

PROJECT INFORMATION DOCUMENT (PID) CONCEPT STAGE

Report No.: PIDC505

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| Project Name | Enhanced Nutrition for Mothers and Children (P131850) |
| Region | SOUTH ASIA |
| Country | Pakistan |
| Sector(s) | Health (90%), Other social services (10%) |
| Lending Instrument | Specific Investment Loan |
| Project ID | P131850 |
| Borrower(s) | Economics Affairs Division, Government of Pakistan |
| Implementing Agency | Department of Health, Government of Sindh, Department of Health, Government of Balochistan, Department of Health, Government of Khyber Pakhtunkhwa |
| Environmental Category | C-Not Required |
| Date PID Prepared | 07-Aug-2012 |
| Estimated Date of Appraisal Completion | 14-Dec-2012 |
| Estimated Date of Board Approval | 21-Mar-2013 |
| Concept Review Decision | Track II - The review did authorize the preparation to continue |

I. Introduction and Context

Country Context

The last few years have been challenging for Pakistan, with unprecedented country-wide floods in 2010 and 2011, coupled with continuing security issues, slow economic growth, and high inflation. Pakistan is going through significant political changes with increased emphasis on provincial autonomy and devolution of authority to the provinces. The 18th Constitutional Amendment devolved authority from the federal government to the provinces in about 40 areas including health which is now fully devolved to the provinces. There are concerns about the ability of provincial governments to assume effective authority in these areas. In health, the federal government's role to manage, finance and implement national programs is now limited, although the Ministry of National Regulations and Services, created in May 2012, may take on some of the policy, oversight, regulatory, monitoring and evaluation functions which are typically the responsibility of the federal government.

Sectoral and Institutional Context

Pakistan is not performing well in improving health and nutrition outcomes or services, especially for the poor. Only Afghanistan has worse maternal and child mortality indicators than Pakistan in the region and Pakistan is not on track to achieve health and nutrition related MDG targets. It needs

to improve significantly its performance in these areas. Otherwise, poor health and nutrition outcomes will remain obstacles to economic growth, especially during times of macroeconomic challenges, political and security related instability and external shocks with a disproportionately negative impact on the poor.

Maternal and child health indicators have improved, but large challenges remain: The under-5 mortality rate has fallen by 24% since 1990 but there has been no change in the poorest income quintile since 1990. Maternal mortality seems to be declining but the maternal mortality ratio (MMR) in Pakistan was 260/100,000 in 2010 according to WHO. The total fertility rate has declined from 5.8 children per woman in 1990 to 4.1 in 2005 with improving coverage during 2003/07 in antenatal care (35% to 61%), skilled attendance at birth (24% to 36%), and proportion of fully immunized children (53% to 76%). Despite these improvements there is still a lot to be done - about one fourth of children are not immunized, two thirds of women are delivering without skilled attendance and there is a large unmet need for family planning.

Pakistan has made minimal progress in improving nutritional outcomes of children and mothers over the last four decades. The 2011 National Nutrition Survey revealed that the rates of child stunting have not changed in Pakistan since 1965. Pakistan suffers from high rates of childhood malnutrition with 44% of children being stunted (<-2SD height for age) and 22% severely stunted (<-3SD). A third (32%) of children under 5 are underweight (<-2SD weight for age) and 12% severely underweight (<-3 SD). Fifteen percent (15%) of Pakistani children under 5 are wasted (<-3 SD weight for height) and 6% suffer from severe acute malnutrition (<-3 SD). One in five children (22%) is born with low birth weight (less than 2.5kg). In addition, micronutrient deficiencies are widespread with high rates of iron-deficiency anemia, zinc, iodine folic acid and vitamin A deficiencies having a particularly damaging impact on the survival, growth, development and productivity of pre-school children and pregnant women. Two out of every three (62%) children 0-5 years and half (51%) of pregnant women suffer from anemia. Malnutrition is also prevalent among women of reproductive age with 18% being underweight (low body mass index - BMI). Inequity in health and nutrition services is also a major concern, with access to services being significantly better for wealthier and urban Pakistanis. Based on current trends and levels of inequity Pakistan is unlikely to achieve MDG 1C, i.e., halving the 1990 level of malnutrition by 2015.

Malnutrition in Pakistan, as in other countries, is caused by a number of factors including inadequate access to a balanced diet, poor caring practices for women and children (including child feeding practices, sanitation practices such as hand washing, etc.) and insufficient access to quality health care. Poverty is a factor in causing malnutrition but addressing poverty alone will not fully address the problem because there are high levels of malnutrition even in households from the highest income quintile (e.g. in the province of Punjab 21% of children from the highest income quintile are stunted), suggesting cultural and knowledge factors. There is also an association between poor environmental sanitation and malnutrition. As with other areas of social development, there is a strong association between the level of mothers' education and the nutritional status of her children, with more educated mothers having less malnourished children. The causes of and solutions to malnutrition in Pakistan thus reside in a number of sectors, including education, agriculture, social protection, water and sanitation (local government) as well as health. Interventions to address malnutrition should follow the approach outlined by the global Scaling Up Nutrition (SUN) framework which calls for scaling-up "nutrition-specific interventions" through the health sector and "nutrition-sensitive interventions" through other sectors. This proposed project

focuses primarily on the nutrition-specific interventions because this is where the evidence is strongest and Pakistan still has very low coverage of these interventions. However, the sub-components on "communication for development" (sub-component 3) and on "strengthening institutional capacity in the health sector and for multi-sectoral coordination" (sub-component 4) would expand action beyond the health sector.

Pakistan has gained some experience in implementing emergency nutrition programs as part of the response to the 2010 and 2011 floods, but most existing nutrition programs are small in scale with very low coverage and minimal equity targeting. The global increase in food prices and economic crisis are other threats to the nutrition of young children and women of child-bearing age. While the malnutrition rates are high in all provinces, the nutritional status of children is worse than the national average in the three provinces covered by this project, Balochistan (52%), Sindh (50%) and Khyber Pakhtunkhwa (KP) (48%), and has worsened in all three provinces since 2001.

The Government of Pakistan (GOP) has been aware of the problem of malnutrition for many years. The Ministry of Health had developed National Nutrition and Micronutrient Strategies outlining its commitment. However, the strategy documents envisaged addressing all nutrition issues and thus fall short in defining clear priorities. The government has tried to develop a national nutrition program a number of times including once with Bank assistance in the 1990s. Only a few successful interventions have been delivered at scale in the last decade, such as vitamin A supplementation (more than 90% coverage) and salt iodization being implemented in almost all districts and resulting in a significant reduction in the prevalence of iodine deficiency from 63% in 2001 to 36% in 2011. However, overall, there has not been significant progress made in addressing malnutrition, mainly due to lack of: (i) investment in nutrition activities; (ii) political commitment and strong, sustained leadership to systematically address malnutrition; (iii) a critical mass of people to work full time on nutrition activities; (iv) accurate and useful information on nutrition status, behaviors, and coverage of services; and (v) a clear, focused, and practical strategy. A national nutrition program plan was developed in 2007 but not approved by the Planning Commission as it failed to prioritize sufficiently those interventions that are most likely to have a nutritional impact on children and women. Following that, the Ministry of Health (MOH) requested the Bank for technical and financial assistance to help the MOH plan a new program that would be evidence-based and focused only on what the health sector could either deliver directly or influence other Ministries to deliver. However, following the 18th Amendment to the Constitution, the responsibility for developing nutrition programs now lies with the provinces.

In September 2011, the D-10 Group led by the Ministry of Finance requested provinces to develop nutrition plans and the Bank (with DFID and ADB) committed to facilitating a coherent response from development partners. The Bank in collaboration with development partners has provided TA to support the development of provincial nutrition programs which are now at advanced stages. In April 2012 the provinces of Balochistan, KP and Sindh requested the Bank's financial assistance for their nutrition projects proposed in this PCN. Nutrition interventions in Punjab would be supported through the Health Sector Program which is currently under preparation. While the support outlined in this PCN focuses mainly on the role of the health sector, the Bank is working concurrently with development partners to support the provinces in identifying key nutrition-sensitive interventions in other sectors such as education, agriculture, water and sanitation, and social protection, which could be financed through other operations in these sectors. This approach is aligned with the global consensus outlined in the Scaling Up Nutrition (SUN) framework that calls for implementing nutrition-specific interventions (through the health sector) as well as nutrition-sensitive

interventions (in other sectors). Pakistan has yet to scale-up most of the basic nutrition-specific interventions, which is what this project would support.

To date, financing for nutrition has come mainly from AusAid, DFID, UNICEF, the Micronutrient Initiative, the World Food Program (WFP), Save the Children (SCF USA), other non-governmental organizations and the Bank. While this support has been well coordinated, it has been relatively modest and has not yet led to increasing coverage of interventions, except in the cases of vitamin A supplementation and salt iodization. With increasing fiscal challenges, the provinces need significant additional financial and technical support in order to scale-up their response to malnutrition to a level that would have an impact on provincial and national indicators. IDA and trust fund support will be crucial for the provision of this financing to complement financial and technical support from the provinces and other development partners. Having the Bank involved in scaling-up nutrition will also raise the profile of nutrition and will help the provinces implement a coordinated program which in turn should help attract additional financing.

Relationship to CAS

The proposed operation is in line with the Country Partnership Strategy (CSP) for FY10-13. The proposed operation is linked with the second pillar of the CSP which envisages support to improve human development and social protection. The CSP envisages seeking opportunities to address malnutrition in a multi-sectoral way by adding nutrition components to programs in various sectors which can contribute to the response. The proposed project will support evidence-based nutrition interventions to be delivered by the health sector and will build the capacity of provincial Departments of Health to engage with other sectors (e.g. agriculture, education) on nutrition issues. The proposed project is also in line with the priority accorded to nutrition within the Bank, in recognition of the magnitude of the problem in South Asia and of the critical role which good nutrition plays in national development.

II. Proposed Development Objective(s)

Proposed Development Objective(s) (From PCN)

The development objective of the project is to assist Pakistan in improving the coverage of effective nutrition interventions delivered through the health sector, with a focus on the poor and on marginalized groups, in order to improve the nutritional status of children under two years old and that of pregnant and lactating women.

Key Results (From PCN)

The project will focus on improving coverage of well-proven, cost-effective nutrition services that address malnutrition in the critical "first thousand days" of life, from conception to the child's second birthday. In order to improve coverage, the project will focus on achievable results both related to the supply of services and to creating awareness and demand from communities for those services and for improved nutrition-related preventive behaviors.

The key indicators to measure project performance will likely include: a) Proportion of children 0-24 months of age receiving the basic package of nutrition services and products financed by the project; b) Proportion of pregnant and lactating women receiving the basic package of nutrition services and products financed by the project; c) Proportion of children under 6 months of age exclusively breastfed; d) Proportion of children 6-24 months of age reported to have consumed a course (60 sachets) of micronutrient powders in the previous 6 months; e) Proportion of children 6-59 months receiving vitamin A supplements twice per year; f) Proportion of pregnant women

consuming a full course of iron-folic acid supplements; and g) Recovery rates for children 6-59 months (proportion of children 6-59 months treated with severe acute malnutrition reaching criteria for discharge).

Given the equity focus of the project, all outcome indicators will be disaggregated by income quintile and gender. In addition to these outcome indicators, the project will also track a range of capacity-related output indicators, such as: a) Increase in KAP score related to nutrition knowledge (health/community and NGO workers); b) Annual district plans for nutrition available on time; c) Proportion of project budget execution (based on released amount from development budget); d) Provincial legislation on salt iodization in place; e) Enforcement mechanism for regulation of salt iodization defined and agreed with relevant departments; f) Provincial annual technical assistance plan developed and status of implementation; g) Size of Annual Development Plan (ADP) allocation for nutrition.

III. Preliminary Description

Concept Description

The project will have interventions in the three provinces of Balochistan, KP and Sindh. The program will be evidence-based and thus focus on: (i) scaling-up those interventions that are proven to work at scale in an environment such as Pakistan, and (ii) supporting operations research for interventions which we know work at small scale but for which delivery models at large scale need to be developed in the Pakistan environment.

While the provincial nutrition programs are expected to have some differences that reflect the specificity of each province, the following components are envisaged in each province: a) Addressing general malnutrition in women and children; b) Addressing micronutrient malnutrition; c) Communication for development; and d) Strengthening institutional capacity in the health sector and for multi-sectoral coordination.

Component 1: Addressing general malnutrition in women and children. This component will address general malnutrition in pregnant and lactating women and children less than two years of age, with the exception of community management of acute malnutrition (CMAM) which will cover children under five as per the national protocol. Targeting children from conception to 24 months is the recommended age group for providing nutrition inputs/interventions and the age at which nutrition interventions are most effective for the physical and intellectual development of children. This component will include: (i) a set of infant and young child feeding (IYCF) interventions implemented in a phased results-based manner at community level that will target a few key behaviors to improve nutritional outcomes and use of micronutrient powders to improve the quality of complementary food; (ii) Community Management of Acute Malnutrition (CMAM) with phased expansion in the same geographical areas as IYCF which as per international guidelines will be primarily community-based, with complications referred to referral facilities. It will support the use of prepared/packaged foods to treat children with severe acute malnutrition at community level and explore the feasibility of producing a similar product in Pakistan; (iii) support scale-up of key maternal nutrition interventions (de-worming and weekly iron folic acid (IFA) supplementation for women of child-bearing age and improving the nutrition quality of ante-natal visits and provision of daily IFA supplementation during pregnancy); and (iv) in order to reach the population not covered by the LHW program and in urban areas, the project will contract with NGOs to promote appropriate infant and young child feeding practices (including micronutrient powders) and

CMAM, with an in-built independent rigorous impact evaluation with a view to outlining policy options for expansion.

Component 2: Addressing micronutrient malnutrition. This component will support micronutrient interventions which will be expanded and sustained across Pakistan. As development partners are actively supporting the scale-up of micronutrient interventions (except zinc supplementation), the project will complement these investments on building the capacity of the government to carry out its stewardship role including: (i) improving the quality of monitoring data for vitamin A supplementation through annual coverage assessment surveys which will help target program improvement efforts; (ii) for salt iodization and wheat flour fortification – as the production side is being supported by partners (Micronutrient Initiative, WFP), the project will focus on enabling the development of legislation, building enforcement capacity and mechanisms, and building consumer demand for fortified foods; and (iii) zinc supplementation for treatment of diarrhea: scaling-up efforts to expand use of zinc supplementation with oral rehydration solution (ORS) in management of diarrhea in children through public sector channels only.

Component 3: Communication for development: Through this component, the project will have a significant focus on behavior change for demand creation of the services outlined above and for generating political and societal support for addressing malnutrition. Along with communication activities focused at ultimate beneficiaries the component will entail advocacy interventions targeted at key stakeholders, policy makers and other players to garner relevant allocation of resources, oversight and support for the project. The first step in implementing this component will be to carry out formative research to inform the development of a strategy and of the tools and media mix for the behavior change communication.

Component 4: Strengthening institutional capacity in the health sector and for multi-sectoral coordination. The existing institutional capacity for nutrition within the health sector at the provincial and district levels is inadequate. The Nutrition Units at provincial levels are weak in their ability to plan programs (as evident in project preparation which has taken longer than expected), to use evidence for decision making and to advocate and provide technical assistance outside the health sector for nutrition interventions. The project will support strengthening and building capacity to provide leadership for nutrition programs in the health sector with a focus on strengthening nutrition units/positions at provincial and at the district level. The project will support organizational strengthening including supporting technical and management staff including staff training; provision of technical assistance for effective implementation including long and short-term nutrition experts, internal capacity as well as firm(s) for monitoring and evaluation including undertaking periodic surveys and program evaluations; and strengthening procurement and financial management capacities. In addition, the project will support operational research to test new interventions/approaches for infant and young child feeding (e.g. models of social marketing of micronutrient powders and soap) and maternal nutrition (e.g. models for working with religious and other leaders to address early marriage and pregnancy and birth spacing).

IV. Safeguard Policies that might apply

| Safeguard Policies Triggered by the Project | Yes | No | TBD |
|---|-----|----|-----|
| Environmental Assessment OP/BP 4.01 | | x | |
| Natural Habitats OP/BP 4.04 | | x | |

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|--|--|---|--|
| Forests OP/BP 4.36 | | X | |
| Pest Management OP 4.09 | | X | |
| Physical Cultural Resources OP/BP 4.11 | | X | |
| Indigenous Peoples OP/BP 4.10 | | X | |
| Involuntary Resettlement OP/BP 4.12 | | X | |
| Safety of Dams OP/BP 4.37 | | X | |
| Projects on International Waterways OP/BP 7.50 | | X | |
| Projects in Disputed Areas OP/BP 7.60 | | X | |

V. Tentative financing

| Financing Source | Amount |
|---|--------|
| BORROWER/RECIPIENT | 13.71 |
| International Development Association (IDA) | 55.00 |
| AUSTRALIA Australian Agency for Internation | 34.85 |
| Total | 103.56 |

VI. Contact point

World Bank

Contact: Luc Laviolette
 Title: Sr Nutrition Spec.
 Tel: 5722+158 / 9
 Email: llaviolette@worldbank.org

Borrower/Client/Recipient

Name: Economics Affairs Division, Government of Pakistan
 Contact: Mr. Javed Iqbal
 Title: Secretary
 Tel: 92519210629
 Email: secretary@ead.gov.pk

Implementing Agencies

Name: Department of Health, Government of Sindh
 Contact: Dr. Dureshehwar Khan
 Title: Program Manager
 Tel: 922135223888
 Email: d-dsk@hotmail.com

Name: Department of Health, Government of Balochistan
 Contact: Dr. Ali Nasir Bugti
 Title: Program Manager

Tel: 92819211592
Email: provincialnutritioncellqta@yahoo.com
Name: Department of Health, Government of Khyber Pakhtunkhwa
Contact: Dr. Qaiser Khan
Title: Program Manager
Tel: 92919210269
Email: drqaa57@gmail.com

VII. For more information contact:

The InfoShop
The World Bank
1818 H Street, NW
Washington, D.C. 20433
Telephone: (202) 458-4500
Fax: (202) 522-1500
Web: <http://www.worldbank.org/infoshop>