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Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 27-Oct-2022 | Report No: PIDA34372

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Pakistan	P178530	Sindh Integrated Health and Population Project	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
SOUTH ASIA	13-Oct-2022	08-Dec-2022	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Islamic Republic of Pakistan	Government of Sindh, Department of Health	

Proposed Development Objective(s)

To improve utilization and quality of basic RMNCAH+N, for poor and vulnerable populations, especially women and children, in targeted areas of Sindh

Components

Component 1: Improving RMNCAH+N services utilization and quality and support during public health emergencies
Component 2: Strengthening demand for RMNCAH+N services including women's empowerment for availing health services
Component 3: Project Management, Monitoring and Evaluation and Research
Component 4: Contingency Emergency Response Component (CERC)

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	230.00
Total Financing	230.00
of which IBRD/IDA	200.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	200.00

IDA Credit	200.00
Non-World Bank Group Financing	
Counterpart Funding	30.00
Borrower/Recipient	30.00

Environmental and Social Risk Classification

Moderate

Decision

The review did authorize the team to appraise and negotiate

B. Introduction and Context

Country Context

1. **Over the past two decades, Pakistan has achieved significant poverty reduction, but human development outcomes have lagged, and economic growth has remained volatile and slow.** Expansion of off-farm economic opportunities, and the increase in migration and associated remittances allowed over 47 million Pakistanis to escape poverty between 2001 and 2018. Despite rapid poverty reduction, human capital outcomes have remained poor and stagnant, with high levels of stunting at 38 percent and learning poverty at 75 percent. Pakistan has also experienced frequent macroeconomic crises due to a growth model based on private and government consumption, with productivity-enhancing investment and exports contributing relatively little to growth. Growth of per capita gross domestic product (GDP) has been low and volatile, averaging under two percent in the last two decades. Recent unprecedented floods are likely to have serious impacts on poverty, human development outcomes and economic growth.

2. **The recent floods have had enormous human and economic impacts.** Pakistan experienced heavy monsoon rains between June and September 2022 which has severely affected millions of households, mainly in Sindh and Balochistan. Around 33 million people have been displaced, and more than 13,000 kilometers of roads destroyed. The flooding has damaged 2.2 million houses, flooded around 9.4 million acres of crops, and killed an estimated 1.2 million livestock, adversely affecting rural livelihoods. Limited access to input and output markets and temporary disruptions to supply chains have driven up food prices and added to existing price pressures resulting from reduced agricultural yields and the global rise of food prices. Food shortages are expected to intensify in the fall and winter due to significant crop and livestock losses. Preliminary estimates suggest that as a direct consequence of the flood, the national poverty rate may increase by up to 4.0 percentage points, potentially pushing around 9.0 million people into poverty.

Sectoral and Institutional Context

3. **Sindh is the second largest province of Pakistan with significant levels of rural poverty and a high reliance on irrigated agriculture.** Covering an area of 140,914 km² (17.7 percent of the total area of Pakistan), Sindh has a population of 50.4 million people (23 percent of the country's population) and generates 27 percent of Pakistan's GDP. Nearly half (48 percent) of Sindh's population lives in rural areas and about 37 percent of the rural population is below the poverty line—higher than the Pakistan average. Poverty rates are much higher in some flood-impacted districts, reaching 53.4 percent in Badin. Satellite data combined with survey data suggest that poorer households were more likely to be affected by the flood within districts and tehsils. Beyond monetary and non-monetary poverty, areas in Sindh affected by the floods showed some of the highest stunting rates in the country, reflecting limited access to sanitation facilities and clean water. Agriculture accounts for about 24 percent and 70 percent of provincial GDP and employment in Sindh, respectively, and poor households derive 56 percent of their income form agriculture.[1] Poverty levels in rural Sindh are closely correlated with farm size or tenure relationship as small farmers tend to have less access to technologies, credit, water, and government support programs.[2]

4. **Sindh has been disproportionately affected by the 2022 floods and human capital outcomes are expected to deteriorate because of the recent catastrophic floods, COVID-19 pandemic and the income losses caused by the global economic contraction.** The province is estimated to have received rainfall in excess of 400 percent over the 30-year average. Between June 14 and September 26, 2022, 747 of the 1,638 nationwide casualties were in Sindh, including 319 children, with 8,422 people injured. Over 1.8 million houses in Sindh were damaged or destroyed, nearly 89 percent of the nationwide total.[3] Reports estimate that more than 3.9 million hectares of agricultural land has been destroyed in Sindh alone, which could contribute to food shortages in the near future. Vast areas in Sindh have witnessed prolonged inundation lasting several weeks with floodwater accumulating from other parts of the country following glacial melt in the mountainous north and record monsoon rains nationwide. Meanwhile, stagnant water in several districts has given rise to skin, gastric, and mosquito borne diseases. Physical damage to education and health facilities are significant as many buildings remained under water, resulting in damaged equipment and unserviceable public buildings. Some education facilities are being used as shelters, and the unavailability of electricity and potable water has made the provision of services challenging. The pandemic and the associated containment measures worsened living conditions across the population as it caused loss of income among workers and lower remittances until June 2020[4], which increased the population's dependance on insufficient public transfers in 2020. In November 2020, the Pakistan Bureau of Statistics estimated 40 percent of households suffered from severe to moderate food insecurity, compared to 16 percent in 2018–19.

[1] Household Income and Expenditure Survey (HIES) 2015-2016, Pakistan Bureau of Statistics.
[2] Approximately 83 percent of farms are less than 5 has but account for only 37 percent of all farmland, and approximately 20 percent of farmland, mainly on the larger farms, is cultivated based on sharecropping or leases. Abdul Wajid Rana and Heman Lohano (forthcoming), Sindh Water and Agriculture Sector Public Expenditure Review. World Bank.
[3] National Disaster Management Authority (NDMA). 2022. *NDMA Monsoon SITREP: Daily SITREP No. 105 Dated 26th Sep, 2022*.
[4] https://www.ceicdata.com/en/pakistan/workers-remittances/workers-remittances

5. **Access to quality reproductive, maternal, newborn, child, and adolescent health with nutrition (RMNCAH+N) is the foundation for a healthy start in life and key for reducing gender imbalances.** The package of essential RMNCAH+N services includes at least four ante-natal care (ANC) checkups; births delivered by a skilled attendant; post-natal care; family planning (FP) information and services; social and behavior change communication (SBCC) to inform, educate, and encourage better health practices; childhood immunizations, including BCG, Hep B, OPV 0-III, Pentavalent I-III, Pneumococcal I-III, Rotavirus I-II, IPV, and Measles I; and nutrition interventions, such as counselling for better nutritional behavior practices, growth monitoring and provision of micronutrients and vitamin supplements.

6. **On average, access to RMNCAH+N services in Pakistan is inadequate, with regional disparities.** About 49 percent of pregnant women do not receive the recommended four or more ANC visits essential for ensuring a safe and healthy pregnancy.[5] With 33.8 percent of births outside of health facilities, the risk of maternal and infant mortality and morbidity[6] is further exacerbated. There is also poor utilization of childhood health services: full immunizations are at 65.6 percent and only 8 percent of children received treatment of diarrhea with zinc and oral rehydration solution, which potentially compromise childhood health outcomes.

7. **There is evidence of improvements in recent years in a range of indicators related to reproductive, maternal, newborn, child, and adolescent health and nutrition (RMNCAH+N) in Sindh.** Under-5 mortality declined overall from 93 deaths per 1,000 live births in 2012–13 to 77 deaths per 1,000 live births in 2017–18, and institutional deliveries increased from 58.6 percent in 2012–13 to 71.8 percent in 2017–18. Immunization coverage also improved from 29.1 percent to 48.8 percent. Childhood stunting has reduced from 56.7 percent to 49.9 percent (table 3). One of the factors contributing to significant improvement in RMNCAH indicators is an increase in the financial resource base for the health sector since devolution in 2010. There has been a faster increase in financial outlay over the past 10 years which has helped to make improvements in the health sector including fostering public private partnerships for primary healthcare. Average real per capita in 2012 was US$5, which doubled by 2019. This shows Sindh's financial commitment to invest more in the health sector.[7]

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

To improve utilization and quality of basic RMNCAH+N, for poor and vulnerable populations, especially women and children, in targeted areas of Sindh.

Key Results

8. The PDO will be measured by the following indicators:

[5] Pakistan DHS 2017–18.

[6] Pregnancy related illness such as hypertensive disorders, gestational diabetes, post-partum hemorrhage, are some of the leading causes of maternal morbidity and mortality that can contribute to preterm and intrapartum complications (e.g. birth asphyxia and its complications).

[7] Fiscal Space Analysis for Health Report 2021.

- Married women who were counseled for family planning at GDs and availed FP services
- Pregnant women who have had at least 4 ANC visits at health facilities during their last pregnancy in the catchment population
- Pregnant women who had their deliveries conducted by a skilled birth attendant at a health facility in the catchment population
- Children between the ages of 12 to 23 months fully immunized as per the age specific protocol
- Children aged 6-23 months who receive yearly a minimum of 90 micronutrient sprinkles sachets for three months in intervention areas

D. Project Description

9. **Component 1: Improving RMNCAH+N services utilization and quality and support during public health emergencies (indicative US$175 million).** This component will support an integrated care of RMNCAH+N services. It will provide seamless and coordinated care for patients and their families with a network of services that begin at GDs with strong referral pathways to a network of care as needed. It will enhance patient referral pathways between GDs and other health facilities such as BHUs, RHCs, Tehsil Headquarter Hospitals (THQ) and District Headquarter Hospitals (DHQ) through proper mapping of facilities and provision of adequate resources. This component will also finance the relief, rehabilitation and reconstruction needs arising from damages and losses to health infrastructure and disruption of healthcare service delivery in the project supported areas due to the current rainfall and flooding since June 2022.

10. **Component 2: Strengthening demand for RMNCAH+N services, including women's empowerment for availing health services (indicative US$14 million).** This component will cover SBCC and related activities to encourage uptake of RMNCAH+N services using social marketing strategy and rebranding of GDs and their services package to create awareness. It will also include women's empowerment for exercising sexual and reproductive health rights. Social and behavior change activities will include extensive community outreach, involvement of community and religious leaders to reach these GD catchment areas and the internally displaced population (IDP) due to flood. There will be mid-media to communicate key messages. This component will support face-to-face discussions or focus groups at the women's community centers and IDP settlements. This will also include interventions to engage other gatekeepers such as husbands, mothers-in-law, and community leaders on key issues such as women's role in decision-making about their own health, birth spacing, and timely uptake of RMNCAH+N services and benefits of reducing violence. The demand will be enhanced through social movement in health by conducting social accountability interventions, annual health assemblies and social audits. These activities will involve partnering with NGOs, community-based organizations, and other private sector organizations.

11. **Component 3: Project Management, Monitoring and Evaluation and Research (indicative US$11 million).** This component will support the strengthening of the DoH and its coordinating structures and agencies for the coordination and management of project activities, including financial management,

procurement, PPP node, stakeholder engagement in line with the Stakeholder Engagement Plan, and compliance with the Environment and Social Commitment Plan. This component would also support monitoring and evaluation (M&E) including third-party monitoring, rapid household surveys and surveys to measure quality of service delivery at health facilities (e.g., Service Delivery Indicator Survey). The relevant structures will be strengthened by recruitment of additional staff/consultants, use of information technology and communication equipment and workshops and training**.** It will also build the capacity of the DoH for clinical and public health research for policy information. A feasibility study on service delivery redesign will be conducted with the support from Global Financing Facility of the World Bank. Based on the findings of the study, Government and the Bank teams will jointly work to test the necessary arrangement to redesign effective delivery care.

12. **Component 4: Contingency Emergency Response Component (CERC) (US$0 million).** In the event of an Eligible Crisis or Emergency, the project will contribute to providing immediate and effective response to said crisis or emergency.

Legal Operational Policies

	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Assessment of Environmental and Social Risks and Impacts

13. **Overall environmental and social risk classification of the project is assessed to be Moderate.** The environmental risks are mainly associated with Component 1 which involves refurbishment of GDs, procurement of equipment, medicines and supplies and ambulances for referral. Civil works of minor to moderate nature will be involved in the refurbishment of GDs. The construction-related issues therefore include air emissions, noise, dust generation caused by repair and construction activities and excavations and running of project vehicles on unpaved roads/tracks, especially in the desert areas, generation of waste (including solid, packaging material, construction waste, medical waste and related waste during ambulance maintenance services), occupational health and safety risks, and use of chemicals/solvents such as paints and varnishes. Establishment of blood storage units warrants measures for infection prevention and control. Provision of medical supplies under the project also faces the risk of counterfeit or expired medicines. This risk will be mitigated by following the World Bank procurement guidelines, and getting the supplies from qualified suppliers only. The transportation of material to the work sites in the desert districts will be an issue. Special type of vehicles will be used in those areas for transportation of material. The ambulance service to manage referrals will be outsourced and the regular maintenance of ambulances will also be responsibility of the outsourced firm. The criteria for firm selection will include provisions for having sufficient capacity and experience to handle and safely dispose of hazardous waste. Additionally, the firm will verify the driving licenses of the drivers and will provide training in safe and defensive driving to the drivers before deploying them on the job.

14. **For Components 1 and 3, involving the purchase of information technology and communication equipment, provisions for procurement of energy efficient machines to mitigate the risk of end-of-life e-waste generation has been included in the environment and social commitment plan along with re-use of this equipment within the departments.** Associated environmental risks are assessed to be localized and temporary in nature and can easily be addressed through management of civil works, good housekeeping, and implementation of easily implemented mitigation measures.

15. **Social risks are assessed to be moderate as the project design is to reach unserved and vulnerable groups and women and children.** Primary social risks include lack of meaningful engagement with vulnerable groups, such as religious and ethnic minorities, seasonal migrants, and people with disabilities, which could lead to their exclusion, particularly in remote and underserved areas, and elite capture and social tensions. These concerns can be largely mitigated by ensuring comprehensive stakeholder engagement throughout the lifecycle of the project. Robust and transparent criteria will be developed for merit-based recruitment of female health workers and clinicians, and for selection of beneficiaries for various trainings. Another important social risk is related with digital privacy and data protection and misuse of sensitive personal data (e.g., medical histories). In order to guard against abuse of sensitive personal data, the project will incorporate good international practices for dealing with such data. Privacy-by-design features for digital privacy will also be considered. Land acquisition is not part of the project; however, there is some possibility of informal settlers found on the sites selected for GD refurbishment. No labor influx is anticipated, as civil works involved will be completed using local contractors who will follow all requirements of Environment and Social Standard 2. Primary suppliers, including those for solar panels, will be screened for forced labor, use of child labor, etc., as per the Labor Management Plan. In such cases, a resettlement action plan, abbreviated action plan, and/or a livelihood restoration plan will be developed proportionate to the site-specific impacts. SBCC under Component 2 might run the risk of being ineffective if not developed with due consideration to the cultural and demographic context of the target population. The material under this component will be developed in local languages, using culturally appropriate messaging.

16. **A Grievance Redress Mechanism (GRM) will also be developed and implemented accordingly, and provisions will be made for extra discretion in handling of grievances.** The GRM will be gender responsive and will be aligned with the accountability and response framework of the SEA/SH Action Plan Finally, operational concerns may arise due to remoteness and security issues, which will be mitigated through informed selection of project locations.

17. **As part of citizen engagement, the project has extensive outreach activities and social accountability platforms.** The DoH will use a beneficiary feedback mechanism, including community platform set up in the project and through dedicated satisfaction surveys in the catchment population. Provisions will be made for a toll-free line and suggestion box at the health facilities to file complaints and receive suggestions to inform project activities.

E. Implementation

Institutional and Implementation Arrangements

18. **The project will be implemented by the DoH in collaboration with the Population Welfare**

Department (PWD), Government of Sindh. The DoH will provide RMNCAH+N services mainly through GDs, as envisioned under the project, with strong referral links to BHUs Plus/RHCs/Tehsil Headquarter Hospitals (THQs)/ District Headquarter Hospitals (DHQs). FP services will be provided by the PWD through its centers, including FWCs and GDs. In addition, community workers such as LHWs, FWW, and social mobilizers will provide services at the doorstep. The project will also provide technical support to the FP2030 secretariat in Sindh in implementing FP commitments. PPPs will be used to provide ambulance services, healthcare waste management, and social mobilization activities.

19. **A Project Management Unit (PMU) will be established at the DoH, to be headed by a Program Director (PD) and supported by qualified health and population program managers; financial management and procurement staff; an M&E team; and social, environment, and gender specialists.** The PMU will have overall responsibility for implementation of the project including preparing the annual work plans and progress reports, conducting procurement and financial management, maintaining audits, reporting on Results Framework indicators, conducting M&E, and providing supportive supervision to the service facilities under the project.

20. **A Project Steering Committee (PSC) chaired by the Minister of Health, with support from the secretaries of the DoH and PWD, will provide guidance and support to the PMU and ensure oversight and accountability of the project.** The implementing agency will be the secretariat for the PSC while collaborating partners will be PSC members. The PSC shall review progress on a quarterly basis, review monitoring data and analytical reports, and take decisions for smooth implementation of the project.

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