Initial Poverty and Social Analysis

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Pakistan: Khyber Pakhtunkhwa Health Systems Strengthening Program (KPHSSP)

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INITIAL POVERTY AND SOCIAL ANALYSIS

Country:	Pakistan	Program Title:	Khyber Pakhtunkhwa Health Systems Strengthening Program
Lending/Financing Modality:	Results-based lending	Department/ Division	Central and West Asia Department Social Sector Division

I. POVERTY IMPACT AND SOCIAL DIMENSIONS

A. Links to the National Poverty Reduction Strategy and Country Partnership Strategy

The proposed program is consistent with the Ehsaas Program, a social safety and poverty alleviation program launched by the Government of Pakistan in March 2019 which recognizes health as a prerequisite for improving all aspects of the quality of life of citizens. The objective of the Department of Health of the Government of Khyber Pakhtunkhwa (DOH), as identified in the Khyber Pakhtunkhwa Health Policy 2018–2025 (KPHP), is "to improve the health status of the population in the province through ensuring access to a high quality, responsive health care delivery system which provides acceptable and affordable services in an equitable manner." It defines five outcomes to be achieved: **Outcome 1:** Enhanced coverage and access of essential health services especially for the poor and vulnerable; **Outcome 2:** Measurable reduction in the burden of disease especially among vulnerable segments of the population; **Outcome 3:** Improved human resource management; **Outcome 4:** Improved governance, regulation and accountability; and **Outcome 5:** Enhanced health financing for efficient service delivery and financial risk protection for people of KP. The proposed Khyber Pakhtunkhwa Health Systems Strengthening Program is consistent with the objective of Asian Development Bank's (ADB) Operational Plan for Health 2015−2020 to increase the share of health to 3% of ADB lending. It is also closely aligned with ADB country partnership strategy for Pakistan 2021−2025 which identifies poor health services as one of the main constraints in reducing poverty and raising living standards. The program also aligns with the Pakistan country operations business plan, 2020−2022.

B. Poverty Targeting

☒General Intervention ☐Individual or Household (TI-H) ☐Geographic (TI-G) ☐Non-Income MDGs (TI-M1, M2, etc.)

The program focuses on improving the quality of health care services provided at the secondary health care (SHC) hospitals at the district headquarter level. This includes increasing the percentage of deliveries by skilled birth attendants and availability of medicines. Many of the lower income groups in Khyber Pakhtunkhwa Province (KP) are pushed to utilize tertiary sector hospital services due to lack of human resources, proper equipment, and medicines at the SHC level. This utilization of tertiary sector hospitals leads to higher costs associated with consulting the specialists and the cost to travel to the tertiary hospitals. Both these factors contribute to catastrophic out-of-pocket health expenditures, leading to an increasing share of population being pushed below the poverty line.

C. Poverty and Social Analysis

1. **Key issues and potential beneficiaries.** Due to the poor quality of the services provided at SHC hospitals, KP continues to lag in achieving the Sustainable Development Goals, and maternal and child health is most severely impacted. The program will lead to improvements in the quality of services provided to the population. Primary beneficiaries will be the lower income groups, women, children, and other vulnerable groups in the population.

2. **Impact channels and expected systemic changes.** Lower income groups continue to face a significantly higher rate of maternal and infant mortality due to lack of access to quality health care services. Increased deliveries by skilled birth attendants will significantly reduce the maternal and infant mortality rate and improve the health of women and children. Proper implementation of standard operating procedures and clinical pathways will also allow people to have higher likelihood of better prognosis and treatment. Upgraded equipment and improved management of medical supplies (including medicines), will result in improved access to quality health care services.

3. **Focus of (and resources allocated in) the transaction technical assistance or due diligence.** International quality of care expert and a health economist will be hired for conducting analysis and studies pertaining to issues and potential intervention and monitoring.

II. GENDER AND DEVELOPMENT

1. **Key issues.** Pakistan's score on the gender gap index has not shown consistent improvement compared to Bangladesh and India. In 2021, Pakistan ranked 153rd out of 156 countries on the gender parity index. In gender-based discrimination experienced, the Social Institutions and Gender Index classified Pakistan as "very high" for sub-indicators revealing son bias and women's lack of protection from legal mandates (family code). Moreover, many women also face domestic violence. For KP, one survey found 15% of female respondents and 12% of male respondents (likely underreported) indicated that men have hit women in their households. Other types of gender-based violence, such as bonded labor, acid throwing, sexual violence, honor killings, and human trafficking, also occur

in all classes, religions, and ethnicities, and in both urban and rural areas. Overall, the majority of Pakistani women are constrained from leaving the home. In KP, around 34% women reported getting permission to go for treatment was a problem (vs. 18% in Pakistan). Among women who do have permission, 85% is for visiting a hospital or doctor. In 2017–2018, ADB conducted a health sector assessment of KP. The hospitals visited had many women visitors (average of four women visitors per woman/child patient).
While the Constitution provides a strong legal framework for many dimensions of women's equality,[a] implementation is weak. Health policy does not reflect support for gender and minority or vulnerable populations. In the health ministry, the assessment noted a special quota for recruiting women (20%) and people with disabilities (5%), yet most of these special positions were filled by men; and the ones filled by women tended to be lower in ranking; women are rarely appointed on leadership positions or are engaged in active decision-making. In the two "women-only hospitals" in Peshawar, most of the doctors and professional staff are also men. On the other hand, primary health care facilities and secondary hospitals are often underutilized, mainly because of insufficient number of female health providers.[1] Within health centers, hospitals, and offices, there are no facilities for staff who are pregnant or nursing mothers to breastfeed or to keep their infants while they are on-the-job. No other facilitation such as transport, separate toilets, or washrooms are available in government offices. The health information system recording district hospital data including daily and monthly progress reports identify a total number of men, women and children. However, the data is not sex-disaggregated for children nor for the patients coming to subspecialties, other than maternal, newborn, and child health.

2. Does the proposed program have the potential to contribute to the promotion of gender equity and/or empowerment of women by providing women access to and use of opportunities, services, resources, assets, and participation in decision-making?

☒ Yes ☐ No

The program will increase the number and percentage of women in nursing and medical staffing (disbursement-linked Indicator [DLI] 3.1 and 3.2). Furthermore, the program will train staff on standard gender-sensitive clinical protocols and pathways (DLI 1.1 and 1.3). Women will have increased access to quality health services (DLI a). As part of the program action plan, women-friendly work and living environment at and near the secondary health care (SHC) hospitals (e.g., privacy assured at hospitals; clean and functioning sex-segregated sanitary; support search for living quarters also for families) will be supported. During transaction technical assistance (TA) the gender actions will be defined for preparation and implementation during program implementation.

3. Could the proposed program have an adverse impact on women and/or girls or widen gender inequality?

☐ Yes ☒ No

All actions and measures are designed to increase the participation and gender equity of women and girls.

4. Indicate the intended gender mainstreaming category:

☐ GEN (gender equity) ☒ EGM (effective gender mainstreaming)
☐ SGE (some gender elements) ☐ NGE (no gender elements)

III. PARTICIPATION AND EMPOWERING THE POOR

1. Who are the main stakeholders of the program, including beneficiaries and affected people? Explain how they will each participate in the program's design.

With the objective to assist Government of Khyber Pakhtunkhwa in achieving its goal to improve the health status of the population in KP, the stakeholders, such as medical, technical, and support staff at SHC hospitals, local population, and DOH will be involved in the program design.

2. Who are the key, active, and relevant civil society organizations (CSOs) in the program area?

During transaction TA, the key, active and relevant CSOs, including relevant medical associations, will be mapped and contacted. See question 4 below.

3. Are there issues during the program design for which participation of the poor and vulnerable is important?

☐ Yes ☒ No If yes, what are these issues?

4. How will the program ensure the participation of beneficiaries and affected people, particularly the poor and vulnerable and/or CSOs, during the program design to address these issues?

The program will engage with non-governmental organizations and community-based organizations, local district governments, district health departments, medical associations, and representatives of the district women's committees.

5. What level of CSO participation is planned during the program design?

_M__ Information generation and sharing _M_ Consultation _L_ Collaboration _NA_ Partnership

IV. SOCIAL SAFEGUARDS

A. Involuntary Resettlement Category ☐ A ☐ B ☒ C

1. Does the program have the potential to involve involuntary land acquisition resulting in physical and economic displacement? ☐ Yes ☒ No

The civil works involved do not foresee in new buildings on new land.

2. What actions are required to address involuntary resettlement as part of the transaction TA or assessment process?

☐ Program safeguard system assessment and actions ☒ None

B. Indigenous Peoples Category ☐ A ☐ B ☒ C

1. Does the proposed program have the potential to directly or indirectly affect the dignity, human rights, livelihood systems, or culture of indigenous peoples? ☐ Yes ☒ No

2. Does it affect the territories or natural and cultural resources indigenous peoples own, use, occupy, or claim, as their ancestral domain? ☐ Yes ☒ No

During the transaction TA, the sites of the hospitals will be visited during which time any ownership, occupation, or claim by indigenous peoples will be addressed.

3. Will the program require broad community support of affected indigenous communities? ☐ Yes ☒ No

Not applicable. This program concerns existing hospitals which will be upgraded providing improved access to life-saving health services.

4. What actions are required to address risks to indigenous peoples as part of the transaction TA or the program assessment process?

☐ Program safeguard system assessment and actions ☒ None

V. OTHER SOCIAL ISSUES AND RISKS

1. What other social issues and risks should be considered in the program design?

☒ Creating decent jobs and employment (L) ☒ Adhering to core labor standards (M) ☐ Labor retrenchment

☐ Spread of communicable diseases, including HIV/AIDS ☐ Increase in human trafficking ☐ Affordability (L)

☐ Increase in unplanned migration ☐ Increase in vulnerability to natural disasters ☐ Creating political instability

☐ Creating internal social conflicts ☐ Others, please specify _____

2. How are these additional social issues and risks going to be addressed in the program design?

These will be further prepared during program preparation and will be parts of the DLIs as part of Output 3: Human resources and health services planning reinforced.

VI. TRANSACTION TA OR ASSESSMENT RESOURCE REQUIREMENT

1. Do the terms of reference for the transaction TA (or program assessments) contain key information needed to be gathered during the transaction TA or the program assessment process to better analyze (i) poverty and social impact, (ii) gender impact, (iii) participation dimensions, (iv) social safeguards, and (v) other social risks? Are the relevant specialists identified?

☒ Yes ☐ No

2. What resources (e.g., consultants, survey budget, and budget for workshop(s)) are allocated for conducting poverty, social, and/or gender analyses; and the participation plan during the transaction TA or the program assessments?

A transaction TA of $500,000 will contract national and international consultants (44 person-months) to support program preparation.

[a] Constitution of Pakistan Art. 25(2) states "There shall be no discrimination on the basis of sex."

Sources: Asian Development Bank (ADB). 2019. *Khyber Pakhtunkhwa Health Sector Review – Hospital Care*. Manila; ADB. Operational Plan for Health, 2015–2020; ADB. Pakistan 2020–2022, Country Operations Business Plan, October 2019; ADB. Pakistan 2021–2025, Country Partnership Strategy, December 2020; ADB. Pakistan: Country Gender Assessment, Vol 1 of 2; Department of Health Khyber Pakhtunkhwa. Health Policy Khyber Pakhtunkhwa; Government of Khyber Pakhtunkhwa. Khyber Pakhtunkhwa Comprehensive Development Strategy 2010-2017; Government of Pakistan. Prime Minister's Policy Statement, Ehsaas Program 2019; M. Adeel, Y. Anthony G. O., and F. Zhang. 2013. Gender, mobility and travel behavior in Pakistan: Analysis of 2007 Time Use Survey. Munich Personal RePEc Archive. MPRA Paper No. 55474.; and World Economic Forum. Global Gender Gap Report 2021.