برنامج الأغذية العالمي
Programme Alimentaire Mondial
World Food Programme
Programa Mundial de Alimentos

Executive Board

Third Regular Session

Rome, 21 - 24 October 1996

PROGRESS REPORTS ON APPROVED PROJECTS

Agenda item 8 d)

E

Distribution: GENERAL

WFP/EB.3/96/8-D/Add.6
2 September 1996
ORIGINAL: ENGLISH

PROJECT PAKISTAN 2237 (Exp. 3)	
Assistance to primary health care	
Total food cost	22 485 306 dollars
Total cost to WFP	25 613 995 dollars
Date approved by the CFA	7 June 1990
Date plan of operations signed	13 February 1991
Date notification of readiness accepted	17 February 1991
Date of first distribution	1 January 1992
Duration of WFP assistance	Four years and six months
Duration of project as at 29 February 1996	Four years and two months

All monetary values are expressed in United States dollars, unless otherwise stated. One United States dollar equalled 34 Pakistani rupees in February 1996.

NOTE TO THE EXECUTIVE BOARD

This document is submitted for consideration to the Executive Board.

Pursuant to the decisions taken on the methods of work by the Executive Board at its First Regular Session, the documentation prepared by the Secretariat for the Board has been kept brief and decision-oriented. The meetings of the Executive Board are to be conducted in a business-like manner, with increased dialogue and exchanges between delegations and the Secretariat. Efforts to promote these guiding principles will continue to be pursued by the Secretariat.

The Secretariat therefore invites members of the Board who may have questions of a technical nature with regard to this document, to contact the WFP staff member(s) listed below, preferably well in advance of the Board's meeting. This procedure is designed to facilitate the Board's consideration of the document in the plenary.

The WFP focal points for this document are:

Regional Manager:	M. Hammam	tel.: 5228-2208
Desk Officer:	J. Taft-Dick	tel.: 5228-2323

Should you have any questions regarding matters of dispatch of documentation for the Executive Board, please contact the Documents Clerk (tel.: 5228-2641).

PURPOSE OF THE PROJECT AND OF WFP ASSISTANCE

1. Despite satisfactory economic growth, Pakistan's social indicators continue to lag behind those of countries at a similar stage of development, especially in respect of health for women and children, and girls' education. In view of the disappointing progress made in the development of human resources, the Government of Pakistan has embarked on a social action programme (SAP) to address the needs of the rural poor in basic education, primary health care, family planning, and rural water-supply and sanitation. In the health sector, the programme seeks to improve the efficiency and utilization of basic health care facilities, and, in particular, to increase women's access to health services. In support of this strategy, the project has been redesigned to use food aid as an investment in the development of human resources to achieve the following objectives:

   a) ***Long-term objective***: assist the Government of Pakistan in its efforts to promote primary health care in rural areas and urban slums.

   b) ***Short-term objectives***: i) promote the attendance of poor expectant mothers at health centres; and ii) promote the use of specific primary health care services.

2. These are core policies, consistent with the WFP Mission Statement to improve the quality of life of the most vulnerable people through health protection and education, transferring food directly to mothers as an incentive (income transfer), and in support of food security at the household level.

IMPLEMENTATION

3. The project is implemented by the Provincial Health Departments under the supervision of the Federal Ministry of Health. Provision of pre and postnatal health care and distribution of oil to the beneficiaries at the centre level are carried out by lady health visitors.[1] The project currently covers about 980 health centres (18 percent of the national total); of these, 200 are in NWFP, 200 in Sindh, 90 in AJK, 90 in Baluchistan and 400 in Punjab, selected in areas where public health conditions are poor and attendance is low.

4. According to the original plan of operations, WFP was committed to supplying a food basket consisting of five commodities for nutritional support to the beneficiaries. The project was redesigned with a view to simplifying distribution and reducing transport costs by reducing the food basket to a single high-value commodity, edible oil. The project's objectives were also revised to focus on the promotion of key MCH services, with food transfer to mothers linked to periods of maximum nutritional risk. Each beneficiary receives a total of up to four tins of oil (four to five kilograms each) during the course of one pregnancy/delivery and postnatal care period. The first tin is given when the pregnancy is confirmed after proper examination; it is accompanied by a tetanus vaccination (TT I) if needed. The second tin is supplied after the sixth month of

[1] Employees of the Health Department in the health centres appointed to deliver MCH services.

pregnancy, when the second tetanus vaccine shot (TT II) is administered. The third is given when the mother brings her new baby for weighing and BCG vaccination, and the fourth when the child is given DPT protection. At each stage, the mother receives relevant health education messages on breast feeding, immunization, child health and nutrition, and family planning advice. The women are encouraged to seek early registration of pregnancy in order to benefit from the preventive health care services.

5. Implementation of the new strategy, together with intensive monitoring, started in early 1995 in Punjab, AJK and Baluchistan and, in late 1995, in Sindh and NWFP. Monitoring of the project by WFP was strengthened with the establishment of a SAP unit, staffed by a programme manager and five field officers (one based in each province), as well as two monitoring and evaluation officers. Check-lists for district- and centre-level monitoring have been designed to collect data on the management of the project as well as the key performance indicators, such as registration and attendance levels of expectant mothers, number of prenatal visits, pregnancy stage at the time of registration, and the extent of TT, BCG and DPT coverage and health advice given.

FOOD MANAGEMENT

6. Originally, WFP was committed to supplying 910 tons of tea, 6,248 of wheat-soya blend, 7,602 of sugar, 4,614 of butter oil and 11,483 of pulses. By 1994, the project had received 131 tons of tea, 1,200 of wheat-soya blend, 1,505 of sugar, 1,508 of butter oil and 4,318 of pulses. As a result of the change in the logistics strategy, the balance of the commitment was converted into vegetable oil (19,000 tons) through a budgetary revision.

7. The commodities supplied under the old strategy were utilized by the end of 1994. By the end of 1995, the project had received 2,345 tons of oil under the new strategy; of these, it had utilized 1,935 tons (83 percent of the total). Post-delivery losses amounted to 15 tons or 0.6 percent of the total receipt of oil. Of the total quantity of oil, 372 tons were allocated to the Sindh Government for flood victims (mothers and children) in 1994. The Government of France provided 27,729 dollars to meet the transportation, training and monitoring costs involved in implementing this operation.

8. The cost of supplying, shipping and delivering WFP vegetable oil to the beneficiaries is estimated at 1,143 dollars a ton (of which 50 dollars is the cost per ton for internal transport), as compared with the average local market price of 1,349 dollars a ton. This gives an alpha value of 1.18, a low government overhead cost and a positive efficiency of food aid as an income transfer.

GOVERNMENT'S CONTRIBUTION

9. The Government's contribution to the project, which is in the form of staff, health services and the cost of transportation of edible oil, corresponds to its obligations, as stated in the plan of operations. There is scope, however, for improving the consistency in its supply of inputs to the health centres.

TECHNICAL SUPPORT AND EXTERNAL ASSISTANCE

10. Major donors, including the World Bank, the Asian Development Bank, the Governments of the United Kingdom and of the Netherlands, the Japan International Cooperation Agency (JICA), WHO, UNFPA, and UNICEF are providing technical support to the primary health care sector to develop institutional capacity, supply inputs, recruit and train additional female staff, and improve services. The Government has recently initiated a lady health workers (LHW) programme to create awareness about health in rural communities. A health management information system (HMIS), to institutionalize systematic data collection in all provinces, and a multi-donor support unit (MSU), to coordinate SAP activities, have also been established. Regular coordination meetings are held between WFP and the MSU to share monitoring results and review matters related to health and basic education.

11. WFP staff have trained counterpart personnel in the new strategy, project implementation, recording and reporting systems, and food management. A beneficiary contact monitoring (BCM) system has been instituted to assess project impact. M&E workshops are being held to review monitoring results, strategies and future plans with the project authorities. The project has also received trucks and pick-ups from the Government of Sweden to facilitate transportation of oil and mobility of the counterpart staff for monitoring purposes.

ASSESSMENT

12. The project has been monitored intensively by WFP (30 percent of outlets visited) since 1995. In addition, annual reviews in each province, with the participation of donors such as the European Union, Catholic Relief Services and UNICEF, were conducted to assess the project's effects and validate monitoring results compiled by WFP. Following the annual review in each province, a management review was undertaken by WFP headquarters to assess the project's progress under the new strategy in the initial stages of its implementation. The outcome of the reviews was discussed with the project authorities and the representatives of various donors and technical agencies. Results have confirmed that the new strategy has been accepted fully. It has enabled the transfer of food aid in a cost-effective and simple way to poor families in rural areas, with mothers receiving the oil during the health centre visit. The income transfer through the oil (200 to 230 rupees) represents about 10 percent of the monthly household income of poor families that are dependent on free government basic health services.

13. As shown in the tables in the annex, the daily registration and examination of expectant mothers in the assisted centres (where oil was distributed) has increased, on average, by 71 percent. The project has been instrumental in extending basic health messages to the women on breast feeding, immunization, nutrition, diarrhoea control and family planning, and strengthened immunization, although lately there have been problems in the supply of vaccines and breakdowns in the cold chain systems in centres. These may have occurred because the Government has recently taken over from the donors the responsibility of supplying these inputs. Moreover, other health inputs, such as iron tablets for the treatment of anaemia and vitamin supplements, are often not available at health centres.

14. Nearly 1,000 BCM interviews were conducted at the centres and at the homes of the mothers in all five regions. On an average, 48 percent of beneficiaries interviewed had registered within the first five months of pregnancy, which compares favourably with the national average, estimated by the Pakistan Health and Demographic Survey (PDHS) at 20 percent. Similarly, the proportion of women going to WFP-assisted MCH centres for three or more prenatal visits is 193 percent higher. Also, the number of attended births for women who have visited the project centres is 68 percent above the national figure. Perhaps the most encouraging factor revealed by the BCM is that a sizable proportion (on average over 40 percent) of women interviewed confirmed that they had received and understood the basic health messages. The proportion of beneficiaries below the age of 20 and those giving birth for the first time was, however, very low (below 10 percent) in all provinces. It appears that the project is not yet reaching young mothers or those at their first pregnancy. This may be due to socio-cultural factors that militate against young women's mobility and/or to a lack of awareness about the services offered at the centres.

15. There is as yet no way of assessing the long-term sustainability of the project, i.e., whether women will continue to attend the centres for prenatal care once oil distribution ends. There are some encouraging signs, however. In Punjab, where the project was recently on hold for some months, data on new registrations show that, although the rate of registration dropped when the oil distribution was interrupted, it did not fall to pre-project levels.

16. Some estimates of the cost effectiveness of the project have been prepared. These show that the recurrent costs per beneficiary of operating a health centre have actually decreased by 3.7 percent, because of the project-engendered increase in the number of beneficiaries attending. WFP monitoring and supervision costs per centre were three percent of the total project costs and 10 percent of the food costs. The market value of the incentive given to mothers was estimated at approximately seven dollars. This exceeded the cost of the oil's procurement, shipment, delivery and monitoring. Health benefits are not calculable in the same way, but importantly include the protection of mothers and children through immunization, advice on safe delivery, education for better child care and nutrition, and awareness of available family planning services.

CONCLUSIONS AND RECOMMENDATIONS

17. The WFP oil incentive has encouraged more expectant mothers to use the existing facilities at health centres, an outcome which is consistent with one of the main objectives of the SAP. They are now registering earlier, having more antenatal check-ups, and more are deciding to have trained birth attendants present at the (usually) home delivery. Clearly, many are attracted by the distribution of a can of oil for key health services. This seems to compensate for the time and cost of travelling to a health centre, often far from their village. Since the provision of vegetable oil is meant only as an "introductory offer" to attract women to obtaining advice and services, it is encouraging that even an incomplete delivery of food incentives has a positive effect on attendance. Sustainability will depend largely on having more and better trained lady health visitors and village-based lady health workers, improved availability of vaccines and other health and micronutrient inputs, and better use of health education and family planning advisory material. The provincial health authorities should make efforts to ensure a consistent availability at WFP-assisted health centres of health service supplies such as expanded programme of immunization (EPI) vaccine, iron/vitamin tablets and family planning material. The project also needs to remain restricted to health facilities in rural areas and urban slums that are fully equipped to deliver primary health care services, but are under-utilized. WFP is now planning to phase out of urban facilities where registrations have already become sufficiently high. A strong linkage needs to be established with the Prime Minister's community health workers programme to create community awareness about the project, available health services and entitlements.

18. In order to maintain continuity, the supply of oil needs to be regularized. The time frame of shipment arrivals should be communicated to the Government in advance (at the beginning of the calendar year) so that the appropriate budgetary allocation can be made for the fiscal year (July to June). Donors should also be requested that the oil be vitamin-fortified and that cartons have dates of production and/or expiry clearly printed on them.

19. Given the positive results of the new strategy encouraging more women to attend the MCH centres and receive preventive health care services and health education messages, it has been recommended that the project be extended in time for two years, without an additional commitment, to coincide with the termination dates of other operational projects in Pakistan under the country programme cycle (July 1994 to June 1998). The project will be evaluated in 1997 to assess, *inter alia*, performance, including the increased uptake in beneficiary numbers (2.6 times the level in 1996, as compared to the initial start-up year of 1995 when the new strategy was successfully tested). This evaluation, which will be undertaken as part of a joint review of WFP's aid to the social action programme in Pakistan, will also determine prospects for expanding project activities in the next country programme cycle.

ANNEX

TABLE I

ESTIMATED NUMBER OF BENEFICIARIES AND OIL REQUIREMENT

	1995	1996	1997	1998	1999	Total
Estimated no. of beneficiaries[1]	67 725[2]	178 250	225 000	225 000	225 000	920 975
Estimated oil utilization (tons)	1 935[3]	3 565	4 500	4 500	4 500	19 000[4]
Annual target (%)	10	18	24	24	24	100

[1] Expected level of participation in Punjab is 45 percent, Sindh 20 percent, NWFP 20 percent, Baluchistan seven percent and AJK eight percent.
[2] The project was implemented in 650 centres in 1995, which increased to 980 in 1996.
[3] Of this, 372 tons were used for flood victims in Sindh.
[4] Balance of revised commitment in terms of edible oil.

TABLE II

AVERAGE DAILY REGISTRATION OF EXPECTANT MOTHERS AT HEALTH CENTRES[1]

	Punjab	NWFP	Sindh	Baluchistan	AJK	Overall
Before oil distribution[2]	1.24	0.67	1.10	0.93	1.13	1.01
After oil distribution[2]	1.78	1.32	1.34	2.11	2.11	1.73
% increase in registration of expectant mothers	44	97	22	127	87	71

[1] Daily average arrived at by dividing the monthly registration of pregnant women by no. of days the LHV was present in the health centre.
[2] Average of the three-month period before and after oil distribution.

N.B. Analysis based on 56 out of 210 centres visited in Punjab, 45 out of 150 visited in NWFP, 45 out of 180 in Sindh, 18 out of 67 in Baluchistan, 18 out of 56 in AJK from July 1995 to March 1996. The high increase in Baluchistan and NWFP is due to low base before the oil distribution in these less populated, more distant provinces.

TABLE III

SUMMARY OF BENEFICIARY CONTACT MONITORING (BCM) RESULTS

	Punjab	NWFP	Sindh	Baluchistan	AJK	Overall
Age profile of beneficiaries (%)						
- Under 20 years	6	8	7	2	8	6
- 20-29 years	54	66	62	38	53	55
- 30-39 years	36	22	31	49	24	35
- 40 years & above	5	5	1	11	8	6
Registration in first five months (%)	59	41	40	25	63	48
Confirmed that oil was received (%)	96	100	100	100	100	99
Awareness of entitlement (%)	43	19	16	54	88	47
More than three prenatal visits (%)	49	25	49	12	52	41
Delivery of baby by trained staff (%)	87	58	28	62	60	64
Number of beneficiaries interviewed	299	157	105	212	175	948