

**PROJECT INFORMATION DOCUMENT (PID)
CONCEPT STAGE**

Report No.: A---

Project Name	IRAQ: Emergency Health Rehabilitation Project
Borrower(s)	Ministry of Finance
Implementing Agency	Ministry of Health
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1. Country and Sector Background

Once considered one of the best in the region, the Iraqi health system has suffered the consequences of three major wars, inappropriate policies, poor management and the absence of adequate resource allocation. During the 1980s, Iraq's health sector consisted of a highly advanced curative system, with little, if any, public health approaches in place. During the 1990s, funds available for health were reduced by 90% and health outcomes became among the poorest in the region and well below levels found in countries of comparable income. According to the 2003 UNICEF/WHO Health and Nutrition Watching Brief, Iraq has the region's second-highest infant mortality (83/1,000 live births in 2002) and under-five mortality rates (117/1,000 in 2001), a stark reversal from the improvements in the late 1970s and early 1980s. During the 1990s, maternal mortality grew close to three-fold, with an estimated 30% of women giving birth without a qualified health worker in attendance.

Prior to 1990, Iraq was entering its epidemiological transition from infectious to non-communicable diseases, but has since been suffering from a double burden in its disease profile. Iraq is experiencing increases in non-communicable disease morbidity and mortality, while at the same time facing increases in the incidence of communicable diseases. The Ministry of Health (MoH) has identified the following as contributing factors to the deteriorating health status: poor investment in the health sector, poorly maintained health infrastructure, inappropriate management of the health sector, poor sanitation and water supply, unsafe food storage, and unhealthy lifestyles and behaviors.

Currently, the Iraqi health system is suffering from institutional inefficiencies due to inadequate resource allocation (financial and workforce) and poor management. The health system's physical infrastructure suffers from severe deterioration due to neglect over time and consequences from last year's war and looting, whereby most of the health infrastructure remains in poor condition and critically lacking essential equipment.

The Iraq Health Sector Situation and Strategy Options Assessment² reports that less than one-third of Iraq's hospitals and health centers have adequate facilities to provide emergency obstetric care. For example, it is estimated that 65% of births occur outside of health facilities, and the proportion of deliveries without trained assistance has increased since the 1990s to 30% in urban areas and 40% in rural areas at the present time. Approximately 15-20% of deliveries classify as high-risk and require emergency obstetric support. Given these obstacles, the maternal mortality ratio in Iraq is extremely high and is

¹ Drafted in October 2003 by the Ministry of Health, the Coalition Provisional Authority, the UN Development Group and the World Bank.

² Drafted in October 2003 by the Ministry of Health, the Coalition Provisional Authority, the UN Development Group and the World Bank.

estimated to be 300 per 100,000 live births. The needs are urgent for improved emergency obstetric care, given the bleak maternal mortality indicators. It is therefore imperative to upgrade key facilities with the essential emergency equipment, drugs, training and referral capacity to provide adequate emergency obstetric care to the population.

In a recent meeting in July 2004 between the senior staff of the Ministry of Health and the donor community (WB, UN agencies, and some bilaterals), the following overall priority areas were identified: (i) pharmaceuticals, vaccines and medical equipment; (ii) emergency medical services; (iii) essential infrastructure rehabilitation; (iv) health information system; (v) communicable disease control and surveillance; (vi) communication equipment (hardware); (vii) capacity building and human resources development; (viii) communication and health promotion strategy for the health sector; (ix) health management; (x) primary health care; (xi) food safety; and (xii) donor coordination.

The Joint WB-UN Needs Assessment identified US\$ 1.6 billion of needs for the health sector in the next four years, focusing on: (i) restoration of effective control, and implementation for public health programs; (ii) equitable access and focus on women, children and other vulnerable groups; (iii) rehabilitation of essential infrastructure and provision of equipment; (iv) resolution of imbalances in the distribution and skill-mix of health professionals; and (v) initiation of a national health plan. More recently, the Ministry of Health has calculated estimates for basic rehabilitation of the health sector to be at least US\$ 4 billion over the next four years.

At the same time, steps need to be taken to develop a medium term policy and program framework, including a master plan for the development of a decentralized health sector to meet present and future health needs. Some of this work has already started and will continue during and beyond 2004.

Existing Health Infrastructure

Primary Health Care Facilities. From a total of 1,285 primary health care centers (PHCs), at least two-thirds require essential rehabilitation, including access to safe water, electricity, sanitation and medical waste treatment facilities. Over the last two decades, the MoH has not been able adequately to maintain its facilities and, as a result, they have become dilapidated and dysfunctional. Due to lack of maintenance or loss to post-war looting, absence of existing or functional equipment is widely reported. More than 80% of health centers lack such basic items as stethoscopes, sphygmomanometers, sterilizers and weighing scales.

Existing Hospitals. There are more than 240 hospitals in Iraq. Of these, 172 are government-owned and operated, of which approximately 12% were partially damaged and/or looted in 2003. It is widely known that most hospitals have suffered from neglect over the last two decades, exacerbated by the aftermath of the 2003 war. There has been a systematic lack of maintenance of the physical infrastructure, essential drugs and equipment, and looting has worsened the conditions in most facilities. In particular, emergency medical services at Iraqi hospitals are in a severely inadequate state, where emergency and critical care principles are lacking, and in many cases, even aseptic management is clearly absent. Shortages of essential and emergency medicines have been recurrent within the Iraqi hospital system.

While significant donor commitments have been made towards the construction of new health facilities, no significant commitments have been made to rehabilitate the existing health facilities. Funding from the US Program Management Office (PMO) is planned for a limited number of new health centers (150), but the MoH notes severe delays in its implementation and the number of centers expected to be constructed is not sufficient to meet the current needs. In addition, PMO funding is planned for a new maternity hospital and a new pediatric hospital. The MoH has identified the rehabilitation of selected key hospitals,

and primary health care facilities, particularly in rural areas, as an urgent and priority need that would help to improve the quality of and access to basic health services in the shortest period of time.

Existing Human Resources Capacity

The MoH capacity to formulate and implement policies, and manage the provision of basic services remains very weak. Empowerment of the Iraqi health system requires more than political will, and skills must be strengthened. Substantial investments are urgently needed to build up a sufficient capacity at the central, Governorate, and district levels. Such activities include national health accounts, facilities-based master-planning, training on health policy and health financing, project management, financial management and procurement.

The establishment of an adequate level of managerial capacity has been recognized as critical. Some donors have begun work on such areas as clinical training (WHO and JICA), but the needs to strengthen the management capacity at both the central and Governorate levels and support public health training are largely unmet. Iraq currently has very few, if any, qualified public health specialists and no system is in place to train health staff in this area.

Proposed Bank Support to the Health Sector

The initial Project aims to address the most urgent needs of the health sector, stemming from years of neglect and the recent conflict, and is expected to be implemented within 18 months after Project Effectiveness. The first Project will be used to establish a sustainable model for planning, procurement and financial management. It will also permit the development of standards for health facilities and will constitute the most effective way for the MOH to acquire the capacity it needs to manage longer-term reconstruction and rehabilitation activities.

Discussions have been held between the Bank and the Iraqi authorities concerning future support to the health sector, possibly in the form of a 3 to 4 year Credit that would follow the initial Grant. In planning the follow-on investment, the MoH will focus on longer term needs for the sector and will prepare a more comprehensive project. Possible areas identified include: (i) support for the repair and rehabilitation of Primary Health Centers, including provision of basic medical equipment and supplies; (ii) support for the repair, rehabilitation and equipping of priority hospital services, such as Emergency Units and Emergency Obstetric Services, building on the results of the first Project; and (iii) continued capacity-building and training for MoH staff. This follow-on investment would be further elaborated at a later date, based on emerging priorities and the results of the initial Project.

2. Rationale for the Bank's Involvement

Given the situation in the health sector, the Minister of Health has approached the World Bank to request assistance in addressing the most urgent rehabilitation to strengthen the Iraqi health system and increase its capacity to alleviate the currently soaring infant and maternal mortality rates. Areas of priority would include:

- Hospital rehabilitation, particularly Emergency Services capabilities and provision of essential equipment and supplies
- PHC rehabilitation and provision of essential equipment
- On-going capacity-building and training of Ministry staff

Building on the stated priorities of the MOH, the Bank can play an important role in supporting the rehabilitation of the health sector in Iraq, based on the Bank's comparative advantages, including: (i)

global experience in development and post-conflict situations, in particular within the past decade; (ii) “best practice” models that can be applied to the current context; (iii) in-depth knowledge and expertise in health systems development; (iv) extensive experience in helping Governments to work effectively with NGOs; and (v) in its role as financier of last resort, the ability to mobilize additional financing to address the most critical needs for basic health service delivery throughout the country.

For the past year, the Bank’s health team has been in frequent consultations with the Iraqi health authorities concerning health policy and priorities, and has provided training to MoH senior staff outside of Iraq (in Amman and Beirut) in technical and project management areas. These frequent meetings have provided a useful venue for continuing dialogue, and have strengthened the cooperation between Government and the Bank.

3. Project Objectives

The principal objective of the Project is to improve the quality of selected health facilities to serve the urgent needs of the Iraqi population through: (i) rehabilitation of priority emergency services, including emergency obstetric care in 10 selected hospitals, (ii) the urgent provision of basic medical and laboratory equipment to the selected rehabilitated hospitals, (iii) the procurement and distribution of a 3 to 6 month supply of up to 20 essential emergency medicines to be used at emergency facilities rehabilitated through this project; (iv) continued support to strengthening of planning and management capacity within the central and provincial health administrations; and (v) support to project management.

4. Project Description

The Project would comprise five components, to be implemented over a period of up to 18 months. It will be fully funded as a Grant under the Iraq Trust Fund, operating under OP 8.50, Emergency Recovery Assistance. The five components are described below:

Component 1: Rehabilitation of priority emergency services in 10 hospitals

Estimated total cost: US\$28 million

Priority hospital services, such as Emergency Units, Emergency Obstetric Services, Critical Care Services (operation departments, ICU, CCU, acute radiology, etc) and Support Services (central sterilization departments, laboratories, etc) will be partly or fully rehabilitated and equipped in 10 carefully selected hospitals. Criteria for selection will be determined at a later date by MoH, in conjunction with PAC, WB and other funding agencies. Criteria should take into consideration: (i) size of population served; (ii) possible duplication with other donors; (iii) existence of other similar medical services within the catchment area; (iv) accessibility for patients and emergency vehicles; (v) utilization; (vi) staff size; (vii) age of facility; (viii) size of facility and land; and (ix) preliminary cost estimates for rehabilitation.

To date, the MoH has conducted a self-administered facility-needs survey (for hospitals, primary health care centers and sub centers), collecting the following essential data needed in all 18 Governorates: (1) physical structures of all health facilities; (2) accessibility and extent of catchments areas; (3) needs for expansion and rehabilitation; (4) human resources needs; (5) individual needs of each facility; and (6) functionality of each facility. Collection of this information has been completed. As soon as this data is made available, the MoH can use this tool to identify rehabilitation priorities for emergency services at hospitals and select the neediest facilities throughout the country to be rehabilitated. Amount of funding for each selected facility will be determined based on each facilities needs, assuming that some facilities will need more rehabilitation than others.

This first phase of the reconstruction effort will concentrate on establishment of a sustainable model for planning, procurement and financial management. It will allow the development of standards for health facilities and will constitute the most effective way for the MOH to acquire the capacity it needs to manage longer-term reconstruction/rehabilitation activities.

Component 2: Provision and distribution of emergency medical services equipment in 15 rehabilitated hospitals

Estimated total cost: US\$5 million

To the extent possible, hospitals undergoing rehabilitation will not have to be closed, and basic emergency diagnostic and treatment equipment and simple furniture will be supplied as soon as possible to these emergency facilities. To avoid unnecessary delays, there will be no need to complete a detailed inventory of existing equipment. The MOH will agree upon the minimum equipment requirements and will define standard emergency care kits, including emergency obstetric care, which will greatly simplify both procurement and distribution.

Component 3: Provision and distribution of essential emergency drugs

Estimated total cost: US\$5 million

The Emergency Health Reconstruction Project will support the procurement and distribution of a 3 to 6 month supply of up to 20 essential emergency medicines to be used at emergency facilities rehabilitated through this project, with particular attention on emergency obstetric drugs. The MoH will select the essential emergency drugs currently included in leading pharmaceutical formularies, which could include, but are not limited to, the following: 1) general anesthetics and oxygen; 2) preoperative medication and sedatives; 3) anti-infective drugs; 4) blood products and plasma substitutes; 5) cardiovascular drugs; 6) oxytocics and anti-oxytocics and 7) oral and parenteral solutions.

Component 4: Capacity-building and training of MoH staff

Estimated total cost: US\$1.2 million

The Emergency Health Reconstruction Project will continue to support on-going technical assistance in the areas of facilities-based master planning, National Health Accounts, project management, financial management and procurement, much of which began in May 2004. Additional training will be provided in Emergency Medical Services and will focus on the development of a comprehensive national plan for strengthening emergency health care services. A combination of short and long-term training programs, as well as limited physical rehabilitation of existing training institutions will allow for the constitution of a core group of public health and health management specialists. The initial training will lead to the possibility in Phase II of helping set up the first Iraqi School of Public Health and Health Management³.

Component 5: Project Management

Estimated total cost: US\$800,000

Project management support will cover the investment and operating costs of the Project Management Team (PMT), including the provision of furniture, equipment, technical assistance and training necessary for the management of the project activities. Salary costs of the PMT, with the exception of consultants, will be covered by the MoH's recurrent budget.

³ There are no internationally accredited schools of public health in the MENA region. Institutions that provide some PH training exist however in Egypt, Tunisia, Iran and Jordan, but none of these offer the range or the quality of training available in Europe or in the US.

5. Tentative financing

Source:	(US\$m)
BORROWER	0
SPECIAL FINANCING (TRUST FUND GRANT) – Phase One	40
Other financing (lending or donor – TBD)	TBD
Total	40

6. Safeguard Policies (including public consultation)

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP/GP 4.01)	[X]	[]
Natural Habitats (OP/BP 4.04)	[]	[X]
Pest Management (OP 4.09)	[]	[X]
Cultural Property (OPN 11.03, being revised as OP 4.11)	[]	[X]
Involuntary Resettlement (OP/BP 4.12)	[]	[X]
Indigenous Peoples (OD 4.20, being revised as OP 4.10)	[]	[X]
Forests (OP/BP 4.36)	[]	[X]
Safety of Dams (OP/BP 4.37)	[]	[X]
Projects in Disputed Areas (OP/BP/GP 7.60)*	[]	[X]
Projects on International Waterways (OP/BP/GP 7.50)	[]	[X]

Despite the fact that the facilities supported by the Project would only be rehabilitated and there will be no new facilities constructed, the Project has been categorized as Environmental Category B because of the difficulties involved for Bank teams to visit Iraq to assess sites. The requirement to carry out a limited Environmental Analysis as part of project preparation will be waived but, for sub-projects with adverse environmental impact, a limited Environmental Analysis will be done during project implementation but before sub-project approval. At the same time, before appraisal, the implementing agency should agree to apply the following minimum standards during implementation: (i) inclusion of standard environmental codes of practice (ECOP) in the repair and reconstruction bid documents of all sub-projects; (ii) review and oversight of any major reconstruction works by specialists; (iii) implementation of environmentally and socially sound options of disposal of debris; and (iv) provisions for satisfactory budget and institutional arrangements to monitor effective implementation and adequately maintain sanitary facilities after completion.

Resettlement and Land Acquisition: Because of the nature of the project which focuses on rehabilitation of existing structures on the same sites, the OP 4.12 should not be activated since there will not be any displacement of populations or new land acquisition. However, the Bank- approved *Environmental and Social Screening and Assessment Framework*, specifically elaborated for due diligence in the case of Iraq, should be used to ensure that this is indeed the case. Should there be any need for land acquisition, the same guidelines will be followed.

* By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas

7. Implementation

The MoH will have overall responsibility for the coordination and execution of all project activities, and will be guided by a Project Advisory Committee (PAC) chaired by two senior representatives of the MoH, and comprising members from the Ministries of Planning and Development Cooperation, Finance, and Housing and Reconstruction. The PAC will meet on a quarterly basis to: (a) ensure accomplishment of the project objective, (b) oversee and guide project design, (c) facilitate coordination with key Ministries and donors, (d) monitor key project indicators, and (e) ensure adequate operational and maintenance funding. The PAC will endorse annual plans and budget allocations.

A “core team” of senior MoH staff and hired consultants (where expertise is lacking) will constitute the Project Management Team (PMT). The key staff of the PMT will receive special training and orientation in key aspects of project management. The Minister of Health has already identified an initial cadre of candidates, and they have undergone the World Bank’s procurement, FM and project management training in Amman in July 2004. The PMT will be responsible for planning and coordination of all project activities, financial management (accounting and disbursements), procurement of works, goods and consulting services (and related contract management), and monitoring and evaluation to ensure timely implementation and coordination of all project activities.

Procurement of Goods: Goods procured under this project will include: construction materials for the rehabilitation of specified facilities, medical equipment, office furniture, equipment and supplies needed for the project implementation. The procurement will be carried out using the Bank’s Standard Bidding Documents (SBD) for all International Competitive Bidding and National SBD satisfactory to the Bank. Shopping will also be used when appropriate.

Selection of Consultants: Consultants’ services procured under this project will include: selection of a procurement management firm to assist the PMT in procurement-related issues, provide training of the MoH procurement staff and undertake physical spot checks; and selection of individual consultants and/or firms to provide training and capacity-building in financial management.

Selection of consultants prior to contract signing could be accomplished using advanced procurement, with signing and initial payments made as soon as the grant agreement is signed.

Operating Costs: The grant will finance expenditures directly related to the management of the project such as: office rent, local transportation, utility cost, communication costs, translation costs, bank charges, fuel, office supply and labor costs not covered by the GOI. These expenditures, which will be financed by the project, will be procured using the implementing agency’s administrative procedures that have been reviewed and are acceptable to the Bank.

Payments: Payments to contractors, vendors and consultants in this project will be made through direct payment by the World Bank. The Iraqi authorities, with international assistance, are currently evaluating and reforming their financial management system which has been assessed by outside auditors as currently being insufficient to provide adequate controls. Based on eventual reform of the system, and a subsequent positive analysis by the Bank’s FM experts, the second phase may adopt a different system than the current direct payment method.

Coordination with other donors: Collaboration with other donors has been very effective since the completion of the Joint Needs Assessment a year ago, and communication has continued on a regular basis with WHO and other members of the UN Health cluster, the EC, and the main bilateral agencies involved in the health sector: USAID, JICA and DFID. Teleconferences between donor agencies, MOH and the ex-CPA have taken place almost weekly for more than year, and some activities such as the

training in National Health Accounts, have been carried out jointly and continue to be supported by the WB, WHO/EMRO and USAID. The Bank will remain in close contact with all partners involved in the health sector and the MOH has recently created a coordination unit to ensure that the right level of communication/coordination is established with and between donors as well as with other ministries, such as the Ministry of Planning.

8. Sustainability.

As the Needs Assessment shows, the huge requirements in meeting the short term needs (\$1.6 billion) greatly outweigh the current funds available through the IRFFI, and current bilateral commitments. Hence, the MoH will need to seek as many sources of finance as possible, necessitating a strong capacity to manage large numbers of donors, multiple commitments, and parallel initiatives. The Project's reliance on direct implementation by the Iraqi authorities provides an opportunity for capacity building that is perhaps more significant than the level of funding being allocated.

Also, the repair and rehabilitation component is a one-time investment to address accumulated repair backlogs. As most of the work involves rehabilitation/reconstruction of existing buildings, it will therefore not increase recurrent costs in the budget. Maintenance of buildings will be covered by the MoH recurrent budget. Hence, the project is intended to be financially sustainable, as well as technically sustainable through capacity building for implementation. The use of phasing in project design will ensure a measured approach that allows for corrections and revisions to the program.

9. Lessons learned from past operations in the country/sector

Based on the World Bank's recent experience in post-conflict countries such as Afghanistan, East Timor, Bosnia, Algeria, Sierra Leone and Kosovo, a number of important lessons have been learned and introduced into the design of the project.

1. For emergency recovery projects, a simple project design that can be quickly and visibly implemented is most effective.
2. The project should be part of a programmatic framework based on needs assessment of the sector and close collaboration with other key donors.
3. Support to emergency priorities should be coupled with capacity building for the implementing institutions and entities in order to improve their ability to implement current and consecutive programs.
4. In contexts where direct Bank supervision is not possible, adequate training should be provided to local representatives to carry out oversight of the project activities.
5. In post-conflict situations where there are numerous donor agencies involved, support should be provided to the MOH in establishing an effective coordinating mechanism. This support could be in the form of technical assistance and training in setting up the mechanism within the framework of the project, as well as through "informal" technical advice from the Bank team itself to the relevant MOH counterparts. In addition, the Bank needs to maintain good and frequent collaboration with development partners.

10. Major Benefits and Risks

Benefits

The major benefit of successful project implementation will be improved access to essential emergency health services that will address the most urgent medical needs of the population in the catchment area, as well as restore the population's confidence in the public health sector and in public providers. Given the

current calamitous state of emergency health services, the rehabilitation of carefully selected emergency facilities will provide immediate impact and meet the current critical needs of the health sector. The provision of basic equipment will be an important component of the system's performance. Partial retraining of primary health care staff by WHO, UNICEF and bilateral agencies has already started, but its effectiveness will remain limited if Iraq does not train its health workforce in public health and management.

Expected to be completed within a one-year timeframe, the first phase of the emergency rehabilitation project will be an entry point into the health sector and will play an essential role in strengthening the capacity of the MoH in many important areas. Lessons learned during the rehabilitation of the first group of facilities will be incorporated in to the design and used during the implementation of the second Phase. Activities supported by the project will result in a significant and visible improvement of the capacity of the MoH to guarantee the provision of essential health services to the Iraqi communities. Moreover, by fostering a structured approach to health planning, the Project will enable the MoH to focus on necessary systems changes and to make evidence-based decisions in its management of the health sector. The project will also help to build institutional capacity in the Ministry in terms of establishing norms and standards as well as developing skills in project implementation.

Risk Analysis

Risk	Rating	Mitigation Measures
From Outputs to Objectives		
New Iraqi administration emerges from January 2005 elections– unknown outcomes that could affect project implementation	S	Keeping project simple. Working closely with Ministry officials to ensure ownership.
Administration changes in MOH – jeopardizing current commitment to project design and inputs	M	Building relationships at the technical level with current officials to ensure continuity in event of changes.
Multiple efforts and parallel tracking by the various agencies and bilateral donors causing fragmented reform efforts	S	Current multi-agency group, chaired by the MOH seeks to harmonize efforts and responsibilities. Also, the Iraqi Strategic Review Board (ISRB) and its required approval before project financing, will ensure minimal overlap.
From Components to Outputs		
Collection of specific information on the status/condition of facilities to enable planning and priority setting may not be collectable within the time constraints of the Project	ML	Working with MOH to identify the major project sites by Governorate and on the basis of agreed criteria. The MOH has already started the process. Ongoing master plan
Security conditions deteriorate making access by contractors to sites and supervision difficult	S	Use of local contractors and local staff for supervision, plus carefully crafted monitoring arrangements by governorate/directorate assigned staff
Possibility of high prices due to high demand on local construction industry.	M	Regional competition is expected to minimize this.
Financial management--inability to comply with Bank requirements due to systemic problems in banking and accounting practices	M	The current disbursement process of direct WB payments for large contracts will be adopted. Early consultation will be sought from Financial Management consultants to design a simple system that meets project needs and the Bank's financial management requirements.
The Bank's inability to carry out in-country supervision	M	Efforts are being made to identify local consultants that would be contracted to assist in supervision. In addition, special monitoring instruments would be designed for the use of MOH implementation staff and these supervision consultants.

H = High Risk; S = Substantial Risk; M = Modest Risk; N = Low or Negligible Risk

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