3. Minutes of inquiry committee meetings 3e. DOH's HR planning / development reports, and annual report	Khyber Pakhtunkhwa Province, especially for women
4. Management of medicine supply chain upgraded	4a. At least 30 hospital pharmacies refurbished with information and communication technology and software (stock, distribution, and procurement management) (2021 baseline: 6 hospitals refurbished) (OP 1.1.2, OP 5.1.1) 4b. Availability of essential medicines, vaccines, and supplies with a 1-month stock buffer at SHC hospitals reaches 97.5% (2021 baseline: 80% availability of essential drugs) (OP 1.1.2) **(DLI 8)** 4c. At least 95% of medicine and consumables for SHC hospitals procured in compliance with the national competitive bidding regulations and procedures. (2021 baseline: 80%)	4a. DOH's activity reports; assessment reports by IMU 4b. Indicator to be monitored and evaluated twice a year by IMU; list of essential drugs and consumables defined by DOH 4c. DOH reports	R: International trade continues to be disrupted, curtailing the availability of imported medicines and vaccines.
5. Effectiveness of service delivery improved	5a. Active contracting of clinical and nonclinical service providers is in place 5a1. At least 30 SHC facilities have concluded service contracts for clinical services (e. g., imaging, laboratory) (2021 baseline: no service contracts signed) **(DLI 9)**	5a1. Hospitals' (annual) performance reports (chapter on	

Results Chain	Performance Indicators	Data Sources and Reporting Mechanisms	Risks and Critical Assumptions
	5a2. At least 30 SHC facilities have concluded service contracts for nonclinical services (e. g. cleaning, catering, security, maintenance) (2021 baseline: no service contracts signed) **(DLI 9)**	contracting of clinical and nonclinical services) 5a2. Hospitals' (annual) performance reports – chapter on contracting of clinical and nonclinical services	
	5b. Hospital financial autonomy is enhanced 5b1. At least 30 SHC facilities shall have management committees established to decide on the use of 90% of revenues generated (2021 baseline: based on cabinet approval, management committees have been established in 6 district headquarter hospitals deciding about the use of 90% of the revenues generated) 5b2. Hospital-generated revenues represent at least 25% of total hospital budget [g] (2021 baseline: revenues generated by 6 pilot hospitals) (OP 6.1)	5b. DOH's annual report	
	5c. Fiduciary and financial management improved: 5c1. PMIU is operational [h] (2021 baseline: PMIU not yet operational) **(DLI 10)** 5c2. Program procurement plans are updated and published on the website of Khyber Pakhtunkhwa Public Procurement Regulatory Authority (2021 baseline: procurement plans prepared for phases 1, 2, and 3 hospitals) (OP 6.1.4) **(DLI 10)** 5c3. All (33) financial and audit reports submitted to DOH (2021 baseline: not applicable) **(DLI 10)**	5c. PMIU's (annual) report; procurement plan; DOH / PMIU's annual reports; hospital financial reports (as part of annual performance reports)	

Key Program Actions

1. Establish independent monitoring and reporting framework for the program
2. Assign medical experts / medical associations to elaborate standard gender-sensitive clinical protocols and pathways for diagnostic and therapeutic procedures in SHC hospitals
3. Draft policy for establishing quality committees at SHC hospitals
4. Procure hospital medical equipment registration software and barcode equipment
5. Support woman-friendly work and living environments at and near the selected SHC hospitals (e.g., privacy assured at hospitals; clean, functioning, and sex-segregated sanitary facilities; support in the search for living quarters also for families)
6. Introduce and operationalize environment-friendly medical waste management regime at SHC hospitals

Financing Plan [i]

Total program financing (FY2022–FY2026): PRs93.7 billion ($417.6 million)
Government of Khyber Pakhtunkhwa: PRs66.3 billion ($295.3 million)
Government of Pakistan: PRs5.0 billion ($22.4 million)
ADB: $100 million (concessional ordinary capital resources)

ADB = Asian Development Bank, DLI = disbursement-linked indicator, DOH = Department of Health of the Government of Khyber Pakhtunkhwa, HR = human resources, IMU = Independent Monitoring Unit, OP = operational priority, PMIU = project management and implementation unit, R = risk, RBL = results-based lending, SHC = secondary health care.

[a] Government of Khyber Pakhtunkhwa, DOH. 2018. *Khyber Pakhtunkhwa Health Policy (2018–2025)*. Peshawar.

[b] The 10 most frequent diagnoses (i.e., causes of admission) will be defined per hospital but likely concern (i) acute respiratory infection, (ii) acute gastrointestinal infection or appendicitis, (iii) pregnancy and/or delivery, (iv) hypertension, (v) diabetes, (vi) chronic obstructive pulmonary disease and asthma, (vii) urogenital infection, (viii) trauma with or without bone fracture, (ix) inguinal hernia, and (x) cholelithiasis or cholecystitis.
[c] The committee is considered operational when it holds at least two documented meetings per annum.
[d] The hospital is considered sufficiently compliant when the percentage of patient records evaluated reaches the proposed target value for the year of evaluation (refer to methodological notes in Program Implementation Document [accessible from the list of linked documents in Appendix 2]).
[e] Selected interventions (tracer diagnoses or procedures) are: (i) non-incarcerated inguinal hernia, (ii) non-perforated appendicitis, and (iii) cholelithiasis without cholecystitis. These are primarily "sterile" interventions where wound contamination can only be caused by the surgeon and/or other health workers involved and/or the instruments or linen used.
Any of the following signs would lead the case to be counted as surgical wound infection: (i) redness; (ii) pain or sore to touch; (iii) hot to touch; (iv) fever, chills; (v) bad smell coming from the wound; and (vi) pus or drainage. Wound inspection should be performed daily and the result noted in the patient record,
[f] The benchmark level is being defined by the infrastructure checklist (refer to Program Implementation Document). Achievements to be verified by qualified engineers (to be fielded by the IMU and/or independent verification agency).
[g] To measure budget autonomy mechanisms, hospitals must be able to retain a percentage of fees generated through additional, medical, and non-medical services (e.g., reimbursements from health insurers, fees for car parking) and can use them for their own planned efforts to improve quality of care, such as improving infrastructure and equipment, and paying incentives to staff.
[h] For the PMIU to be considered operational, it needs to have at least: 1 program (PMIU) director, 1 procurement director, 1 financial management director, 1 director for environmental aspects, 1 director for gender aspects.
[i] Numbers may not sum precisely because of rounding.

Contribution to Strategy 2030 Operational Priorities

The expected values and methodological details for all OP indicators to which this operation will contribute results are detailed in the Contribution to Strategy 2030 Operational Priorities (accessible from the list of linked document in Appendix 2). In addition to the OP indicators tagged in the design and monitoring framework, this operation will contribute results for:

OP 2.2.2: Quality and access to women's and girls' health services improved (number)
OP 3.3: People benefiting from strengthened environmental sustainability (number)
OP 5.1.3: Health care, education, and financial services established or improved (number)

Source: Asian Development Bank.

LIST OF LINKED DOCUMENTS

http://www.adb.org/Documents/RRPs/?id=54297-001-3

1. Loan Agreement
2. Program Agreement
3. Sector Assessment (Summary): Health
4. Program Soundness Assessment
5. Program Results Assessment
6. Program Results Framework
7. Program Expenditure and Financing Assessment
8. Program Monitoring and Evaluation System Assessment
9. Program Fiduciary Systems Assessment
10. Program Safeguard Systems Assessment
11. Risk Assessment and Risk Management Plan
12. Contribution to Strategy 2030 Operational Priorities
13. Summary Poverty Reduction and Social Strategy
14. Program Implementation Document
15. Program Action Plan

Supplementary Documents

16. Financial Analysis
17. Climate Change Assessment
18. Public Financial Management Assessment
19. Financial Management Assessment

DISBURSEMENT-LINKED INDICATORS, VERIFICATION PROTOCOLS, AND DISBURSEMENT SCHEDULE

Table A3.1: Disbursement-Linked Indicators

Results Indicators	Baseline Value	Baseline Year & Prior results	Target Values of Results Indicators			
			FY2023	FY2024	FY2025	FY2026
OUTCOME: QUALITY OF CARE OF SECONDARY HOSPITAL SERVICES IN KHYBER PAKHTUNKHWA ENHANCED						
DLI 1: SHC hospital services improved [a]						
a1. Outpatient contacts increased By end of 2027, the number of patient contacts in OPDs of SHC facilities b reaches at least 16,074,000 per annum.	12,060,000 p.a.	2019 No prior result	The number of patient contacts in OPDs of SHC facilities increases to at least			
			12,422,000 p.a.	13,167,000 p.a.	14,352,000 p.a.	16,074,000 p.a.
a2. Inpatient admissions augmented By end of 2027, the number of patient admissions for inpatient care (including daycare) to SHC facilities reaches at least 662,000 per annum.	496,000 admissions p.a.	2019 No prior result	The number of patient admissions to SHC facilities increases to at least			
			511,000 p.a.	542,000 p.a.	591,000 p.a.	662,000 p.a.
DLI 2: Maternal care ameliorated						
b. Number of hospitals deliveries expanded By end of 2027, the number of deliveries managed at SHC facilities reaches at least 166,000 per annum.	124,000 hospital deliveries	2019 No prior result	The number of annual deliveries managed at SHC facilities increases to			
			128,000	136,000	148,000	166,000
OUTPUT 1: CLINICAL PROTOCOLS, STANDARDS, AND GUIDELINES AVAILABLE AND IMPLEMENTED AT SECONDARY HOSPITALS						
DLI 3: Gender-sensitive quality assurance mechanisms established						
1e. Gender-sensitive performance and quality reporting established By the end of 2026, at least 30 SHC hospitals submitted gender-sensitive performance and quality reports. A report template is provided in the Program Implementation Document.[b]	No report available in 2021	2021 No prior result	Before the end of Q1 2023, at least 5 SHC hospitals issue 2022 annual performance and quality report	Before the end of Q1 2024, at least 10 SHC hospitals issue 2023 annual performance and quality report	Before the end of Q1 2025, at least 15 SHC hospitals issue 2024 annual performance and quality report	Before the end of Q1 2026, at least 30 SHC hospitals issue 2025 annual performance and quality report
OUTPUT 2: HOSPITAL INFRASTRUCTURE AND MEDICAL EQUIPMENT MODERNIZED						
DLI 4: Infrastructure upgraded						
2a. Infrastructure of SHC program hospitals upgraded to quality benchmark level By the end of 2026, all SHC hospital infrastructures upgraded with average	N.A.	2021 Rehabilitation works have started in 6 hospitals	By the end of 2022, the average score achieved by all hospitals undergoing	By the end of 2023, the average score achieved by all hospitals undergoing	By the end of 2024, the average score achieved by all hospitals undergoing	By the end of 2025, the average score achieved by all hospitals undergoing

Results Indicators	Baseline Value	Baseline Year & Prior results	Target Values of Results Indicators			
			FY2023	FY2024	FY2025	FY2026
score of ≥ 9 and in compliance with SPS requirements. The infrastructure rating is calculated according to the infrastructure weighted criteria rating (see below). Achievements to be verified by qualified engineers.			rehabilitation works is ≥3	rehabilitation works is ≥5	rehabilitation works is ≥7	rehabilitation works is ≥9
DLI 5: Medical equipment modernized						
2b. Essential equipment of the A&E, OR, sterilization area, and obstetrical departments is functioning, tagged and centrally registered By the end of 2026, 85% of essential equipment of A&E, OR, sterilization, and the obstetrical departments are tagged, registered, and functioning. The list of essential equipment can be found in the Program Implementation Document.[b]	According to IMU evaluation, only 40% of the existing essential equipment is available and operational	2021 Procurement of new equipment has already started	By the end of 2022, at least 45% of the essential equipment is available and functioning at all SHC hospitals	By the end of 2023, at least 55% of the essential equipment is available and functioning at all SHC hospitals	By the end of 2024, at least 70% of the essential equipment is available and functioning at all SHC hospitals	By the end of 2025, at least 85% of the essential equipment is available and functioning at all SHC hospitals
OUTPUT 3: HUMAN RESOURCES AND HEALTH SERVICE PLANNING REINFORCED						
DLI 6: Qualified, gender-balanced human resources available						
3c1. Sanctioned doctor posts for SHC facilities are filled By the end of 2026, at least 90% of sanctioned doctor posts for SHC facilities are filled.[c]	77% of doctor sanctioned posts filled	2020 The hiring of doctors continues No prior results	By the end of 2022, at least 78% of doctor sanctioned posts for SHC facilities are filled	By the end of 2023, at least 80% of doctor sanctioned posts for SHC facilities are filled	By the end of 2024, at least 85% of doctor sanctioned posts for SHC facilities are filled	By the end of 2025, at least 90% of doctor sanctioned posts for SHC facilities are filled
3c2. Percentage of female doctors working at SHC facilities is increased By the end of 2026, female doctors working at SHC facilities represent at least 40% of total doctors, and ≥20% for NMDs. [c]	33.3% share of female doctors	2015 The hiring of female doctors continues	By the end of 2022, female doctors working at SHC facilities represent ≥35% of doctors, and ≥15% for NMDs	By the end of 2023, female doctors working at SHC facilities represent ≥36.5% of doctors, and ≥16% for NMDs	By the end of 2022, female doctors working at SHC facilities represent ≥39% of doctors, and ≥18% for NMDs	By the end of 2022, female doctors working at SHC facilities represent ≥40% of doctors, and ≥20% for NMDs
3c3. Absenteeism of doctors is reduced By the end of 2026, absenteeism of doctors is reduced to less than 5%, and less than 10% for NMDs.[d]	40% absenteeism of doctors / total number of posts filled	2021 Absenteeism has been reduced to 22% in 2020	By the end of 2022, absenteeism of doctors is reduced to ≤12% of the	By the end of 2023, absenteeism of doctors is reduced to ≤10% of the	By the end of 2024, absenteeism of doctors is reduced to ≤7.5% of the total working	By the end of 2025, absenteeism of doctors is reduced to ≤5% of the total

Results Indicators	Baseline Value	Baseline Year & Prior results	Target Values of Results Indicators			
			FY2023	FY2024	FY2025	FY2026
	in all SHC facilities	and further to 13% in 2021 for all DHQ hospitals	total working hours of filled posts, and ≤24% for NMDs	total working hours of filled posts, and ≤20% for NMDs	hours of filled posts, and ≤15% for NMDs	working hours of filled posts, and ≤10% for NMDs
DLI 7: Gender issues are adequately considered						
3d1. Training on gender-based violence for all staff categories By the end of 2026, at least 60% of staff working at SHC facilities, of which 30% are women, reporting improved knowledge on GBV		2021 The training initiative has been launched in 4 DHQ hospitals	By the end of 2022, ≥10% of all staff working at SHC facilities has received training on GBV	By the end of 2023, ≥25% of all staff working at SHC facilities has received training on GBV	By the end of 2024, ≥45% of all staff working at SHC facilities has received training on GBV	By the end of 2025, ≥60% of all staff working at SHC facilities has received training on GBV
3d2. Counseling desks established in all OPDs on reproductive health and mental health By the end of 2026, at least 30 SHC facilities established in the OPDs counseling desk on reproductive and mental health Desks for reproductive health and mental health are to be counted separately.	Desks or consultation rooms for psychosocial care available in 7 of the program hospitals	2021 Development program funded program to be transformed from PC-1 to routine funding and implementation	By the end of 2022, ≥5 SHC facilities have both (i) a desk for counseling on reproductive health and (ii) a desk on mental health	By the end of 2023, ≥10 SHC facilities have both (i) a desk for counseling on reproductive health and (ii) a desk on mental health	By the end of 2024, ≥20 SHC facilities have both (i) a desk for counseling on reproductive health and (ii) a desk on mental health	By the end of 2025, ≥30 SHC facilities have both (i) a desk for counseling on reproductive health and (ii) a desk on mental health
3d3. Inquiry Committees established and operational By the end of 2026, inquiry committees in at least 28 SHC facilities established and operational. Code of conduct is displayed in offices and staff training is conducted.[e] The committee is considered operational when there are at least two documented meetings per annum.	No formal (permanent) functional inquiry committee in any of the SHC facilities	2021 Inquiries have been conducted in several hospitals by ad-hoc committees, often initiated by ombudspersons identified at many hospitals	By the end of 2022 ≥ 3 SHC facilities have formally established and functional inquiry committees	By the end of 2023 ≥ 9 SHC facilities have formally established and functional inquiry committees	By the end of 2024 ≥ 18 SHC facilities have formally established and functional inquiry committees	By the end of 2025 ≥ 28 SHC facilities have formally established and functional inquiry committees
OUTPUT 4: MEDICINE SUPPLY CHAIN MANAGEMENT UPGRADED						
DLI 8: Essential medicines are available						
4b. Availability of essential medicines, vaccines and supplies with 1-month stock buffer at SHC hospitals By the end of 2026, the availability of	80% availability of essential drugs	2021 Ongoing procurement of	By the end of 2022, 85% of essential drugs and consumables	By the end of 2023, 90% of essential drugs and consumables	By the end of 2024, 95% of essential drugs and consumables	By the end of 2025, 97.5% of essential drugs and consumables

Results Indicators	Baseline Value	Baseline Year & Prior results	Target Values of Results Indicators			
			FY2023	FY2024	FY2025	FY2026
essential medicines, vaccines, and supplies with a 1-month stock buffer at SHC hospitals reaches 97.5% List of essential drugs and consumables defined by DOH.		essential drugs and consumables	are available at SHC facilities	are available at SHC facilities	are available at SHC facilities	are available at SHC facilities
OUTPUT 5: SERVICE DELIVERY EFFICACITY IMPROVED						
DLI 9: Active contracting of clinical and non-clinical service providers is in place						
5a1. Contracting of clinical services in selected SHCs By the end of 2026, at least 30 SHC facilities have concluded service contracts for clinical services (e. g., imaging, laboratory)	No service contracts signed	2021 Elaboration of draft contracts and identification of interested service providers has already started	By the end of 2022, ≥3 contracts will be signed for the provision of clinical services to any of the SHC hospitals	By the end of 2023, ≥9 contracts will be signed for the provision of clinical services to any of the SHC hospitals	By the end of 2024, ≥18 contracts will be signed for the provision of clinical services to any of the SHC hospitals	By the end of 2025, ≥30 contracts will be signed for the provision of clinical services to any of the SHC hospitals
5a2. Contracting of non-clinical services in selected SHCs By the end of 2026, at least 30 SHC facilities have concluded service contracts have been concluded for non-clinical services (e. g. cleaning, catering, security, maintenance)	No service contracts signed	2019 Service contracts (security) signed for 7 of the program hospitals	By the end of 2022, ≥10 hospitals will be included in contracts for the provision of non-clinical services	By the end of 2023, ≥15 hospitals will be included in contracts for the provision of non-clinical services	By the end of 2024, ≥20 hospitals will be included in contracts for the provision of non-clinical services	By the end of 2025, ≥30 hospitals will be included in contracts for the provision of non-clinical services
DLI 10: Fiduciary and financial management improved						
5c1. Establishment of PMIU The PMIU is operational, i. e. has at least: 1 Program (PMIU) Director 1 Procurement Director 1 Financial Management Director 1 Director for Environmental Aspects 1 Director for Gender Aspects	PMIU not yet operational	2020 PMIU became operational by nominating senior management staff through “additional charges” mechanism	By the end of 2022 on a total of total number of 36 staff <12 positions are vacant	By the end of 2023 on a total of total number of 36 staff <9 positions are vacant	By the end of 2024 on a total of total number of 36 staff <6 positions are vacant	By the end of 2025 on a total of total number of 36 staff <4 positions are vacant
5c2. Project Procurement Plans are updated and published on KPPRA Website	1 Procurement Plan for 6	2021	By the end of 2022, ≥13 procurement plans	By the end of 2023, ≥25 procurement plans	By the end of 2024, ≥33 procurement plans	-

Results Indicators	Baseline Value	Baseline Year & Prior results	Target Values of Results Indicators			
			FY2023	FY2024	FY2025	FY2026
	hospitals already published	Procurement plans prepared for phases I, II and III hospitals	have been published on the KPPRA website	have been published on the KPPRA website	have been published on the KPPRA website	
5c3. All (33) financial and audit reports submitted to DOH	No annual financial and audit reports submitted	2021 No prior result	Before the end of Q4 2022, ≥6 financial and audit reports have been submitted to DOH / ADB	Before the end of Q4 2023, ≥13 financial and audit reports have been submitted to DOH / ADB	Before the end of Q4 2024, ≥25 financial and audit reports have been submitted to DOH / ADB	Before the end of Q4 2025, all (33) financial and audit reports have been submitted to DOH / ADB

ADB = Asian Development Bank, A&E = Accident and Emergency, COVID-19 = Corona Virus Disease 2019, DHQ = district headquarter, DLI = disbursement-linked indicator, DOH = Department of Health of the Government of Khyber Pakhtunkhwa, DP = development programme, GBV = gender-based violence, HRH = human resources for health, HRMIS = human resources management information system, IMU = Independent Monitoring Unit, KP = Khyber Pakhtunkhwa Province, KPPRA = Khyber Pakhtunkhwa Public Procurement Regulatory Authority, MOF = Ministry of Finance, NMD = Newly Merged Districts, OPD = outpatient department, OR = operating room, p.a. = per annum, PMIU = Project Management and Implementation Unit, Q1 = quarter 1, Q4 = quarter 4, SHC = secondary health care.

[a] = list of program health facilities can be found below.

[b] = the Program Implementation Document can be accessed through Appendix 2.

[c] = Definition of filled sanctioned posts include staff absent for education and training purposes. There are different targets for NMDs due to access and security issues.

[d] = Absenteeism is defined as non-justified or non-permitted absence (justified or permitted absence would be leave for various reasons).

[e] = This is a legal requirement: According to the Protection against *Harassment of Women at the Workplace* Act (2010), any organization shall have a committee established within 30 days of its enactment to enquire into related complaints. The Committee shall consist of three members, of whom at least one shall be a woman.

Sources: Asian Development Bank; and Department of Health of Khyber Pakhtunkhwa Province.

List of Health Facilities

Nb	Hospital	District	Nb	Hospital	District
Phase 1			Phase 3		
1	DHQ Hospital Abbottabad	Abbottabad	1	DHQ Hospital Battagram	Battagram
2	DHQ Hospital, Charsadda	Charsadda	2	DHQ Hospital, Daggar (Buner)	Buner
3	DHQ Hospital Haripur	Haripur	3	DHQ Hospital Chitral	Chitral
4	DHQ Karak	Karak	4	DHQ Hospital Hangu	Hangu
5	Naseer Ullah Babar Hospital	Peshawar	5	Women and Children / Liaqat Memorial Kohat	Kohat
6	Molvi Jee Hospital Peshawar	Peshawar	6	DHQ Hospital, Lakki Marwat	Lakki Marwat
Phase 2			7	DHQ Hospital, Batkhela	Malakand
1	DHQ Hospital Bannu	Bannu	8	King Abdullah Teaching Hospital	Mansehra
2	DHQ Hospital DI Khan	DI Khan	9	DHQ Hospital Mardan	Mardan
3	DHQ Hospital Timergara	Dir Lower	10	Emergency Satelite/Mian Rashid Hussain Shaheen Hospital Pabbi	Nowshera

4	DHQ Hospital Dir Khas	Dir Upper	11	DHQ Hospital Alpuri	Shangla
5	DHQ Hospital KDA Kohat	Kohat	12	DHQ Hospital Tank	Tank
6	DHQ Nowshera	Nowshera	Phase 4		
7	DHQ: Hospital Swabi	Swabi	1	DHQ Hospital Khar	Bajaur
			2	DHQ Hospital Parachinar	Kurram
			3	DHQ Hospital Landikotal	Khyber
			4	DHQ Hospital Ghallanai	Mohmand
			5	DHQ Hospital Miran Shah	North Waziristan
			6	DHQ Hospital Wana	South Waziristan
			7	DHQ Mishti Mela	Orakzai
			8	Dabori Hospital	Orakzai

Source: Department of Health.

Infrastructure Weighted Criteria Rating (per Hospital)

Item	Description	Target	Weighing factor	Score	Comment
1	Functional washrooms available in sufficient and equal numbers for male and female users (patients, staff, visitors)	1 toilet room male & 1 toilet room male female per 15 number of staff 1 toilet room male & 1 toilet room male per 6 number of beds 1 toilet room male & 1 toilet room male per 6 number of consultation rooms	2	91-100% = 1.0 81-90% = 0.9 71-80% = 0.8 61-70% = 0.7 51-60% = 0.6 <51% = 0.0	Criteria for functionality: continued water supply for toilet flush, free drainage of the toilet, appropriate cleanliness
2	Hand sanitizing wall dispenser, elbow operated, available in sufficient number	1 functional dispenser per 20 beds in ward areas 1 functional dispenser per 20 staff in ward areas Minimum: 50%	0.5	91-100% = 1.0 81-90% = 0.9 71-80% = 0.8 61-70% = 0.7 51-60% = 0.6 <51% = 0.0	Criteria for functionality: fixed and filled with disinfectant to at least half of the total volume
3	Scrub up rooms and areas are equipped with stainless-steel sinks and functional elbow or foot operated water taps	1 functional tap per 2 operating rooms Minimum: 80%	1	91-100% = 1.0 81-90% = 0.9 <81% = 0.0	Criteria for functionality: continued water supply, free drainage of clean sink
4	OR, induction and recovery rooms are properly separated, following minimum standards	OT, induction and recovery rooms are clearly separated by doors or clearly visible separators such as color tapes on the floor	0.5	fulfillment = 1.0 non-fulfillment = 0.0	
5	The air flow in the OR shall be directed from the ceiling to the floor and from the far end of the room to the door	AC outlets or split units and air exhaust ducts or door gaps allow for appropriate and correct/continuous airflow (avoiding turbulences around the OR table).	1.5	in all ORs = 1.0 >90% of ORs = 0.9 >80% of ORs = 0.8 >70% of ORs = 0.7 >60% of ORs = 0.6 ≤60% of ORs = 0.0	

Item	Description	Target	Weighing factor	Score	Comment
6	Electric cabling is compliant with relevant engineering norms and standards	Electric cables shall be flush-mounted or routed in a cable duct. Duct materials shall allow for cleaning with disinfectant.	1	in all ORs = 1.0 >90% of ORs = 0.9 >80% of ORs = 0.8 >70% of ORs = 0.7 >60% of ORs = 0.6 ≤60% of ORs = 0.0	
7	OT and ICU areas have airlocked changing rooms for both male and female staff	2 airlocked changing rooms for each OR or ICU area. Airlock = separate transit area for incoming and/or outgoing personnel to isolate two different environments and to avoid (minimize the risk for) contamination of the connected cleanroom (OR or ICU area). The airlocked changing room has two doors one of which has to remain closed.	1.5	fulfillment in all OT and ICU areas = 1.00 fulfillment in come OT and ICU areas = 0.50 non-fulfillment in any of the OT / ICU areas = 0.00	
8	OT and ICU areas are equipped with seamless conductive floor including a 10 cm skirting board	Use of non-porous vinyl / rubber or antistatic tiles	1	in all ORs = 1.0 >90% of ORs = 0.9 >80% of ORs = 0.8 >70% of ORs = 0.7 >60% of ORs = 0.6 ≤60% of ORs = 0.0	
9	Appropriate hospital waste management facilities and equipment are in place	Segregation of normal household type of waste, sharps, and potentially infectious waste; Waste storage rooms available and used; Reduction of single use items and plastic packaging as appropriate. (0-0.5) Sterilization or incineration of potentially infectious waste before depositing / handing-over to waste management companies or organizations (0-0.5)	1	In all clinical departments 0.50 In some clinical departments 0.25 Nowhere 0.00 For the sterilization: For the whole hospital 0.50 For some of the potentially infectious waste 0,25 Neither solution exists 0.00	
				10	**Maximum hospital score**

AC = air condition, ICU = intensive care unit, OR = operating room
Source: Asian Development Bank.

Table A3.2: Verification Protocols

Disbursement-Linked Indicators	Definition and Description of Achievement	Information Source and Frequency	Verification Agency and Procedure	Verification Time Frame
Outcome				
DLI 1: SHC hospital services improved				
a1. Outpatient contacts increased	Outpatient visits uses aggregated 12 months number of outpatient visits of the 33 hospitals.[a]	Assessment reports by IMU based on hospital reported data	AGP is the IVA and relies on DHIS and IMU for periodical data collection and reporting on the DLIs and other performance indicators. Annual data (or more frequent at the request of DOH) will be used by the AGP related to the outpatient visits and inpatient admissions. IMU will continuously update/record the number of outpatient visits. IMU will submit this to ADB on achievement each year. The AGP as the IVA will verify the submitted documents, and the AGP will confirm based on this whether the DLI has been achieved or not. Similar to the outpatient visits, IMU will also continuously update/record the inpatient admissions, and AGP as IVA will use the p.a. data to verify the achievement of DLI targets.	Annual First quarter of following year
a2. Inpatient admissions augmented	Inpatient admissions use aggregated 12 months number of inpatient admissions of the 33 hospitals.			
DLI 2: Maternal care ameliorated				
b. Number of hospitals deliveries expanded	This indicator uses aggregated 12 months number of hospital deliveries of the 33 hospitals.	Assessment reports by IMU based on hospital reported data	AGP is the IVA and relies on DHIS and the IMU for periodical data collection and reporting on the DLIs and other performance indicators. Annual data (or more frequent at the request of DOH) will be used by the AGP related to the number of hospital deliveries. IMU will continuously update/record the number of deliveries. IMU will submit this to ADB on achievement each year. The AGP as the IVA will verify the submitted documents, and the AGP will confirm based on this whether the DLI has been achieved or not.	Annual First quarter of following year
Outputs				
DLI 3: Gender-sensitive quality assurance mechanisms established				Annual First quarter of the following year
1e. Gender-sensitive performance and quality reports	There is no baseline value for this. This DLI is defined as the hospitals (SHC) issuing the gender-sensitive annual performance and quality	Assessment reports by IMU based on the gender-sensitive performance	IMU will submit the reports to ADB on achievement each year. AGP as the IVA will utilize the IMU provided assessments and the hospital annual activity/quality reports to verify the achievement of the DLI.	

	report. Currently none of the hospitals that are part of the program are issuing these reports. This indicator is considered achieved when before the end of 2025 at least 30 SHC hospitals will issue an annual performance and quality reports.	and quality reports		
DLI 4: Infrastructure of SHC hospitals upgraded				
2a. SHC hospital infrastructures upgraded with average scoring and in compliance with SPS requirements.	There is no baseline value for this indicator. The indicator is considered achieved when the average score achieved by all hospitals undergoing rehabilitation works is ≥9 based on a standard checklist defining criteria and scores that can be achieved	Assessment reports by IMU based on average scoring with infrastructure list	IMU will submit the assessment report to ADB on achievement each year. The AGP as the IVA will verify the submitted documents	
DLI 5: Essential equipment tagged, registered and functioning				
2b. Essential equipment of the A&E, OR, sterilization area, and obstetrical departments is functioning, tagged and centrally registered	According to IMU evaluation, only 40% of the existing essential equipment is registered, available and operational at the baseline value. The DLI is achieved when at least 85% of the essential equipment is available and functioning at all SHC hospitals	Assessment reports by IMU based on hospital equipment inventory register, preventive and corrective maintenance plans	IMU will submit multiple documents to ADB on achievement each year. The AGP as the IVA will verify the submitted documents	
DLI 6: Qualified, gender-balanced human resources available				
3c1. Sanctioned doctor posts for SHC facilities are filled.	Definition of filled sanctioned posts include staff absent for education and training purposes. There are different targets for NMDs due to access and security issues. The DLI is considered achieved if the sanctioned posts are filled in the SHC hospitals per the stated percentage, or higher, in Table A3.1: Disbursement-linked Indicators.	Assessment reports by IMU	IMU will submit the multiple publications, as mentioned, to ADB, and these will be utilized to verify the DLI by AGP as the IVA.	
3c2. Percentage of female doctors working at SHC facilities is increased.	For the share of female doctors, different targets for NMDs apply due to access and security issues. The DLI is considered achieved if the sanctioned posts for doctors are filled by women in the SHC hospitals per the stated percentage, or higher, in Table A3.1: Disbursement-linked Indicators.	Assessment reports by IMU	IMU will submit the multiple publications, as mentioned, to ADB, and these will be utilized to verify the DLI by AGP as the IVA.	

3c3. Absenteeism of doctors is reduced.	Absenteeism is defined as non-justified or non-permitted absence (justified or permitted absence would be leave for various reasons). Different targets for NMDs apply due to access and security issues. The DLI is considered achieved if the absenteeism is less or equal to the stated target percentage in Table A3.1: Disbursement-linked Indicators.	Assessment reports by IMU	IMU will submit the multiple publications, as mentioned, to ADB, and these will be utilized to verify the DLI by AGP as the IVA.	

DLI 7: Gender issues adequately considered				
3d1. Training on gender-based violence for all staff categories	No baseline available. The DLI is considered achieved when at least 60% of staff working at SHC facilities, of which 30% are women, reporting improved knowledge on GBV. The attendance training logs, signed by the hospital manager and the attending staff, must be reported by the hospitals to IMU.	Assessment reports by IMU based on DOH HR report	IMU will submit the report to ADB on achievement each year. The AGP as the IVA will verify the submitted documents	
3d2. Counseling desks established in all OPDs on *- reproductive health and* *- mental health*	For the baseline value desks / consultation rooms for psychosocial care are available in 7 of the program hospitals The DLI is considered achieved when ≥30 SHC facilities have both (i) a desk for counseling on both (i) reproductive health and a (ii) a desk on mental health	Assessment reports by IMU	IMU will submit the DOH report to ADB on achievement each year. The AGP as the IVA will verify the submitted documents	
3d3. Inquiry Committees established and operational	At the baseline value, there was no formal (permanent) functional inquiry committee in any of the SHC facilities. The DLI is considered achieved when at least 28 SHC facilities have formally established and functional inquiry committees, and code of conduct is displayed in offices and staff training is conducted	Assessment reports by IMU based on availability minutes of Inquiry Committee Meetings	IMU will submit the minutes of inquiry committee meetings and hospital activity reports to ADB on achievement each year. The AGP as the IVA will verify the submitted documents	
DLI 8: Essential medicines, vaccines & supplies available				
4b. Availability of essential medicines, vaccines and supplies with 1-month stock buffer at SHC hospitals	Baseline value: 80% availability of essential drugs The DLI is considered achieved when 97.5% of essential drugs and consumables are available at SHC facilities	Assessment reports by IMU List of essential drugs and consumables defined by DOH	IMU will submit both the reports from the year to ADB on achievement each year. The AGP as the IVA will verify the submitted documents	Every 6 months during the month following the semester period
DLI 9: Contracting of clinical & non-clinical service providers in place				
5a1. Contracting of clinical services in selected SHCs	At the baseline value, no contracts have been signed. The DLI is considered achieved when ≥30 contracts for the provision of clinical to any of the SHC hospitals are signed	Assessment reports by IMU based on hospital (annual) performance reports – chapter on contracting of clinical and non-clinical services	IMU will submit the hospital's annual performance report section on contracting of clinical and non-clinical services to ADB on achievement each year. The AGP as the IVA will verify the submitted documents	Annual First quarter of the following year

5a2. Contracting of non- clinical services in selected SHCs	At the baseline value, no contracts have been signed. The DLI is considered achieved when ≥30 contracts for the provision of non-clinical services to any of the SHC hospitals are signed	Assessment reports by IMU based on hospital (annual) performance reports – chapter on contracting of clinical and non-clinical services	IMU will submit the hospital's annual performance report section on contracting of clinical and non-clinical services to ADB on achievement each year. The AGP as the IVA will verify the submitted documents	
DLI 10: Fiduciary and financial management improved				
5c1. Establishment of PMIU	Baseline: PMIU not yet operational The DLI is achieved when PMIU is operational and for a total of total number of 36 staff less than 4 positions are vacant.	PMIU (annual) Report	IMU will submit the PMIU report to ADB on achievement each year. The AGP as the IVA will verify the submitted documents.	
5c2. PPP are updated and published on KPPRA Website	Baseline: 1 procurement plan for 6 hospitals already published The DLI is achieved when ≥33 procurement plans have been published on the KPPRA website.	PMIU (annual) Report Procurement plan DOH / PMIU Annual Report Hospital Financial Reports (as part of the annual performance report – cf. 1.4)	IMU will submit the procurement plan report to ADB on achievement each year. The AGP as the IVA will verify the submitted documents.	
5c3. Financial and audit reports submitted to DOH	The DLI is achieved when the financial and audit reports are submitted within 3 months at the end of the financial year	Annual Report Hospital Financial Reports (as part of the annual performance report – cf. 1.4)	IMU will submit the financial and audit reports to ADB on achievement each year. The AGP as the IVA will verify the submitted documents.	

ADB = Asian Development Bank, A&E = Accident and Emergency, AGP = Auditor General of Pakistan, COVID-19 = Corona Virus Disease 2019, DHQ = district headquarter, DLI = disbursement-linked indicator, DOH = Department of Health of the Government of Khyber Pakhtunkhwa, DP = development programme, GBV = gender-based violence, HRH = human resources for health, HRMIS = human resources management information system, IMU = Independent Monitoring Unit, IVA = Independent Verification Agency, KP = Khyber Pakhtunkhwa Province, KPPRA = Khyber Pakhtunkhwa Public Procurement Regulatory Authority, MOF = Ministry of Finance, NMD = Newly Merged Districts, OPD = outpatient department, OR = operating room, p.a. = per annum, PMIU = Project Management and Implementation Unit, PPP = project procurement plans, SHC = secondary health care.

[a] = total population in catchment area will be based on the 2017 census.

Source: Asian Development Bank.

Table A3.3: Disbursement Schedule

($ million)

Disbursement-Linked Indicators	Total ADB Financing Allocation	Share of Total ADB Financing	FY2023	FY2024	FY2025	FY2026
DLI1: SHC hospital services improved						
a1. Outpatient contacts increased	5	5%	1.25	1.25	1.25	1.25
a2. Inpatient admissions augmented	5	5%	1.25	1.25	1.25	1.25
DLI2: Maternal care ameliorated						
b. Number of hospitals deliveries expanded	5	5%	1.25	1.25	1.25	1.25
DLI3: Gender-sensitive quality assurance mechanisms established						
1e. Gender-sensitive performance and quality reporting established	15	15%	3.75	3.75	3.75	3.75
DLI4: Infrastructure upgraded						
2a. Infrastructure of SHC program hospitals upgraded to quality benchmark level and in compliance with SPS requirements	15	15%	3.75	3.75	3.75	3.75
DLI5: Medical equipment modernized						
2b. Essential equipment of the A&E, OR, sterilization area, and obstetrical departments is functioning, tagged and centrally registered	10	10%	2.50	2.50	2.50	2.50
DLI6: Qualified, gender-balanced human resources available						
3c1. Sanctioned doctor posts for SHC facilities are filled	5	5%	1.25	1.25	1.25	1.25
3c2. Percentage of female doctors working at SHC facilities is increased	5	5%	1.25	1.25	1.25	1.25
3c3. Absenteeism of doctors is reduced	5	5%	1.25	1.25	1.25	1.25
DLI7: Gender issues are adequately considered						
3d1. Training on gender-based violence for all staff categories	3	3%	0.75	0.75	0.75	0.75
3d2. Counseling desks established in all OPDs on reproductive health and mental health	4	4%	1.00	1.00	1.00	1.00
3d3. Inquiry Committees established and operational	3	3%	0.75	0.75	0.75	0.75
DLI8: Essential medicines are available						
4b. Availability of essential medicines, vaccines and supplies with 1-month stock buffer at SHC hospitals	10	10%	2.50	2.50	2.50	2.50
DLI9: Active contracting of clinical and non-clinical service providers is in place						
5a1. Contracting of clinical services in selected SHCs	3	3%	0.75	0.75	0.75	0.75
5a2. Contracting of non-clinical services in selected SHCs	2	2%	0.50	0.50	0.50	0.50
DLI10: Fiduciary and financial management improved						
5c1. Establishment of PMIU	2	2%	0.50	0.50	0.50	0.50
5c2. PPP are updated and published on KPPRA Website	1	1%	0.25	0.25	0.25	0.25
5c3. Financial and audit reports submitted to DOH	2	2%	0.50	0.50	0.50	0.50
Total	**100**	**100**	**25.00**	**25.00**	**25.00**	**25.00**

ADB = Asian Development Bank, A&E = Accident and Emergency, DLI = disbursement-linked indicator, FY = fiscal year, HRH = human resources for health, OPD = outpatient department, OR = operating room, PMIU = Project Management and Implementation Unit, PPP = project procurement plans, SHC = secondary health care.

Source: Asian Development Bank.