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Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 21-Feb-2022 | Report No: PIDC33482

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Pakistan	P178530		Sindh Integrated Health and Population Project (P178530)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
SOUTH ASIA	May 31, 2022	Oct 20, 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 of essential health and population services, for poor and vulnerable populations, especially women, in targeted areas of Sindh

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	200.00
Total Financing	200.00
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

Environmental and Social Risk Classification	Concept Review Decision
Moderate	Track II-The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **Pakistan has made significant progress over the last two decades toward reducing poverty.** Over 47 million people escaped poverty between 2001 and 2015, making Pakistan one of the most successful South Asian country in reducing poverty. Nonetheless, challenges remain. Human capital outcomes are poor and stagnant, with high levels of stunting at 38 percent and learning poverty at 75 percent. Per capita GDP growth has also been low, averaging around 1.8 percent annually. Economic growth has historically been fueled by private and government consumption, with productivity-enhancing investments and exports contributing relatively little. Consumption-led growth has been associated with frequent macroeconomic imbalances. Achieving sustained economic growth is important to reduce inequality and increase shared prosperity.

Sectoral and Institutional Context

2. **Access to quality reproductive, maternal, newborn, child, and adolescent health along with nutrition (RMNCAH+N) is the foundation for a healthy start in life.** Good maternal health and well-being not only preserves a woman's human capital, but it also supports her children as they grow. Availability, access to, and use of essential reproductive, maternal, and child health services are critical for the health of mothers and young children. Foundational services include at least four antenatal care checkups, births delivered by a skilled attendant, postnatal care, family planning information and services, childhood immunization, and nutrition. However, such services are not accessible by all, especially the poor and vulnerable population and those that reside in the remote and rural areas. Furthermore, health facilities which are close to these population groups are not equipped to provide quality services.

3. T**here is evidence of improvements in recent years in a range of RMNCAH related indicators 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, representing around 20 percent decrease during this period. Institutional deliveries increased overall from 58.6 percent in 2012-13 to 71.8 percent in 2017-18. Immunization coverage also improved considerably. One of the factors contributing to significant improvement in RMNCH indicators is an increase in the financial resource base since devolution in 2010. There has been a faster increase in financial outlay over the past ten years.

4. **However, RMNCAH+N indicators still need to be improved further.** Underutilization of health services is a barrier to women and children's human capital formation. For example, only 50 percent of the demand for contraception is met, and 35 percent of children have received age-appropriate vaccinations; and there are disparities across districts, by wealth quintiles and by urban/rural areas. In Sindh, demand for family planning satisfied by modern methods is between 60-70 percent in only 20 percent of districts and majority of districts have less than 50 percent. Women receiving antenatal care with at least 4 visits (ANC 4) are less than 50 percent in more than 70 percent of districts. While Sindh has one of the higher coverages on skilled attendance at birth, it is only 63 percent

of rural compared to nearly 90 percent of urban areas. Concurrent Stunting and Wasting of under-five children is more prevalent in rural areas (13 percent) than in urban areas (6.4 percent).[1]

Relationship to CPF

5. **The proposed project is aligned with the World Bank Group's (WBG) Pakistan Country Partnership Strategy FY15-19.[2]** The proposed project supports Outcome 4.2-Improved Access to Maternal and Child Health Services of Results Area 4-Service Delivery, as well as the Results Area on inclusion. Finally, through supporting the Department of Health (DoH) to build its capacity for research and implementation (including for better accountability of public-private partnerships), and establishing an electronic records system, the project also aims to enhance governance capacity.

C. Proposed Development Objective(s)

To improve utilization of essential health and population services, for poor and vulnerable populations, especially women, in targeted areas of Sindh.

Key Results (From PCN)

- Women whose demand for contraception is satisfied by modern Family Planning (FP) methods.
- Women of reproductive age who had at least 4 ANC visits during their last pregnancy.
- Pregnant women who had their deliveries conducted by skilled health personnel at a health facility.
- Women and girls with accurate knowledge and information about reproductive and maternal health and services available.
- Children 12-23 months fully immunized.
- Children aged 6-24 months who received micronutrient sprinkles sachets.

D. Concept Description

6. **Component 1: Ensuring and improving RMNCAH+N services utilization and support during public health emergencies (US$180 million).** This component will strengthen service delivery of RMNCAH+N services at the PHC level, particularly Government Dispensaries (GDs). It will support five main activities**:** (1) refurbishment of GDs in target districts to adhere to the Minimum Service Delivery Standards for RMNCAH+N, including purchase of equipment, medicines and supplies, and ambulance services for referral; (2) recruitment, training and deployment of female health-workers, specifically Women Medical Officers (WMO), Community Midwives (CMW), Lady Health Visitors (LHV) and Lady Health Workers (LHW)/Community Health Workers (CHW) to fill gaps in underserved areas; (3) effective structural and functional integration of health facility-based FP services and community-based services; (4) training of the health care providers on disaster and epidemic response and disease surveillance; (5) provision of telehealth for RMNCAH+N at the primary care level, primarily GDs, to reduce mobility barriers; and

[1] Pakistan DHS 2017/18

[2] The CPS was subsequently extended to FY20 under the 2017 Performance and Learning Review. The new Country Partnership Framework is currently under preparation.

(6) the establishment of a dynamic, integrated electronic medical records (EMR) system linked to the Sindh District health Information System (DHIS), and other key health databases to track patients.

7. **Component 2: Strengthening demand for RMNCAH+N services and women empowerment (US$14 million).** This component will cover social, and behavior change communication and related activities to encourage uptake of RMNCAH+N services with an updated social marketing strategy and rebranding of GDs and their services package to create awareness and encourage uptake of services. It will also include women's empowerment to exercise their sexual and reproductive health rights. Social and behavior change activities will include public awareness campaigns, use of media to communicate key messages regarding health, hygiene, and nutrition, and face to face discussions or focus groups at the women's community centers. This will also include interventions to engage other stakeholders, 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. These activities will involve partnering with Non- Governmental Organizations (NGOs), Community Based Organizations (CBOs), and other private sector organizations.

8. **Component 3: Project management, monitoring and evaluation (US$6 million).** This component will support the strengthening of the DOH, its coordinating structures and agencies for the coordination and management of the project, coordination of project activities, financial management, procurement, stakeholder engagement in line with the Stakeholder Engagement Plan (SEP), and compliance with the Environment and Social Commitment Plan (ECSP). This component would also support monitoring and evaluation, building capacity for clinical and public health research and enhanced accountability, especially in terms of managing public-private partnerships. The relevant structures will be strengthened by the recruitment of additional staff/consultants, information technology and communications equipment, workshops and training, research contracts, staff travel and monitoring visits.

Legal Operational Policies	**Triggered?**
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Screening of Environmental and Social Risks and Impacts

9. Overall Environmental and Social Risk Classification of the project is assessed to be Moderate at this stage. The Environmental Risk Rating is Moderate. The environmental impacts are primarily associated with component 1 which involves refurbishment of GDs as well as procurement of related goods including medical equipment, medicines and ambulances (the ambulances will be provided by a third-party- private contractor and will not be owned by GDs). The associated risks envisaged, pertain to infection prevention and control, medical waste management, occupational hazards associated with refurbishments (construction and equipment installation) of

GDs and related impacts due to civil works including minor to moderate amounts of construction waste generation, noise and air emissions, use of chemicals/solvents such as paints, generation of used oils and oil filters during ambulances operations and maintenance etc. The regular maintenance of ambulances will also be outsourced, and the criteria of firm selection will include provisions for having sufficient capacity to and experience to handle and safely dispose hazardous waste. Additionally, the firm will train drivers in safe and defensive driving and install signage, as/when required on roads in coordination with local authorities to reduce the hazards associated with accidents. The environmental risks and impacts are expected to be temporary, localized, and reversible in nature if the mitigation measures proposed are implemented as part of the design and implementation phase. Likely operational risks pertain to infection prevention and control as well as medical waste management. With regards to establishment of a dynamic, integrated electronic medical records (EMR) system linked to the Sindh DHIS, and other key health databases to track patients, IT equipment will be procured. However, it must be noted that this ICT equipment will not replace any existing equipment but supplement the existing systems/processes. Therefore, the risk of e-waste generation during procurement is low. Further, in order to address any issues associated with disposal of ICT equipment procured under this project at the end of its use life cycle, will be catered by inclusion of buy-back clause in the contracts for ICT equipment procurement. It will also be ensured that the energy efficient equipment is procured. Since the exact locations and scale of works is not known, a framework approach is proposed and an Environmental and Social Management Framework (ESMF) along with an Environmental and Hospital Care Waste Management Plan (EHCWMP) will be developed to address the risks and impacts in accordance with the Environmental and Social Standards (ESS) of the Environmental and Social Framework (ESF).

10. Social risks are moderate as the project design is to reach the underserved and vulnerable groups, as well as 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. Gender based violence (GBV) including Sexual Exploitation and Abuse (SEA), and Sexual Harassment (SH) risks could emerge for different community groups including children and women, women health care workers in and around health centers, and at the household-level of beneficiaries. This risk will be mitigated through explicit inclusion in robust stakeholder identification and consultation processes, and by the development of a strong SEA/SH action plan which will be implemented throughout the project duration. A Grievance Redress Mechanism (GRM) will also be developed and implemented accordingly, and provisions will be made to allow for extra discretion in the handling of grievances. Finally, operational concerns may arise due to remoteness and security issues, which will be mitigated through informed selection of project locations.

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APPROVAL

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