PROJECT INFORMATION DOCUMENT (PID)
APPRAISAL STAGE

Report No.: AB1235

Project Name	Emergency Health Project
Region	MIDDLE EAST AND NORTH AFRICA
Sector	Health (100%)
Project ID	P091305
Recipient(s)	MINISTRY OF FINANCE
Implementing Agency	MINISTRY OF HEALTH
Environment Category	[ ] A [X] B [ ] C [ ] FI [ ] TBD
Safeguard Classification	[ ] S_1 [X] S_2 [ ] S_3 [ ] S_F [ ]
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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 is critically lacking essential equipment.

The Iraq Health Sector Situation and Strategy Options Assessment[1] 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 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 (World Bank, UN agencies, and some bilaterals), the following overall priority areas were identified by the Ministry: (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.

In view of the health situation in Iraq, where infant and maternal mortality rates are extremely high and conflict-related injuries are very common, and taking into account the priority areas identified by the MOH and the donor community, this Project will meet several of the urgent needs listed above in response to the current post-conflict situation. Of the twelve aforementioned priority areas, this Project is designed to address five in a manner involving technical soundness, quick implementation, proper procurement and financial management: (i) pharmaceuticals and medical equipment; (ii) emergency medical services; (iii) essential infrastructure rehabilitation; (iv) capacity building and human resources development; and (v) health management.

Existing Health Infrastructure

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.

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

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 to maintain its facilities adequately 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.

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. PMO funding is also 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 Resource 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 training activities include health planning, national health accounts, health policy and health care financing, project management, financial management and procurement (including pharmaceutical 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.

2. Objectives

The principal objective of the Project is to improve access to quality emergency services in selected health facilities to serve the urgent needs of the Iraqi population. This objective would be achieved through: (i) rehabilitation of priority emergency services, including emergency obstetric care in 12 selected hospitals, and the urgent provision of basic medical and laboratory equipment to the selected rehabilitated hospitals; (ii) the provision of a 3 to 6 month supply of up to 37 essential emergency drugs to be used at emergency facilities rehabilitated through this project; (iii) continued support to strengthening of planning and management capacity within the central and Governorate health administrations; and (iv) support to project management. By the end of this project, it is expected that:

- Twelve carefully selected hospitals will have functioning emergency medical services defined by adequate physical infrastructure, essential equipment and drugs, adequate staffing and well-trained emergency teams.
- The Ministry of Health will have strengthened its planning and management capacity at both central and Governorate levels.

3. Rationale for Bank 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 needs 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 emergency equipment and pharmaceuticals;
- Capacity-building and training of MOH 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) applicable experiences from relevant 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.

4. Description

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

Component 1: Rehabilitation of Priority Emergency Services (estimated total cost US$19.5 million)

The Project will support the repair, rehabilitation and equipping activities of hospital emergency facilities to restore fully functional emergency services in 12 carefully selected hospitals in 9 Governorates of Iraq. These activities have been identified and prioritized using explicit criteria of need, feasibility and affordability (see Annex 8A). Repairs and rehabilitation will focus on the priority structural, electrical, mechanical and heating/air conditioning systems for: (a) emergency room reception and administrative counter; (b) triage areas; (c) diagnostic services rooms; (d) patient examination areas; (e) patient wards; (f) minor surgery operating theatre; (g) doctors' and nurses' offices and rest areas; (h) nurses' station; (i) emergency drug dispensary; and (j) other support areas (sterilization room, kitchen, restrooms, storage, janitorial space).

The Project will also provide the selected facilities with their most urgent needs in diagnostic and therapeutic equipment for emergency services, including specific emergency room equipment. Examples of such equipment selected are: diagnostic equipment, emergency resuscitation equipment, and emergency life support equipment (see Annex 8B for a complete list of specific planned investments).

This first phase of the reconstruction effort will concentrate on establishment of a sustainable model for planning, procurement and financial management. It will allow for the development of a standardized approach to the rehabilitation of 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. The Project will provide financing for the rehabilitation activities, emergency medical equipment and technical assistance for design and supervision of the sites.

Component 2: Provision of Essential Emergency Drugs (estimated total cost US$3.2 million)

The Project will support the procurement and distribution of a 3 to 6 month supply of up to 37 essential emergency drugs to be used at the 12 emergency facilities rehabilitated under Component 1. Categories of essential emergency drugs include the following: (i) general anesthetics; (ii) preoperative medication and sedatives; (iii) anti-infective drugs; (iv) cardiovascular drugs; and (v) oral and parenteral solutions. This component will be supported through the provision of pharmaceuticals.

Component 3: Capacity Building and Training (estimated total cost US$1.6 million)

The Project will support capacity-building and training activities in Emergency Medical Services for the 12 selected sites. These activities will include: (i) technical training of emergency 5-person teams from each selected site to improve the quality of emergency services; (ii) training in management of emergency services for the hospital directors, emergency chief doctors, head nurses and central-level emergency services planners; and (iii) the development of a comprehensive national plan for strengthening emergency health care services. Additionally, the Project will support training to build the general capacity of MOH in health planning and management at both the central and Governorate levels. A number of short-term training programs will allow for the constitution of a core group of public health and health management specialists. The project will also provide assistance to the MOH in developing a sustainable plan for procurement and distribution of essential emergency drugs. This component will be supported through the provision of technical assistance and training activities.

Component 4: Project Management (estimated total cost US$ 0.7 million)

The objective of this component is to ensure effective administration and coordination of the project activities. The Project Management Team (PMT) will comprise eleven staff, five of whom will be local consultants hired under the Project. PMT staff will include: a Project Director to manage and coordinate the implementation of the Project; a Deputy Project Director to be responsible for day-to-day management of the project; a Technical Coordinator to ensure that the technical aspects of the project are being implemented; a Procurement Officer, assisted

by three staff, to supervise tendering, purchasing and delivery of works, goods and services; a Financial Officer, assisted by an accountant, to maintain project financial records; an Administrative Secretary, and a Junior Secretary to support the needs of the office. Drivers for the three project vehicles and a messenger will also be hired to support the project.

The component will finance: (i) minor refurbishment of the PMT offices agreed between the MOH and the Bank; (ii) adequate office equipment and supplies, and three project vehicles; (iii) technical assistance and training for PMT staff in project management, procurement and financial management; (iv) annual external audit of the project; (v) operating costs for the PMT, including vehicle and equipment operation and maintenance, communications costs, banking fees, transportation costs, meeting expenses, advertisement fees, representation, and office security arrangements.

5. Financing

Source:		($m.)
RECIPIENT (IRAQI GOVERNMENT)		1.9
SPECIAL FINANCING (TRUST FUND GRANT) – Phase One		25
	Total	26.9

6. Implementation

This project is the first in the health sector to be financed from the World Bank Iraq Trust Fund (WBITF) within the International Reconstruction Fund Facility for Iraq (IRFFI). The Ministry of Planning and Development Cooperation (MOPDC) is the Government's designated donor coordination agency for Iraq's reconstruction program.

A Project Management Team (PMT) will be established to coordinate and manage the Emergency Health Rehabilitation Project (EHRP) under the authority of the Ministry of Health. The PMT will have the responsibility for the day-to-day management, coordination and monitoring of the Project activities. The Project will adopt the management structure put in place for EHRP.

The PMT will: (i) coordinate project implementation, and manage the resources of the project; (ii) procure all Bank-financed goods and services under the project; (iii) operate the financial management system according to World Bank requirements; (iv) act as liaison between the technical agencies involved in the project and the World Bank; and (v) carry out, on an annual basis, an independent audit of the project. Specifically, in its management capacity, the PMT will ensure that: (a) the project activities are well-coordinated; (b) issues affecting or potentially affecting project implementation are identified and addressed in a timely manner; (c) technical advice is provided to project component coordinators and relevant MOH staff in how to develop work plans, write terms of reference, and effectively manage consultant services; (d) safeguard issues are addressed in compliance with the Environmental and Social Assessment Framework (ESSAF); (e) necessary project inputs are provided in a timely and cost-effective manner; (f) project resources are appropriately managed in accordance with Bank requirements for procurement and financial management; (g) effective project monitoring and progress reporting are carried out; and (h) there is a systematic out-reach to various stakeholders to promote project objectives.

All procurement for project activities will be carried out at the central MOH level, with participation as needed from the MOH Directorates level. Given the urgency of this project, it has been decided that a technical assistance firm will be selected under the project to provide support and training to the PMT in procurement. This support will involve: (i) preparing civil works design and tender documents; (ii) preparing tender documents for medical equipment; (iii) providing support and advice in carrying out of tendering and selection procedures for both rehabilitation and medical equipment; and (iv) giving on-the-job training to the PMT staff and other relevant staff within the MOH. The technical assistance firm for this assignment should have extensive prior experience in World Bank procurement guidelines and procedures, as well as the technical and logistics capacity to provide this support within the current security environment in Baghdad.

7. Sustainability

The proposed Project aims to address the most urgent needs of the health sector, stemming from years of neglect, the recent conflict, and dramatic increases in violence in areas that had until recently been relatively untouched. Expected to be implemented within 18 months after Project Effectiveness, the Project will be used to establish a model for planning, procurement and financial management within the health sector. It will also allow for the development of a standardized approach to rehabilitation of 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.

8. Lessons Learned from Past Operations in the Country/Sector

Lessons from Post-Conflict Experience. 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 proposed project. Below are key lessons learned:

- For emergency recovery projects, a simple project design that can be quickly and visibly implemented is most effective.
- The project should be part of a programmatic framework based on needs assessment of the sector and close collaboration with other key donors.
- 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.
- 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.
- 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.

9. 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)	[ ]	[ ]
Pest Management (OP 4.09)	[ ]	[ ]
Cultural Property (OPN 11.03, being revised as OP 4.11)	[ ]	[ ]
Involuntary Resettlement (OP/BP 4.12)	[ ]	[ ]
Indigenous Peoples (OD 4.20, being revised as OP 4.10)	[ ]	[ ]
Forests (OP/BP 4.36)	[ ]	[ ]
Safety of Dams (OP/BP 4.37)	[ ]	[ ]
Projects in Disputed Areas (OP/BP/GP 7.60)*	[ ]	[ ]
Projects on International Waterways (OP/BP/GP 7.50)	[ ]	[ ]

Environmental Safeguards: The Project is rated category "B". Impacts would be those associated mainly with (i) rehabilitation works (e.g., safety, dust, noise, waste material, traffic); (ii) provision of sanitary services, water supply and waste management; and (iii) maintenance of facilities. Because of the emergency conditions, the requirement to carry out a limited Environmental Analysis as part of project preparation will be waived. However, for sub-projects with adverse environmental impacts, a limited Environmental Analysis will be done during project implementation but before sub-project approval. The Environmental and Social Screening and Assessment Framework (ESSAF) was disclosed in the country and in the Infoshop on October 7, 2004. Based on the ESSAF, the following standards will be applied during implementation: (i) inclusion of standard environmental codes of practice (ECOP) in the rehabilitation and extension bid documents of all sub-projects; (ii) use of Safeguard Procedures for Inclusion in the Technical Specifications of Contracts; (iii) use of the Checklist of likely Environmental and Social Impacts of Subproject; (iv) review and oversight of any major reconstruction works by specialists; (v) implementation of environmentally and socially sound options for civil works; and (vi) provision for adequate budget and satisfactory institutional arrangements to monitor effective implementation and adequately maintain sanitary facilities after completion. Capacity building on Safeguards and on the implementation of the ESSAF has already been undertaken with the Ministry of Environment and other line Ministries.

Resettlement and Land Acquisition: There will be no construction of new facilities in the Project. However, there will be some site extensions that will be limited to vacant sites that are on public property assigned by the relevant authorities for the use of MOH. OP 4.12 should not be triggered since there should not be any displacement of populations or new land acquisition. However, the ESSAF, specifically elaborated for due diligence in the case of Iraq, should be used to ensure that this is indeed the case and should there be any need for land acquisition or population resettlement, the same guidelines will be followed.

An MOH-PMT specialist will be trained in World Bank safeguards policies, and MOH engineering staff (or consultants where capacity is lacking) will carry out site supervisions to

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

check on compliance of contractors with environmental and social safeguards. Site supervision reports will include a section on environmental and social safeguards that will be filed with the MOH-PMT. The first three site supervision reports will be sent to the Bank for review.

10. Contact point

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