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Report No: PAD3335

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT
ON A
PROPOSED CREDIT

IN THE AMOUNT OF JPY 21,713,100,000
(US$ 200 MILLION EQUIVALENT)

TO THE

ISLAMIC REPUBLIC OF PAKISTAN

FOR A

# PUNJAB HUMAN CAPITAL INVESTMENT PROJECT

February 05, 2020

Social Protection & Jobs
Health, Nutrition and Population
Education
South Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective Dec 31, 2019)

| | |
|---|---|
| Currency Unit = | Pakistani Rupee (PKR) |
| US$1 = | PKR 154.61 |
| US$1 = | JPY108.915 |

FISCAL YEAR
July 1–June 30

| | |
|---|---|
| Regional Vice President: | Hartwig Schafer |
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ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| AEO | Administrative Education Officers |
| ADP | Annual Development Plan |
| ANC | Ante-Natal Care |
| ATM | Automated Teller Machine |
| BHU | Basic Health Unit |
| BISP | Benazir Income Support Programme |
| CCT | Conditional Cash Transfer |
| CPS | Country Partnership Strategy |
| DA | Designated Account |
| DFID | Department for International Development |
| DHS | Demographic and Health Survey |
| ECE | Early Childhood Education |
| EHCWMP | Electronic Healthcare Waste Management Plan |
| EMR | Electronic Medical Record System |
| EPI | Expanded Program on Immunization |
| ESMF | Environmental and Social Management Framework |
| FM | Financial Management |
| FMIS | Financial Management Information System |
| FY | Fiscal Year |
| GDP | Gross Domestic Product |
| GNI | Gross National Income |
| GoPb | Government of Punjab |
| GRM | Grievance Redress Mechanism |
| GRS | Grievance Redress Service |
| HCI | Human Capital Index |
| HCP | Hepatitis Control Program |
| HIES | Household Income and Expenditure Survey |
| HSRP | Health Sector Reform Project |
| IFAD | International Fund for Agricultural Development |
| IMF | International Monetary Fund |
| INT | Integrity Vice Presidency |
| IE | Implementing Entity |
| IRMNCH&NP | Integrated Reproductive, Maternal, Newborn and Child Health & Nutrition Program |
| IFR | Interim Unaudited Financial Report |
| LFS | Labor Force Survey |
| LHW | Lady Health Worker |
| LM | Labor Market |
| LMR | Labor Market Readiness |
| M&E | Monitoring and Evaluation |
| MICS | Multiple Indicator Cluster Survey |
| MIS | Management Information System |
| MNCH | Maternal and Newborn Child Health Program |
| MSDS | Minimum Service Delivery Standards |

| | |
|---|---|
| NEET | Not in Employment, Education or Training |
| NSER | National Socio-Economic Registry |
| OP | Operations Policy |
| OTP | Outdoor Therapeutic Program |
| PC-I | Planning Commission I |
| PCC | Project Coordination Committee |
| PD | Project Director |
| PDMA | Punjab Disaster Management Authority |
| PDO | Project Development Objective |
| P&D | Planning & Development Board |
| PESP III | Punjab Education Support Project III |
| PHCIP | Punjab Human Capital Investment Project |
| PHFMC | Punjab Health Facilities Management Company |
| PKR | Pakistan Rupees |
| PLW | Pregnant and Lactating Women |
| PMIU | Project Management and Implementation Unit |
| PPSD | Project Procurement Strategy for Development |
| PSC | Project Steering Committee |
| PSHD | Primary and Secondary Healthcare Department |
| PSPA | Punjab Social Protection Authority |
| QAED | Quaid-e-Azam Academy for Educational Development |
| RHC | Rural Health Center |
| SED | School Education Department |
| SIS | School Information System |
| SP | Social Protection |
| SPD | Standard Procurement Document |
| STEP | Systematic Tracking of Exchanges in Procurement System |
| TA | Technical Assistance |
| ToRs | Terms of Reference |
| TVET | Technical and Vocational Education and Training |
| UNDB | United Nations Database |
| VfM | Value for Money |
| WB | World Bank |
| WeT | Waseela-e-Taleem |
| WINGS | Women's Income Growth and Self-Reliance Programme |
| ZeT | Zevar-e-Taleem |

TABLE OF CONTENTS

DATASHEET

## BASIC INFORMATION

| Country(ies) | Project Name | |
|---|---|---|
| Pakistan | Punjab Human Capital Investment Project | |
| **Project ID** | **Financing Instrument** | **Environmental Assessment Category** |
| P164785 | Investment Project Financing | B-Partial Assessment |

### Financing & Implementation Modalities

| | |
|---|---|
| [ ] Multiphase Programmatic Approach (MPA) | [ ] Contingent Emergency Response Component (CERC) |
| [ ] Series of Projects (SOP) | [ ] Fragile State(s) |
| [ ] Disbursement-linked Indicators (DLIs) | [ ] Small State(s) |
| [ ] Financial Intermediaries (FI) | [ ] Fragile within a non-fragile Country |
| [ ] Project-Based Guarantee | [ ] Conflict |
| [ ] Deferred Drawdown | [ ] Responding to Natural or Man-made Disaster |
| [ ] Alternate Procurement Arrangements (APA) | |

| Expected Approval Date | Expected Closing Date |
|---|---|
| 03-Mar-2020 | 30-Jun-2025 |

Bank/IFC Collaboration

No

### Proposed Development Objective(s)

The Project Development Objective is to increase the utilization of quality health services, and economic and social inclusion programs, among poor and vulnerable households in select districts in Punjab.

### Components

| Component Name | Cost (US$, millions) |
|---|---|
| Health services quality and utilization | 115.00 |

| | |
|---|---|
| Economic and social inclusion | 65.00 |
| Efficiency and sustainability through social protection services delivery system and Project Management | 20.00 |

### Organizations

| | |
|---|---|
| Borrower: | Islamic Republic of Pakistan |
| Implementing Agency: | Punjab Social Protection Authority, Government of Punjab<br>Primary and Secondary Healthcare Department, Government of Punjab<br>School Education Department, Government of Punjab |

## PROJECT FINANCING DATA (US$, Millions)

### SUMMARY

| | |
|---|---|
| **Total Project Cost** | 330.00 |
| **Total Financing** | 330.00 |
| **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 | 130.00 |
| Local Govts. (Prov., District, City) of Borrowing Country | 130.00 |

### IDA Resources (in US$, Millions)

| | Credit Amount | Grant Amount | Guarantee Amount | Total Amount |
|---|---|---|---|---|
| **Pakistan** | 200.00 | 0.00 | 0.00 | 200.00 |
| National PBA | 200.00 | 0.00 | 0.00 | 200.00 |

| | | | | |
|---|---|---|---|---|
| **Total** | **200.00** | **0.00** | **0.00** | **200.00** |

### Expected Disbursements (in US$, Millions)

| WB Fiscal Year | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 |
|---|---|---|---|---|---|---|
| Annual | 0.13 | 44.00 | 49.80 | 47.35 | 34.25 | 24.47 |
| Cumulative | 0.13 | 44.13 | 93.93 | 141.28 | 175.53 | 200.00 |

## INSTITUTIONAL DATA

### Practice Area (Lead)

Social Protection & Jobs

### Contributing Practice Areas

Education, Health, Nutrition & Population

### Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

## SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

| Risk Category | Rating |
|---|---|
| 1. Political and Governance | Substantial |
| 2. Macroeconomic | Substantial |
| 3. Sector Strategies and Policies | Moderate |
| 4. Technical Design of Project or Program | Moderate |
| 5. Institutional Capacity for Implementation and Sustainability | Substantial |
| 6. Fiduciary | Substantial |
| 7. Environment and Social | Moderate |
| 8. Stakeholders | Moderate |
| 9. Other | |
| 10. Overall | Substantial |

## COMPLIANCE

### Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

| Safeguard Policies Triggered by the Project | Yes | No |
|---|---|---|
| Environmental Assessment OP/BP 4.01 | ✓ | |
| Performance Standards for Private Sector Activities OP/BP 4.03 | | ✓ |
| Natural Habitats OP/BP 4.04 | | ✓ |
| Forests OP/BP 4.36 | | ✓ |
| Pest Management OP 4.09 | | ✓ |
| Physical Cultural Resources OP/BP 4.11 | | ✓ |
| Indigenous Peoples OP/BP 4.10 | | ✓ |
| Involuntary Resettlement OP/BP 4.12 | | ✓ |
| Safety of Dams OP/BP 4.37 | | ✓ |
| Projects on International Waterways OP/BP 7.50 | | ✓ |
| Projects in Disputed Areas OP/BP 7.60 | | ✓ |

### Legal Covenants

Sections and Description

1. Additional Event of Suspension, Section 4.01 of the Financing Agreement:
The PSPA Act 2015 has been amended, suspended, abrogated, repealed or waived, whether in whole or part, so as to materially and adversely affect PSPA's capacity to oversee Project implementation and carry out its Respective Parts of the Project.

2. Additional Event of Acceleration, Section 4.02 of the Financing Agreement:
The event specified in Section 4.01 of this Agreement occurs and is continuing for a period of 30 days after notice of the event has been given by the Association to the Recipient.

3. The Project Implementing Entity shall carry out the Project in accordance with the Implementation

| |
|---|
| Arrangements set out in Section I of the Schedule of the Project Agreement |
| **Conditions** |

# I. STRATEGIC CONTEXT

## A. Country Context

1. **Pakistan, the sixth most populous country in the world is at a crossroads.** The economy accelerated with gross domestic product (GDP) growth of 5.3 percent in FY18 and slowed down to 3.5 percent in FY19 as fiscal and external imbalances persisted[1]. Poverty declined from 64.3 percent in 2001 to 24.3 percent in 2015[2], but inequality persists. The country ranks low on the 2018 Human Capital Index (HCI)[3], at 134 out of 157 countries. Gender disparities continue, and female labor force participation was only 26.5 percent in 2018. After the onset of another boom and bust cycle, a US$6 billion International Monetary Fund (IMF) program commenced in July 2019. Growth is expected to pick up as structural reforms take effect and macroeconomic imbalances are addressed. Over the medium to long term, Pakistan needs to invest more, and better in human capital, raise more revenue, simplify doing business procedures, expand regional trade and exports, and manage its natural endowments sustainably, as articulated in Pakistan@100: Shaping the Future.[3]

2. **Pakistan has made important strides in poverty reduction, but it remains an unfinished agenda.** While the country has lifted more than 23 million people out of poverty in the past 15 years, there are significant disparities in poverty rates between rural (30.7 percent) and urban areas (12.5 percent), with poverty having declined faster in urban areas. Pakistan's poverty reduction efforts have been widely documented.[4] Remittances, safety net transfers and resilience of a large informal economy have contributed to poverty reduction. However, the challenges of poverty reduction are exacerbated by climate change and disaster-risk related vulnerabilities. In addition, inequalities in service delivery and low investment in the social sectors impede accumulation of human capital, as noted in the HCI.

3. **Pakistan's aspiration to become a middle-income country by 2047 largely depends on human capital accumulation, which is very low.** According to the HCI, if no improvements in health and education service delivery take place, a Pakistani child born today is expected to be only 40 percent as productive as s/he could be by age 18. With a large share of births taking place outside health facilities (33.8 percent), and low immunization rates (65.6 percent) children are deprived of a strong start to life. High rates of malnutrition and low learning outcomes contribute to the country's low HCI: 37.6 percent of Pakistani children under age five are stunted. Learning poverty is very high with 75 percent of Pakistani children not being able to read and understand a short age-appropriate text by age 10. Further, 44 percent of children ages 5-16 years old are out-of-school (22.8 million). More than half of those out-of-school are girls. Provincial disparities are also significant [5]. Sindh and Balochistan have the lowest human capital accumulation, whereas Khyber Pakhtunkhwa (KP) has the highest gender disparity. Punjab's indicators are highest, but still far from what is required for a future productive society in the province. (Table 1)

[1] World Bank Group (2018). "Pakistan Development Update 2018 – At a Cross Road."
[2] World Bank Group (2018). "From Poverty to Equity – Pakistan at 100." World Bank Group.
[3] World Bank. 2019. Pakistan at 100: Shaping the Future. World Bank, Washington, DC. © World Bank. *https://openknowledge.worldbank.org/handle/10986/31335* License: CC BY 3.0 IGO.
[4] See Redaelli, Silvia (2018). "From Poverty to Equity – Pakistan at 100." World Bank Group.
[5] In 2010, Pakistan amended its Constitution and devolved responsibility of service delivery to the country's four provinces: Balochistan, Khyber Pakhtunkhwa, Punjab and Sindh.

**Table 1. Underlying HCI indicators disaggregated by provinces and gender**

| Province | HCI value | | Not Stunted Rate | | Expected Years of Schooling | | Harmonized Test Scores | | Learning Adjusted Years of Schooling | | Survival to Age 5 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | M | W | M | W | M | W | M | W | M | W | M | W |
| **Punjab** | **0.43** | **0.43** | 0.68 | 0.72 | 10.6 | 10.1 | 346 | 346 | 5.9 | 5.6 | 0.92 | 0.93 |
| **KP** | **0.45** | **0.39** | 0.62 | 0.57 | 11.0 | 8.2 | 360 | 358 | 6.3 | 4.7 | 0.94 | 0.94 |
| ***Pakistan*** | ***0.41*** | ***0.39*** | *0.62* | *0.63* | *10.1* | *8.5* | *342* | *338* | *5.5* | *4.6* | *0.92* | *0.93* |
| **Sindh** | **0.36** | **0.35** | 0.50 | 0.51 | 8.7 | 7.2 | 320 | 322 | 4.5 | 3.7 | 0.92 | 0.94 |
| **Balochistan** | **0.35** | **0.32** | 0.48 | 0.58 | 9.2 | 6.1 | 338 | 324 | 5.0 | 3.2 | 0.88 | 0.90 |

*Source:* World Bank (WB) estimates using the 2017-8 Demographic Health Survey (DHS), the 2015-6 Household Income Expenditure Survey (HIES), the 2018 Annual Status of Education Report.

4. **Pakistan has adopted a holistic approach to accelerate human capital accumulation.** This entails a set of reforms and interventions, including: (i) the launch of a national poverty alleviation program: Ehsaas[6]; (ii) expansion of quality primary healthcare for improved health, nutrition and population outcomes through a 'life cycle' approach; (iii) focusing on learning in primary education to decrease learning poverty by half in a decade; and (iv) revision of legislation for women empowerment and increased participation in the labor force. Pakistan is also an Early Adopter of the WB Human Capital Project. This reform agenda is an intrinsic part of the national dialogue, supported by the WB through the Moving the Needle in Human Capital initaitive and Human Capital summits. The proposed Punjab Human Capital Investment Project (the Project) is one in a set of WB-supported federal and provincial engagements[7], which bring together core interventions aligned with the policy reform of the Government of Pakistan.

5. **Punjab is home to about 48 percent of the country's poor, and inequality remains a challenge in the province**. A large proportion of Punjab's population is clustered around the poverty line and thus remains vulnerable to poverty, especially during shocks, whether environmental or economic. There are large variations in poverty rates across districts, and in human capital indicators by household income as well as by geographic location. Overall health and education outcomes are far poorer among households in South Punjab, where the poverty rate (39 percent) is almost twice as high as the province's average (21 percent)[8].

## B. Sectoral and Institutional Context

6. **Early childhood is a critical life stage for human capital accumulation.** A weak start in the first 1,000 days, followed by inadequate investment in early childhood education (ECE), limits children's cognitive development. This lowers their school readiness and leads to poor school enrollment, retention, learning outcomes, and completion, creating a vicious cycle. Human capital challenges faced in early childhood are disproportionately high among low-income households and lagging regions in Punjab**.** The infant mortality rate in Punjab is 60 per 1,000 live births. It is higher among poorer households with 83 per 1,000 live births among the bottom quintile households as compared with 27 per 1,000 live births among the top quintile.[9]

[6] In 2019, the Prime Minister launched a new poverty alleviation program, *Ehsaas (Compassion, in Urdu )*, consolidating the role of safety nets in protecting the most vulnerable. It also includes investments in human capital with a focus on improving health care, nutrition, supporting women and youth employment, and entrepreneurship.

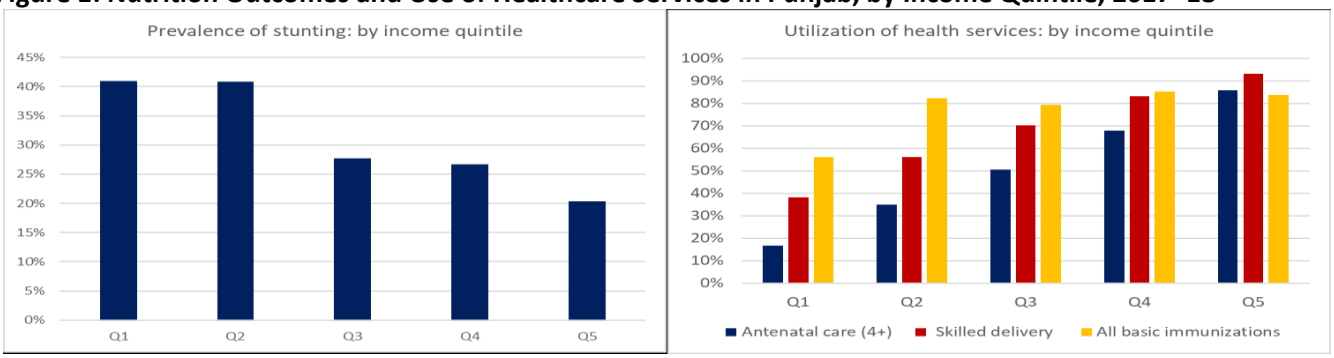
[7] The set of operations includes a federal Development Policy Operation (Securing Human Capital Investments to Foster Transformation, SHIFT), Human Capital Investment operations in Balochistan, Khyber Pakhtunkhwa, and Sindh, and a federal program in Universal Health Coverage, in addition to this one.

[8] Poverty estimates based on Household Income and Expenditure Survey, 2015-16.

[9] The multiple indicator cluster survey (MICS) shows different levels of the infant mortality rates than the DHS (overall rate in Punjab is 60

Despite progress over time, malnutrition remains prevalent. Low-income households are particularly vulnerable: as seen in Figure 1 (left-side panel), the stunting rate among households in the lowest income quintile (over 40 percent) is double that for the highest income quintile. The gap in school enrollment between poor and non-poor households persists from primary through secondary schooling.

**Figure 1: Nutrition Outcomes and Use of Healthcare Services in Punjab, by Income Quintile, 2017–18**




*Source:* Demographic and Health Survey, 2017–18.

7. **Underutilization and low quality of key health services is an immediate source of lagging early childhood human capital outcomes among vulnerable households.** There is a set of key health services that are critical for the health of mothers and young children: at least four antenatal care checkups, birth delivered by a skilled attendant, timely counselling for mothers and children's immunization. However, as may be seen in Figure 1 (right-side panel), such services are not adequately utilized by low-income households. There are substantial financial and non-financial barriers to availing health services among women in poor households, such as lack of money, opportunity costs for both patients and those accompanying them, burden of household chores and childcare, and low perceived benefits from utilizing health services due to poor quality. Furthermore, health facilities are not equipped to provide quality services.

8. **Children, especially girls, from vulnerable households are less likely to progress in their education.** There is an average 20 percentage points gender gap in the net school enrollment rate at age 13. This gap increases to 25 percentage points for low income households. Net enrollment in primary school (among children ages 6 to 10) is less than 50 percent. Close to 40 percent of students from households in the lowest income quintile drop out before completing primary school.[10] Primary school completion rates in the poorest five districts in Punjab are less than 40 percent, and particularly low among girls (less than 30 percent). Labor market (LM) conditions in Punjab are also challenging. Almost half of Punjab's working age population is out of the labor force and the female labor force participation rate is particularly low.[11] About a quarter of Punjab's young people (ages 15 to 29) fall in the category of not in employment, education, or training (NEET) as per the 2017–18 Labor Force Survey (LFS). Those who dropped out of school early in their lives and lack basic literacy and numeracy are unlikely to benefit from typical government technical and vocational education and training (TVET) or entrepreneurship initiatives.

out of 1,000 live births). However, MICS also suggests a large gap between the poor and non-poor households (83 among the bottom quintile vs. 27 among the top quintile).

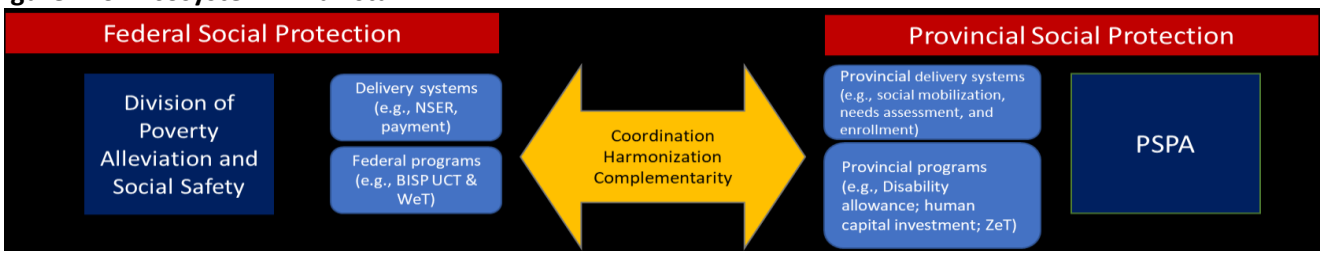
[10] Based on the Household Income and Expenditure Survey, 2015

[11] LM outcomes of women significantly lag behind those of men (e.g., in urban Punjab the female labor force participation rate at 14 percent is considerably lower than that of males at 80 percent, according to the 2017–18 LFS.

9. **Balanced partnership between federal and provincial governments has been high on the policy agenda.** Since the announcement of the 7th National Finance Commission Award and the 18th Amendment of the Constitution in 2010, provincial governments have more financial resources and responsibility for the delivery of social services. However, the division of responsibilities and resources has been unclear in certain areas. For instance, although health is a devolved subject, certain vertical programs such as Maternal, Newborn, Child Health Program (MNCH) were maintained as federal programs, only to be transferred to the provincial government recently. Any new intervention should be complementary to existing federal and provincial programs**.**

10. **Further efforts are needed to clearly define how key services will be delivered leveraging federal social protection (SP) delivery systems.** Figure 2 highlights areas of coordination. Federal investment in service delivery systems includes the National Socio-Economic Registry (NSER) that has been instrumental for targeting, and the payment systems that have evolved from manual cash delivery to biometrically authenticated digital payment. Provincial programs should complement federal programs and focus on meeting specific provincial needs and ensuring last-mile service delivery. The Punjab Social Protection Authority (PSPA), established in 2015, has been making efforts to coordinate with the federal government, as well as other provincial entities. Close coordination between federal and provincial entities through a formal modality (Memorandum of Agreement) is anticipated to clearly delineate the budgetary and service delivery responsibilities among involved entities.

**Figure 2: SP Ecosystem in Pakistan**




11. **Annex 2 summarizes key human capital challenges and relevant programs**, many of which are, or have been, supported by the WB and other development partners. Currently, there is no demand-side program to help poor and vulnerable households increase their uptake of critical health and education services for early years. Meanwhile, the scope of supply-side programs to strengthen healthcare service provision has decreased. There are significant gaps in quality ECE and early learning programs**.** Similarly, programs supporting young individuals in the poorest quintiles to participate in the LM primarily emphasize skills development through TVET, and therefore, have limited ability to address the challenges of poor and vulnerable households with a low level of education.

## C. Relevance to Higher-Level Objectives

12. **The Punjab Human Capital Investment Project (PCHIP) is fully aligned with the World Bank Group's Country Partnership Strategy (CPS, FY 15–20)** and with the twin goals of ending extreme poverty and promoting shared prosperity. It is also aligned with the recent *Pakistan@100* report which highlights the necessary reforms for Pakistan to become an upper-middle income country by 2047.[12] The Project contributes directly

[12] World Bank Group (2014) Islamic Republic of Pakistan: Country Partnership Strategy, 2015-2020 (Report No. 84645-PK), the Performance and Learning Review (Report No. 113574).

to Results Area 3 of the CPS (Inclusion) and its sub-outcome of 3.2 (Reduced Vulnerability for Groups at Risk). It also contributes to Results Area 4 of the CPS (Service Delivery) and its Sub-outcome 4.2 (Improved Access to Maternal-Child Health and Nutrition Services) and Sub-outcome 4.3 (Increased School Enrollment). The Project is expected to impact Results area 3.1 (Improved Financial Inclusion for Women) through its employability and livelihood intervention.

## II. PROJECT DESCRIPTION

### A. Project Development Objective

**PDO Statement**

13. The proposed project development objective (PDO) is to increase the utilization of quality health services, and economic and social inclusion programs, among poor and vulnerable households in select districts in Punjab.

**PDO-Level Indicators**

- **PDO Indicator 1:** Percent of pregnant women, among Conditional Cash Transfer (CCT)[13] beneficiaries, who delivered a child attended by skilled health personnel
- **PDO Indicator 2:** Percent of children between the ages of 12 and 23 months, among CCT beneficiaries, fully immunized as per the age specific protocol.
  - Percent disaggregated by gender
- **PDO Indicator 3:** Percent of beneficiaries who reported an overall income increase due to asset support.
  - Percent disaggregated by gender.
- **PDO Indicator 4:** Percent of children who transition from preschool to Grade 1

### B. Project Components

14. **The financial instrument for this Project will be Investment Project Financing (IPF).** Key principles of the Project are as follows:
    - **Poverty targeting:** For objective targeting based on the household poverty status, the NSER will be used.[14]
    - **Geographic targeting of most vulnerable districts:** Initially, 11 out of 36 districts in Punjab will be prioritized. Among the 11 districts, 8 districts are from South Punjab, where poor households are concentrated.[15] The number of districts covered by the Project depends on the scope and cost of planned activities, as well as available resources.
    - **Integrated, but selective:** Interventions will be integrated (addressing both demand and supply challenges) in the same set of locations within the same households, multisectoral (health, education, SP) and selective (complementing existing programs).

[13] Conditional Cash Transfer programs provide a Conditional Cash Grant (CCG), conditional upon the verification of requirements.
[14] The NSER is being updated, and new information is expected to be available by early 2020 with authentication through the national identification system (Computerized National Identity Card, CNIC). In case the NSER update is delayed, the Project would be supported by the existing NSER database, until the new information becomes available.
[15] Districts selected based on the multi-dimensional poverty indicators include: Muzaffargarh, Bahawalpur, Rajanpur, D.G. Khan, R. Y. Khan, Bhakkar, Mianwali, Bahawalnagar, Lodhran, Layyah, and Khushab. These are subject to change during implementation if necessary.

- **Gender-focused:** The Project will: (i) address gender gaps in immunization and school enrollment for early education; (ii) promote ante-natal care (ANC) and skilled birth attendance; and (iii) address specific constraints faced by women in income-generating activities and diversification of income sources.

**Component 1: Health services quality and utilization (approximately US$115 million equivalent)**

15. **The component will improve maternal and new-born health, especially among poor and vulnerable households.** This will enable a strong start in a child's first 1,000 days.

*Sub-component 1.1: Quality of health services (approximately US$45 million equivalent)*

16. **This sub-component will include:** a) Strengthening the primary health-care facilities in the provision of good quality services and their adherence to Minimum Service Delivery Standards (MSDS) by: (i) upgrading of selected basic health units (BHUs) in selected districts to provide uninterrupted (24/7) services all days of the week, including provision of essential equipment, medicines and supplies; and (ii) upgrading of selected rural health centers (RHCs) in the selected districts to provide neonatal intensive care on a pilot basis; (b) hiring/recruiting and/or training healthcare personnel, including pediatricians, medical officers, lady health workers (LHWs) and lady health visitors; (c) providing nutrition services through outdoor therapeutic program (OTP) counters; (d) providing population welfare services in close coordination with the department responsible for population welfare; and (e) upgrading and scaling-up the electronic medical records system (EMR) for, and implementing the Environmental and Health Care Waste Management Plan (EHCWMP) in, health facilities in the selected districts.

17. **Facilities rehabilitated under the Project will include measures to facilitate access for persons with different abilities; have improved resilience to climate shocks such as floods or extremely high temperatures; and improved energy efficiency with rooftop solar power, where possible.** Considering climate risks in targeted districts, medicines including vaccinations would be strategically stockpiled in selected health facilities, particularly prior to the annual monsoon season.

*Sub-component 1.2: Utilization of health services (approximately US$70 million equivalent)*

18. **This sub-component will increase the utilization of key health services among poor and vulnerable households, as identified through the NSER, in the select districts, through:** (a) implementing a CCT program and providing Conditional Cash Grants (CCGs) to eligible pregnant or lactating women and/or parents of children up to 2 years of age (eligible CCG Beneficiaries); and (b) carrying out outreach, social mobilization and information dissemination campaigns among health service beneficiaries.

19. **CCT co-responsibilities (conditionalities) include:** regular health checkups of PLW, skilled birth delivery and birth registration, growth promotion, immunization of children under two years of age and participation in counseling and awareness sessions on population welfare, hygiene, feeding and caring practices, children's cognitive development, as well as food security and healthy foods for nutrition (See Annex 3 for a detailed description of co-responsibilities). The Project Operational Manual (POM) contains a section on the CCT describing operational procedures and implementation arrangements. It was prepared jointly by the PSPA and the Primary and Secondary Healthcare Department (PSHD). The service delivery process will include beneficiary outreach through information campaigns, social mobilization and LHWs[16]. Service delivery will be

[16] Ibid.

mainly at primary and secondary healthcare facilities. Upon verification of compliance with co-responsibilities, transfers will be made digitally to the individuals' bank accounts.[17] Business processes related to the program will be supported by the service delivery platform described in Component 3. The amount of transfers would be greater for services critical to child health and nutrition, and for which the take-up has been low. Based on the number of Benazir Income Support Programme (BISP) beneficiary women; and assumptions regarding the likelihood of pregnancy, conditionality schedules, and coverage of children up to the age of two, the Project financing of approximately US$65 million would be used for cash benefits to (up to one million beneficiaries) beneficiaries, and the remaining US$5 million would be used for social mobilization and empowerment support by PSPA.

**Component 2: Economic and social inclusion (approximately US$65 million equivalent)**

20. **This component comprises supplementary activities to improve households' economic and social inclusion.** It will be introduced and are expected to contribute to building early childhood human capital among poverty-stricken households.

*Sub-component 2.1: Economic inclusion (approximately US$35 million equivalent)*

21. **This sub-component will promote the economic inclusion of poor and vulnerable eligible young parents[18] through the provision of technical assistance, goods and training, including and not limited to provide:** (a) labor market readiness (LMR) training; (b) Livelihood Support Grants (LSGs) or the Productive Assets; and (c) intensive coaching aimed at improving productive behavior to help increase resilience of households of the eligible young parents.

22. **The POM sets out the requirements for participation.** Prior to receiving a productive asset, individuals from target households will participate in the LMR component, which will include training on basic literacy and numeracy to equip participants with record-keeping skills for managing a livelihood; social and health awareness; and confidence-building. Market analysis and beneficiary profiling exercises will be conducted during LMR delivery, to recommend a list of livelihood packages that are viable for the targeted poor, considering participant skillsets, interest, care burden, resources as well as the environment, particularly climate risks and the associated need for income diversification. The completion of the LMR package is expected to pave way for technical skills development (e.g., animal husbandry, entrepreneurship, financial literacy). Livelihood support, including the transfer of productive assets (e.g. livestock, tools, merchandise, material on climate-smart agriculture etc.), will then be accompanied by bimonthly coaching services. The entire series of activities will be directly delivered or informed by community organizations that have local presence, supervised and monitored by the PSPA. The Project financing would be used to procure community organizations' service delivery.

*Sub-component 2.2: Social inclusion for education (approximately US$30 million equivalent)*

23. **This subcomponent will strengthen the selected education programs/initiatives through:** (a) conducting an initial needs assessment; (b) filling the gaps in learning through training of school-related staff; (c) developing

[17] "Digital payment" refers to payment transferred to a recipient's individual transactional account and withdrawn through an electronic instrument (e.g., debit cards, mobile phones, national identification cards, etc.) using enhanced authentication measures (e.g., personal identification number, fingerprints, finger veins, etc.).
[18] "Eligible young parents" means a parent whose age is between 18 and 29 with children up to 5 years of age from poor and vulnerable households as identified though the NSER.

detailed lessons; (d) conducting specialized early childhood education social mobilization campaign; (e) upgrading classroom facilities to be conducive to learning; and (f) establishing and building capacity for a special foundational learning cell in the School Education Department (SED).

24. **Selected education programs to be strengthened in Punjab are ECE and early grades learning (grades 1-3).** There are 3,400 ECE classrooms in the Project's target districts and communities, but not all of them meet the minimum ECE quality standards prescribed in the 2017 Punjab ECE Policy. The ECE component will include: (i) conducting an initial assessment of existing ECE classrooms' infrastructure, the condition and status of existing learning kits, and the capacity of existing ECE teachers and caregivers; (ii) filling the gaps in learning environment and supplies (e.g. learning kits, tablets) and capacity of teachers and caregivers; (iii) developing detailed lessons to operationalize the soon-to-be notified Punjab 2-year ECE curriculum and complementary new activities; (iv) conducting a specialized ECE social mobilization campaign; and (v) establishing and building capacity for a special Foundational Learning Cell in the SED to ensure close monitoring, sustainability and ultimately innovation in early learning interventions. These activities are expected to reach 150,000 children, 20,400 teachers, 1,300 recently empowered Administrative Education Officers (AEOs) [19] and 3,400 ECE classrooms.[20]

25. **With respect to early grade learning, renewed efforts will be made to build strong early literacy and numeracy foundations of pre-primary and primary students through a new pedagogy (e.g. play-based learning).** Project activities for early grades learning include: (i) strengthening of the capacity of primary school teachers, head teachers, school councils and support staff (such as AEOs), and (ii) improvement of the quality and availability of teaching and learning, reading, and other support materials particularly focusing on early grade literacy and numeracy acquisition[21].

**Component 3: Efficiency and sustainability through social protection services delivery systems and project management (approximately US$20 million equivalent)**

26. **The component will involve modernizing and improving coordination and interoperability of Punjab's SP systems and programs by strengthening the administrative, operational, policy and planning functions and capabilities of the PSPA, including the development of IT systems and technical assistance for:** (i) enhancing procurement, financial management (FM), human resources, auditing, and monitoring and evaluation (M&E) functions; as well as (ii) upgrading and/or customizing their systems for identifying and mobilizing program beneficiaries, defraying benefits and/or rendering welfare services/program, and redressing grievances.

27. **PSPA has already started building a beneficiary database and program dashboards to keep track of major initiatives and beneficiaries' information in Punjab.** In addition to this horizontal coordination and collaboration, the platform will vertically coordinate with federal entities and build interoperable systems. Three functions to be strengthened are as follows:
    a. **Administrative functions** include IT systems, procurement and FM, audit and control, human resource

[19] This training will be provided through the Quaid-e-Azam Academy for Education Development (QAED).
[20] These activities will be staggered so as not to overlap with activities of PESP-III which are supporting the establishment of 7,000 ECE classrooms that meet quality standards, the training of teachers, AEOs, caregivers and head teachers and the creation of an ECE cell. Activities under PESP-III conclude in 2021.
[21] This approach would ensure a close link between the newly enhanced approach to ECE, promoting greater transition from ECE to primary school, and primary school completion especially of children from poor and vulnerable households.

management, and capacity building, among others.

b. **Programmatic operational functions** support the business process of service delivery for pro-poor programs and would need to be customized to the requirements of each program[22].
c. **Policy and planning functions** involve conducting M&E for the SP sector, compiling sector knowledge and evidence, and undertaking horizontal coordination with other stakeholders in Punjab.

28. **The platform will support relevant institutions in the Government of Punjab (GoPb), including but not limited to, the PSHD, SED, and departments of population welfare, agriculture, social welfare, zakat, women's development, and labor, and Punjab Disaster Management Authority (PDMA) that provide SP services to poor and vulnerable households.** The PSPA will work closely with the PDMA to improve Punjab's disaster resilience in two ways: (i) households most vulnerable to shocks can be identified in advance, through the NSER, which enables taking preemptive measures to build their resilience e.g. through cash transfers and (ii) once hit by a shock, assistance can be provided to affected households in an effective and efficient way, Second, the PSPA will further strengthen the SED's Zevar-e-Taleem (ZeT) program,[23] by further encouraging and mobilizing girls from poor and vulnerable households to attend and remain in school. The PSPA can consider targeted mobilization for BISP families and Waseela-e-Taleem (WeT) graduates to further encourage secondary education and ZeT participation.

## C. Project Beneficiaries

29. **The Project will directly benefit poor and vulnerable households in select districts in Punjab.** The target populations—such as PLW and their children under two, children in pre-primary and lower primary schools, and young parents receiving services and transfers from Project initiatives, would be direct beneficiaries. In addition, positive spillovers are expected from Project activities and investments. By improving the quality of primary healthcare services, households that use target primary health facilities, even if they are not beneficiaries of the nutrition-sensitive CCT program, would benefit from the Project's investment. Additionally, the benefit of the platform, will go beyond the Project, by supporting other agencies in Punjab and their beneficiaries, such as PDMA, Social Welfare and Zakat, among others.

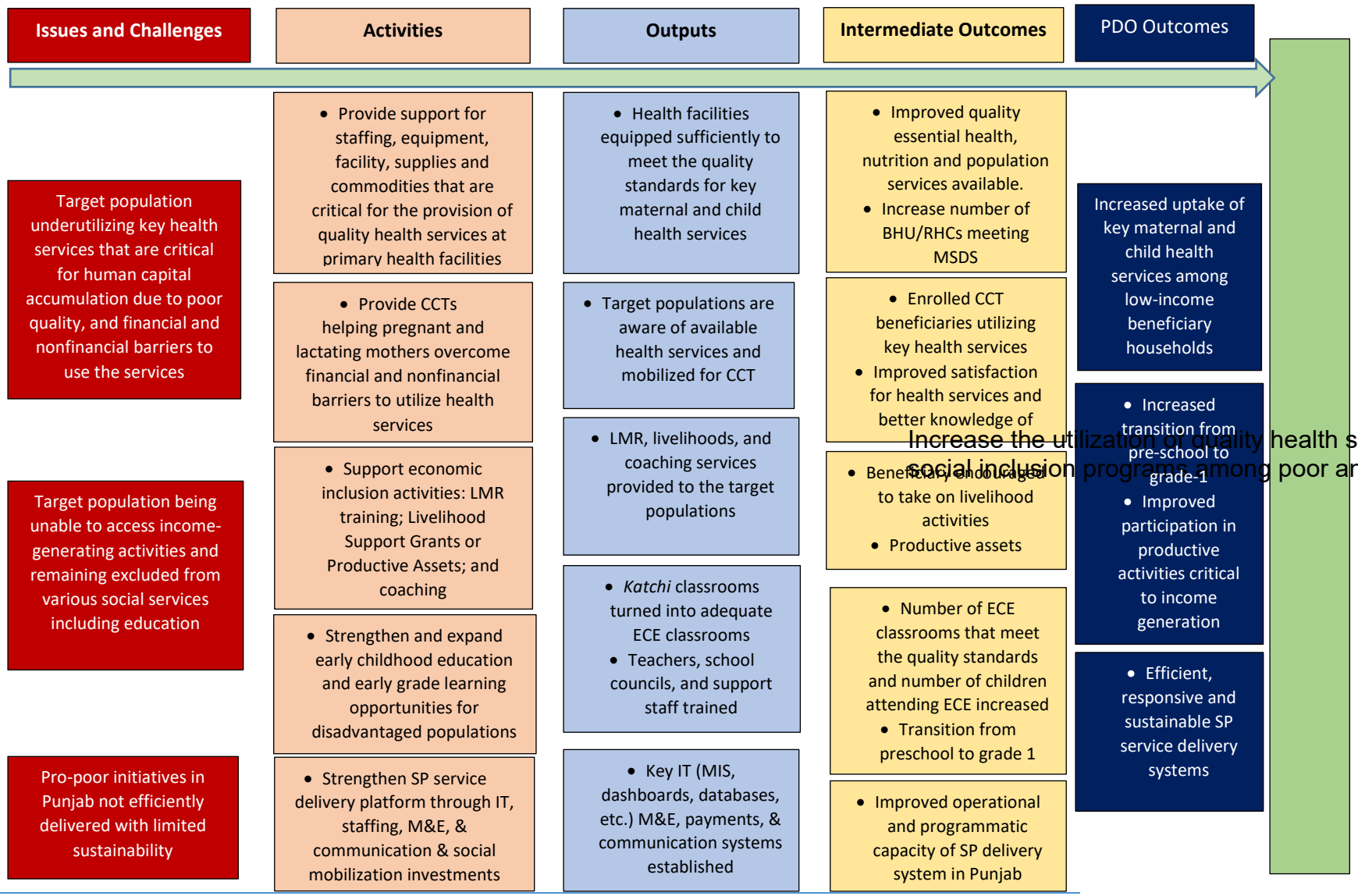
## D. Results Chain

30. **Key challenges to achieving the goal include the underutilization and sub-optimal quality of key health services; poverty and social and economic exclusion – all of which lower households' investment in human capital**. Figure 3 provides details on the results chain.

[22] The process of service delivery in safety net programs involves: (i) identification and mobilization of eligible households; (ii) intake and registration; (iii) needs assessment; (iv) enrollment of eligible households to relevant programs; (v) assessment of conditionality and benefits; (vi) notification of enrollment and onboarding; (vii) provision of services, verification of compliance if relevant, and payment or transfer of resources as defined in each program; (viii) M&E of program results and achievements as well as grievance redressal if any; and (ix) graduation and exit as well as recertification These activities will need to consider specific constraints faced by women – including targeted mobilization efforts for women.

[23] The program was initially introduced to increase demand and improve access for secondary girls' education in lagging districts of Punjab, with a modest payout of PKR 200 per girl each month in 2002–03. In 2017, the stipend program was rebranded as ZeT and converted into a CCT program in public schools (operated jointly by PSPA and SED and supported by PESP III) in 16 districts of Punjab.

**Figure 3: Results Chain**



### E. Rationale for Bank Involvement and Role of Partners

31. **The WB is working closely with both federal and provincial governments to support their policy reforms and necessary investments.** The Bank's policy engagement at the federal level focuses on two key pillars: (i) protecting the poor and vulnerable against the impact of the macro-fiscal reforms required to set the country on a stable growth path; and (ii) setting the foundations for human capital accumulation, needed for sustained growth and protection from future risks. At the same time, the Bank is assisting provincial governments in making the investments necessary to achieve these objectives. The Project, through investing in foundational human capital accumulation among vulnerable populations, and by facilitating GoPb's close coordination with federal initiatives, as well as within various provincial programs and entities, is expected to help achieve synergies in reaching shared goals.

32. **The Bank's convening power and technical coordination with development partners, including the U.K. Department for International Development (DFID) will be instrumental.** DFID is supporting GoPb in strengthening resilience through the productive inclusion of the most vulnerable populations with a grant of £35 million. The Bank is also working with international and national organizations, including the United Nations Children's Fund (UNICEF), International Fund for Agricultural Development (IFAD) and national nongovernmental organizations. The Project will geographically map out relevant partners' activities in Punjab and ensure synergies among selected villages and union councils.

### F. Lessons Learned and Reflected in the Project Design

33. **The Project takes a multisector, integrated approach to enhance human capital investment in Punjab.** To identify the areas of intervention, the GoPb has carried out analytical activities, supported by the Bank, to assess obstacles to the accumulation of human capital along the course of the human life cycle, review relevant programs, and identify critical gaps. The Bank's own analytical exercises such as "moving the needle" and "Pakistan@100," were used to identify key areas for policy intervention. Also, the Bank's Human Capital Project, in which Pakistan participated as an early adopter, reaffirmed Pakistan's commitment to human capital and the need for provincial governments' complementary investments.

34. **The Project will build on global evidence and Pakistan-specific lessons learned.** Global evidence highlights the importance of an integrated approach to improve human capital investment. While the Project alone would not be able to address all constraints faced by poor and vulnerable households, it will address direct and indirect challenges that lower human capital investment in early childhood. It incorporates key lessons from similar multisectoral approaches implemented in other parts of Pakistan. It will promote close coordination and collaboration across different entities and line departments, maximize geographical and household level convergence, and address weak institutional and operational capacity challenges by investing in the SP service delivery platform. Third, recognizing difficulties in fund flows across Implementing Entities (IEs), the Project will use each Implementing Entities' (IEs) own fiduciary management. This will allow each IE to plan and execute its operational activities, while closely coordinating with other partners in the Project.

## III. IMPLEMENTATION ARRANGEMENTS

### A. Institutional and Implementation Arrangements

35. **Given the multisectoral nature of the Project, multiple entities will implement it.** To the extent possible, existing institutional structures will be used to implement and oversee the Project. The PSPA would serve as the lead implementing agency. The responsibilities of overall coordination, planning, and reporting will reside with the PSPA. It will take the lead in demand-side engagement: CCTs (sub-component 1.2) and economic inclusion components (sub-component 2.1), as well as social mobilization of all Project activities. The PSPA will also manage the SP service delivery platform (Component 3).

36. **For health services (sub-component 1.1), the PSHD will be responsible for implementing activities.** The PSHD will use existing systems at the provincial and district levels to ensure timely implementation of various activities: The Project Management and Implementation Unit (PMIU), which will be housed in the Punjab Health Facilities Management Company (PHFMC) will manage the sub-component along with existing programs such as the Integrated Reproductive, Maternal, Newborn, and Child Health & Nutrition Program (IRMNCH&NP), which is already responsible for the LHWs Program, the MNCH Program, the Nutrition Program, and 24/7 Basic Emergency Obstetric and Newborn Care services; Expanded Program on Immunization (EPI); and Hepatitis Control Program (HCP). The District Health Authorities will be responsible for the implementation and management of district level activities. To support additional responsibilities, and effective and efficient implementation and management of the planned activities, the Project will finance key implementation support personnel as well as incremental operating costs.

37. **The SED will be the lead IE for sub-component 2.2.** Through the Program Monitoring and Implementation Unit[24], SED will implement activities to: (i) strengthen the ECE program in government-run schools, in close collaboration with Quaid-e-Azam Academy for Educational Development (QAED), ensuring alignment with the new ECE policy ii) strengthen school level early grade literacy and numeracy teaching. To support additional responsibilities, the Project will finance the establishment of a Foundational Learning Cell in the PMIU with key implementation support personnel as well as incremental operating costs.

38. **Each IE would have its own Designated Account (DA) for fiduciary responsibility for their respective areas of intervention.** A Project Steering Committee (PSC) headed by the Chairman of the Planning and Development Board (P&D) will be constituted, for strategic guidance and oversight. In addition, for operational coordination of various activities, a Project Coordination Committee (PCC) will be formed consisting of representatives of the PSPA, SED, and PSHD and headed by the PSPA representative. This committee will then report to the PSC for policy decisions and discussions. These arrangements will be included in the legal document of the Project.

### B. Results Monitoring and Evaluation Arrangements

39. **Overall responsibility for M&E:** The responsibility for M&E resides with each IE for its respective activities. Project progress will be monitored based on the Project Results Chain, as outlined in sub-section D of section

[24] The *Programme Monitoring and Implementation Unit* established under the WB-financed Punjab Education Support Project (PESP III) will also serve as the PMIU with management and fiduciary responsibility.

II. Various information technology (IT) systems—including the PSPA's MIS, PSHD's MIS (until the EMR is fully functional), and the SED's School Information System (SIS) —will be utilized for the monitoring of activities and outputs.

40. **Monitoring of results and reporting:** The M&E team in each IE will produce progress reports every six months, based on real-time information from the health EMR, CCT and economic inclusion MIS, and SED's education information system. Based on each agency's progress reports, achievements vis-à-vis the Project results chain will be monitored and reported through the Project's biannual progress reports to be collated by the PSPA and shared with the WB. Key indicators will be traced and disaggregated by gender. Consultancy for operational review and third-party validation will be procured to conduct regular evaluation activities and identify any major bottlenecks.

41. **Impact evaluations:** A baseline survey for Component 1 in two districts in southern Punjab was conducted to inform the Project activities. The survey covered demographic details, LM activities, and access to human capital services. A detailed evaluation strategy was developed to assess the impact of health-and-nutrition-promoting CCTs on maternal and children's outcomes. The viability of the evaluation strategy would depend on timely execution of the intervention of Component 1. Impact evaluations for other component activities would be further considered as part of the Bank executed technical assistance activities, depending on availability of resources.

42. **Implementation support:** Quarterly implementation support missions during the first year of Project implementation and six-monthly regular implementation support missions thereafter are envisaged.

### C. Sustainability

43. **Sustainability of the Project's outcomes is underpinned by several factors.** Firstly, there is strong government ownership of the proposed activities and agenda, evidenced by multiple high-profile commitments. The announcement of *Ehsaas* to strengthen the investment in people, and strong emphasis on the reduction of stunting by both federal and provincial governments, are such examples. Secondly, institutional arrangements are established in a way to ensure sustainability. The lead agency, PSPA, will build IT based systems and platform within PMIU so implementation experience and capacity can be absorbed by the agency. Similarly, other implementing entities are also recommended to build systems and make investments in the departments' core programs that go beyond the Project period. Thirdly, as the Project provides time-bound support (e.g., first 1,000 days; early grade; 24 months of coaching since the completion of LMR) and robust evaluation, there will be flexibility for further scale up and down depending on implementation quality.

## IV. PROJECT APPRAISAL SUMMARY

### A. Technical, Economic and Financial Analysis

44. **The Project combines multiple interventions that address challenges to foundational human capital accumulation.** To quantify the potential impact—both direct and indirect—of the proposed activities, and assess their effectiveness, a technical, economic, and financial analysis discusses global evidence of similar

interventions. Further, based on the cost of intervention and potential benefits, the analysis presents a range of cost-benefit ratios.

**Global Evidence**

45. **A large body of literature emphasizes the substantial costs of inaction in addressing human capital challenges during the early years, especially the first 1,000 days.** For instance, almost 70 percent of stunting occurs during the first 1,000 days and has a long-term impact on future educational and economic outcomes.[25] Undernutrition and disease in childhood can also lead to impaired cognitive and brain development, lower socioemotional skills, lower educational outcomes, and ultimately lower incomes.[26] Malnutrition also leads to lost earnings – studies estimate productivity losses as high as 11 percent of GDP in Latin America, Africa and Asia, each year.[27]

46. **CCT programs, if designed and implemented well, are well known for improving human capital indicators by incentivizing investment in health services while providing resources for consumption smoothing.[28]** For instance, CCTs led to a large increase in the child vaccination rates (by 7.1 percentage points in Indonesia and 8.7 percentage points in the Philippines).[29] CCTs can also indirectly contribute to nutrition outcomes by ensuring food security and improving food consumption. At a given level of household expenditure in Colombia, Ecuador, and Nicaragua, CCT households spend a larger proportion of their income on food and often better-quality food.[30]

47. **Similarly, increased resources from economic inclusion activities are expected not only to improve the well-being of households but also to enhance child health and nutrition.** Evidence of the effectiveness of comprehensive economic inclusion Projects that combine multiple interventions, including asset transfers, comes from rigorous impact evaluations of the Consultative Group to Assist the Poor (CGAP) and Ford Foundation's pilots in six countries,[31] including Pakistan, along with Ethiopia, Ghana, Honduras, India, and Peru. The study shows that the long-term benefits outweigh the costs (total benefit/cost ratio was about 179 percent in Pakistan), suggesting potential for success. This evaluation and subsequent studies suggest that factors including market analysis of business activities, comprehensive counseling, and social empowerment are critical. Evidence from Bangladesh also shows that children under five from participant households experienced an 8 and 19 percent reduction in wasting and underweight, respectively.[32]

[25] Jef L. Leroy, Marie T. Ruel, Jeanne-Pierre Habicht, and Edward A. Frongillo, "Linear Growth Deficit Continues to Accumulate beyond the First 1000 Days in Low- and Middle-Income Countries: Global Evidence from 51 National Surveys," *Journal of Nutrition* 144, no. 9 (2014): 1460–66.
[26] Emanuela Galasso and Adam Wagstaff, "The Aggregate Income Loses from Childhood Stunting and the Returns to a Nutrition Intervention Aimed at Reducing Stunting" (policy research working paper WPS 8536, World Bank Group, Washington, DC, 2018).
[27] Rodrigo Martinez and Andres Fernandez, "The Cost of Hunger: Social and Economic Impact of Child Undernutrition in Central America and Dominican Republic," *Documentos de Proyetos,* no. 144 (2008).
[28] Ariel Fiszbein et al., *Conditional Cash Transfers: Reducing Present and Future Poverty*, World Bank Policy Research Report (Washington, DC: World Bank, 2009), https://openknowledge.worldbank.org/handle/10986/2597.
[29] Dian Kusuma, "Essays on Health Financing for the Poor" (doctoral dissertation, Harvard T.H. Chan School of Public Health, 2015), http://nrs.harvard.edu/urn-3:HUL.InstRepos:16121155.
[30] Fiszbein et al., Conditional Cash Transfers.
[31] Abhijit Banerjee, "A Multi-Faceted Program Causes Lasting Progress for the Very Poor: Evidence from Six Countries," *Science* 348, no. 6236 (2015).
[32] Raza, W. 2017. "(Accidentally) Harvesting higher hanging fruits: addressing under-5 malnutrition using the Graduation Approach". Policy in Focus: Debating Graduation. 14. 43-46.

48. **Any subsequent interventions that contribute to human capital accumulation and earnings potentials (e.g. ECE and schooling) complement investment in early years through better school readiness, retention and learning**. Based on data from 139 countries, the estimated returns to an additional year of education, secondary education, and postsecondary education for females at 8.3, 6.0, and 5.3 percent, respectively.[33] Women's education and empowerment improve women's autonomy and access to financial resources and tend to induce more investment in children,[34] and is positively associated with a delay in marriage and childbearing.[35]

**Cost-benefit calculation**

49. **Costs  Costs per child of the Project can come from**: (i) additional investments in target primary healthcare facilities to sustain the improvement in quality divided by the potential number of children who would benefit from the health service; (ii) CCT benefits; (iii) per child costs for education services; and (iv) per household costs for economic inclusion divided by the average number of children in typical low-income households.

50. **Benefits per child are the incremental value of human capital resulting from the investment of the Project activities.** It refers to the productivity of an average worker in the future determined by child survival, education, and health, in line with the Bank's HCI. For simplicity, the present value of human capital of an individual is specified as:

$$HC = \Pr(<5 \text{ survival}) * \Pr(\text{adult survival}) * ((p_L * LE_L) + (p_H * LE_H))$$

Where Pr(<5 survival) is the under 5 child survival rate, Pr(adult survival) is the adult survival rate, $p_L$ and $p_H$ denote the likelihoods of the individual turning out to be low and high productivity person, yielding the present value of lifetime earnings of $LE_L$ (low) and $LE_H$ (high), respectively. Then each of these become the parameters to be adjusted as investments through the Project would affect them (Table 3). The baseline figures come from actual health and education data, and discounted present value of potential earnings are calculated in a way that the annual earning is equal to per capita gross national income (GNI).[36] The Project intervention is expected to change the parameters: the health intervention will improve both child and adult survival rates, education will increase the likelihood of an individual turning out to be a high productivity person, and the economic inclusion intervention will likely have an impact on child's survival, education, and

[33] Claudio E. Montenegro and Harry A. Patrinos, "Comparable Estimates of Returns to Schooling around the World (English)" (policy research working paper WPS 7020, World Bank Group, Washington, DC, 2014).
[34] For example, Marcos A. Rangel, "Alimony Rights and Intrahousehold Allocation of Resources: Evidence from Brazil," *The Economic Journal* 116, no. 513 (2006): 627–58; Esther Duflo, "Grandmothers and Granddaughters: Old-Age Pensions and Intrahousehold Allocation in South Africa," *World Bank Economic Review* 17, no. 1 (2003): 1–25; and Duflo, Esther. (2006). Poor but Rational? Understanding Poverty. 10.1093/0195305191.003.0024.
[35] Jungho Kim, "Female Education and Its Impact on Fertility," IZA World of Labor 2016: 228, doi: 10.15185/izawol.228; Oriana Bandiera et al., "Women's Empowerment in Action: Evidence from a Randomized Control Trial in Africa," BRAC, Uganda, 2018; Sarah Baird, Craig Mcintosh, and Berk Özler, "Cash or Condition: Evidence from a Cash Transfer Experiment," *Quarterly Journal of Economics* 126, no. 4 (2011): 1709–53.
[36] We use per capita GNI (PKR 170 thousand) instead of using actual earnings data given that the majority of women are not in the labor force and do not generate earnings. Given life expectancy in Pakistan at 15 is 58, lifelong earnings are estimated for 43 productive years using gross GNI per capita with a discount rate of 6.3 percent, Pakistan's real interest rate as per World Development Indicators.

earnings prospects of low productivity individuals. Then the incremental change in human capital generates the benefits of intervention.

**Table 2. Value of Human Capital Parameters**

| Parameters | Baseline numbers (data source) | Additional Intervention | | |
|---|---|---|---|---|
| | | Health (1) | Education (2) | Economic Inclusion (3) |
| Pr (<5 survival) | 0.93 (DHS 2017-18) | √ increase | | √ increase |
| Pr (Adult survival) | 0.84 (DHS 2017-18) | √ increase | | |
| $p_L$ | 0.34 (Less than primary, HIES 2015-16) | | √ increase | √ increase |
| $p_H$ | 0.66 (1- $p_L$ ) | | √ decrease | √ decrease |
| $LE_L$ | PR 139 thousand per year | | | √ increase |
| $LE_H$ | PR 187 thousand per year | | | |

51. **The benefits calculated in this way are likely to underestimate other rippling effects and positive externalities.** For example, better provision of antenatal services is expected not only to increase survival rates, but also to improve primary school completion rates and lifetime earnings due to better health, nutrition, and cognitive development. Similarly, for education services, we only consider their impact on increases in primary completion rates, but they are likely to improve lifetime earnings as well, through better learning quality. However, for the sake of simplicity and parsimony, we will only account for the direct effects (as seen in Table 2).

52. **Four scenarios are considered for calculating lifelong earnings assuming each intervention will complement the benefits of the preceding one**:
    - The baseline refers to the status quo value of human capital based on current conditions;
    - The first scenario assumes that with investment in the quality of health services and better take-up, Punjab will accelerate in the improvement in child and adult survival rates to achieve 97 and 86 percent rates, respectively[37];
    - The second scenario assumes that a child benefiting from education services on top of health services, is more likely to complete primary school (meaning the increase in the probability of becoming a high productivity individual), and the primary completion rate is expected to increase to 72 percent[38]; and
    - The third scenario assumes the addition of economic inclusion intervention to health and education services. The economic inclusion intervention will further improve child survival and primary completion and increase the earnings of low productivity individual by overall 7.5 percent.[39]

53. **The Benefit over cost (B/C ratio) per person investment, by scenario, is presented in Table 3.** When only the health intervention is carried out, based on assumptions described above, the B/C ratio is 4.88. This suggests that a one-dollar investment will yield the net present value of 4.88 dollars, indicating high cost-effectiveness. When education services and economic inclusion interventions are added, the B/C ratio

[37] It is assumed that the Project intervention will improve child and maternal survival rates one percentage point faster than the trend without intervention.
[38] With the provision of ECE services, the expected increase in primary completion rates is up to 10 percentage points (*https://ijccep.springeropen.com/articles/10.1186/s40723-018-0054-1*). But given the take-up rates, we assume that ECE provision will increase the primary completion rate from 66 to 72 percent.
[39] Based on studies regarding the graduation approach, it is assumed that about 75 percent of low productivity individuals' earnings stream increase by 10 percent.

remains high at 4.84 and 5.60 respectively.

**Table 3. Cost Benefit Ratios by Scenario**

| | Baseline (current trends) | Additional intervention | | |
|---|---|---|---|---|
| | | Health | + Education Services | + Economic Inclusion |
| **Value of human capital (PR)** | 1.963 million | 2.096 million | 2.120 million | 2.681 million |
| **Incremental Benefits (PR)** | - | 88,452.71 | 23,308.72 | 472,877.65 |
| **Cumulative Benefits (PR)** | 44,728.93 | 133,181.63 | 156,490.35 | 629,368.00 |
| **Incremental Cost (PR)** | - | 27,308.37 | 5,000.00 | 80,000.00 |
| **Cumulative Cost (PR)** | - | 27,308.37 | 32,308.37 | 112,308.37 |
| **B/C Cumulative** | - | 4.88 | 4.84 | 5.60 |

**Implementing Agency Assessment**

54. **The PSPA is a relatively nascent agency established in 2015.** The Bank provided technical assistance to this entity until June 2018 for initial capacity-building. With growing capacity, the PSPA has taken on increased responsibility and is implementing several initiatives in Punjab. The Project will support its institutional, operational, and policy capacity-building. For administrative capacity, some key technical staff positions are yet to be filled, particular for procurement, FM, safeguards, and M&E activities. Programmatic operational capacity should be ensured to implement large-scale programs in collaboration with multiple line departments. Moreover, in the context of Pakistan's macroeconomic conditions and associated impacts on the poor, the PSPA's policy and planning capacity to adopt important SP policies in coordination with the federal government is required. Component 3 activities involve investing in the PSPA's IT, backend systems, and human resources to augment its capacity and contribute to efficient SP service delivery in Punjab. Further, the Bank is initiating a capacity-building technical assistance for Women's Economic Empowerment and Livelihoods (with the DFID's Bank Executed Trust Fund, amounting approximately US$4.2 million) to specifically assist the PSPA's capacity building activities.

55. **The PSHD has been involved in the recently closed Bank-supported Punjab Health Sector Reform Project (HSRP).** The Project implementation completion and results report pointed to several institutional and implementation capacity challenges including: weak management capacity particularly at the district level; lack of a results-based culture; limited emphasis on accountability; limited use of data for planning and management. The HSRP did provide modest capacity-strengthening support for the PSHD, however challenges remain. The Project would in part mitigate these challenges by delegating management to the PHFMC, already managing BHUs in 14 districts, financing key implementation support personnel within the PHFMC, and supporting the scale up of the EMR, enabling timely M&E.

56. **The SED is currently involved in the Bank-supported Punjab Education Support Project (PESP III).** A few challenges associated with the SED include: frequent and recent leadership changes; the PMIU's occupation with the PESP III's workloads and responsibilities; and additional coordination with, and greater level of effort required from, QAED for ECE strengthening. Given the PESP III's activities associated with ECE and Early Grade Learning, the additional activities proposed are a natural continuation and complement it. To mitigate the issue of increased workloads and responsibilities, the Project would support financing a Foundational Learning Cell with provision for key, additional implementation support personnel and building and strengthening the IT infrastructure.

## B. Fiduciary

**Financial Management**

57. **FM will mainly rely on country systems, and thus the GoPb's budgeting processes will apply.** The Project's budget will be a part of the government's annual budget and will be reflected in the province's Annual Development Plan (ADP). Disbursements will be report-based, and the Bank will transfer funds to DAs on the basis of six months' cash forecast as reported in the bi-annual interim unaudited financial reports (IFRs). Separate DAs in U.S. dollars will be established for each IE, that is, for the SED, PSHD, and PSPA. In FM units of each IE, it is recommended that two staff members with experience in finance be deputed by the GoPb, in addition to a mandatory FM specialist. The FM unit staff will document the expenditure against advances based on the IFRs.

58. **All IEs will maintain separate books of accounts on a cash basis, to record the Project's receipts and payments and prepare separate IFRs.** While the FM unit of the PSPA would not play any authorizing role in other entities' FM and operation, it will be responsible for collating three IFRs into a consolidated report and will submit this to the Bank biannually. The Project's financial statements will be prepared in accordance with the Cash Basis International Public Sector Accounting Standards and audited by the Auditor General of Pakistan. The audited financial statements will be submitted to the Bank within six months of the close of the financial year. FM supervision of the Project will also be conducted biannually (through regular submission of the IFRs), to verify that proper controls are exercised in Project operations.

59. **A comprehensive MIS to be developed for all components of the Project is expected to mitigate the potential risks involved in the Project payments.** These payments will be made to a diverse category of beneficiaries, including vendor organizations and individual beneficiaries. It will primarily focus on the identity management of the beneficiaries and will authorize payments based on verification using the MIS system. An audit firm will conduct regular internal audits of all DAs and report to the PCC. The internal audit report will also be shared with the PSC, which will check the actions taken by IEs on the recommendation of the internal audit firm.

**Procurement**

60. **Procurement will be carried out in accordance with the World Bank's Procurement Regulations for Borrowers for Goods, Works, Non-Consulting and Consulting Services dated July 1, 2016; and revised August 2018 (Procurement Regulations).** The Project will be subject to the World Bank's Anticorruption Guidelines, dated October 15, 2006, and revised in January 2011 and July 2016. Procurement assessment has been carried out and a simplified Project Procurement Strategy for Development (PPSD) has been prepared by the PSPA. Project procurements largely cover minor works, goods, and consultancies (both firms and individuals). Procurement responsibility would rest with each of the IEs, with the PSPA playing a key role in Project-wide activities. Each IE will be required to hire a full-time procurement specialist with qualifications and experience acceptable to the Bank, within three months of Project effectiveness. In addition, the Systematic Tracking of Exchanges in Procurement (STEP) system—the Bank's planning and tracking system—will be implemented to prepare and manage the Project procurement plan and procurement transactions. The procurement plan will be updated semiannually (or as required) using the STEP system.

### C. Safeguards

61. **Environmental safeguards:** Some low-scale potential environmental impacts are expected from the rehabilitation and upgrade of BHUs and RHCs, as well as ECE classrooms. These impacts are expected to be temporary, localized, and reversible in nature. In addition, increases in the demand for services are expected due to demand-side interventions, which will likely produce more healthcare waste. Given these, Environmental Assessment OP/BP 4.01 is triggered, and the Project safeguard category is B with partial assessment. To investigate any potential environmental and social impacts and to identify mitigation measures, the PSPA took a lead in conducting an environmental and social impact assessment study, which includes: (i) Environmental and Social Management Framework (ESMF), largely for construction-related activities; and (ii) EHCWMP. Since the scale of impacts is expected to be low, the ESMF consists of sub-project screening, mitigation, supervision, monitoring, and checklists. As guided by ESFM, the sub-project specific ESMP/checklist will be updated or adjusted to specific works whenever the locations and designs of each sub-project are known during Project implementation. The EHCWMP has incorporated the World Bank Group's General Environment, Health and Safety Guidelines and Industry Sector Guidelines for Healthcare Facilities. The safeguard documents (ESMF and EHCWMP), along with their Urdu translation of Executive Summaries, were publicly disclosed by the GoPb on December 10, 2019. In addition, the final SG documents were disclosed on WB ImageBank on December 11, 2019.

62. **Social safeguards:** No social safeguard policies are applicable. The Project's main activities, including the strengthening of citizen engagement and Grievance Redress Mechanism (GRM), are expected to have positive effects with respect to social outcomes. Furthermore, measures to address the concerns of socially excluded groups (such as persons with different abilities, etc.) will be considered—for instance, wheelchair ramps would be constructed for health facilities supported by the Project. Gender-based violence issues will be factored in all Project components. ECE and Early Grade Learning master trainer sessions—as well as parent and community engagement sessions—will include content on child sexual abuse and creating safe learning environments.

63. **Other safeguards:** No other safeguard policies are applicable.

### D. Gender

64. **Significant gender gaps in human capital investment were identified, particularly gaps in education and LM opportunities, associated with overall weak gender empowerment.** The Project's activities to enhance mothers' and children's health and nutrition, to help women in their earnings generating activities and economic empowerment, to promote ECE and early grade learning for children from poor and vulnerable children particularly girls, and to carry out targeted mobilization for secondary girls' education, would contribute to reducing gender gaps and strengthening gender empowerment. Table 4 provides a summary of gender gaps, Project interventions and indicators for monitoring interventions.

**Table 4: Gender gaps, Project interventions, and indicators**

| Gender gaps | Project actions/ interventions | Relevant indicators |
|---|---|---|
| 1. Lagging human development indicators:<br>• limited use of health services<br>• enrollment in ECE<br>• progression to first grade<br>• progression to secondary education | Improving human endowments:<br>• CCTs for women and children promoting utilization of health services (such as immunization)<br>• ECE intervention with gender sensitive mobilization<br>• Promotion of secondary girls education | • Percent of pregnant women, among CCT beneficiaries, who delivered a child attended by skilled health personnel<br>• Percent of children ages 12-23 months, among CCT beneficiaries, fully immunized as per the age specific protocol, disaggregated by gender<br>• Percent of children who transition from preschool to Grade 1, disaggregated by gender |
| 2. Low rate of LM activities and limited occupational choice:<br>• low female labor force participation<br>• concentration in limited options of livelihoods | • Removing constraints for more and better jobs<br>• Economic empowerment and confidence building<br>• Provision of productive assets for female friendly activities<br>• Facilitation of secondary economic activities | • Percent of economic inclusion beneficiaries who complete the LMR package by gender |

## E. Climate Co-benefits

65. **The Project areas and communities are vulnerable to climate-induced risks, particularly droughts and floods which impact nutrition and disease and affect women and young children disproportionately.** During the 2010 floods, SP programs played a critical role in providing cash transfers to affected families. The proposed Project, through its investment in SP systems strengthening, especially using the updated NSER and biometric-enabled payment systems, will help the PDMA identify and create a financial protection system for vulnerable households exposed to climate risks ex ante.

66. **In addition, foundational investment in the areas of improved health and livelihoods are expected to strengthen the resilience of poor and vulnerable households to mitigate the effects of climate shocks.** The improved healthcare system, particularly cold chain management and availability of vaccines, will improve post-disaster epidemic management Extreme climate events impact crop diversity, forcing people to rely on a limited set of food items, thereby worsening their nutrition situation. Under sub-component 1.2, counselling sessions will inform vulnerable households on food choices and dietary diversity. Secondly, heavy reliance on agriculture as a livelihood source makes households vulnerable to climate events. Sub-component 2.1, through its focus on income diversification will contribute to mitigating household vulnerability to climate change. In providing options for productive assets and livelihood options, climate risks will be considered so that household can build resilience against them, through climate-smart livelihoods. Additionally, measures will be taken to make health and education facilities more responsive and resilient to climate shocks such as floods by better ventilation and insulation. Energy efficiency would be promoted through solar energy systems.

### F. Citizen Engagement

67. **Citizen engagement is an integral part of the Project.** During implementation, the role of local institutions and buy-in from the community will be ensured. The Project will attach emphasis on its Communications Strategy, as a tool to ensure both clients and communities are able to engage with the program, thereby strengthening community capacity. Continuous beneficiary feedback will be solicited through exit interviews for H&N CCT beneficiaries, through a continuous interface between mentors and beneficiaries of the economic inclusion component, and a robust GRM for the Project. A clearly articulated and communicated regular social mobilization campaign before the start and during the program will build awareness among citizens about their rights, eligibility and the services they can access, with a special emphasis on engaging women.

### G. Grievance redress mechanism

68. **The GRM for the Project, will be housed in the PSPA in collaboration with GRM units in each IE and will be responsible for providing oversight on the entire GRM process and monitoring of complaints management.** The GRM will have the following elements: simple procedures and accessible interface; transparent resolution process; participatory feedback mechanisms; timely resolution; and confidentiality. Through its citizen engagement and social mobilization activities, the Project will strengthen GRM efforts. PSPA's MIS will include a GRM module for effective management and tracking of grievances and tracking of grievances and resolution. The structure and processes are described in detail in the POM.

69. **Bank grievance redress mechanisms.** Communities and individuals who believe that they are adversely affected by Bank–supported Project may submit complaints to existing project-level GRMs or the World Bank's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project-affected communities and individuals may submit their complaint to the World Bank's independent Inspection Panel, which determines whether harm has occurred, or could occur, as a result of noncompliance with WB policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank management has been given an opportunity to respond. For information on how to submit complaints through the GRS, please visit *http://www.worldbank.org/en/Projects-operations/products-and-services/grievance-redress-service*. For information on how to submit complaints to the World Bank Inspection Panel, please visit http://www.inspectionpanel.org.

## V. KEY RISKS

70. **The overall risk rating for the Project is Substantial.** This is driven by an array of Substantial risks related to political and governance, macroeconomic, institutional capacity and fiduciary issues, described in detail below alongside proposed mitigation measures.

**Political and governance risks are Substantial**. As Punjab's strategy and priorities are in line with the federal government's directions, thus, political risks seem relatively moderate. However, the governance risk is assessed substantial, as accountability mechanisms have been unclear owing to frequent management changes in the IEs. To mitigate the risks, the Project's implementation will be overseen by the two layers of PCC and PSC.

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b. **Macroeconomic risks are Substantial**. These risks mostly stem from the recent deterioration in the macro-fiscal situation in Pakistan. The early effects are being felt through continued depreciation of the currency and hike in energy tariffs. This, in the medium term, will increase inflationary impacts and reduce development spending that can further adversely impact poor households and their decisions on human capital investment. This will be mitigated through the economic reform program recently negotiated with the IMF and also with the Bank's support on policy reforms related to human capital.

c. **Institutional capacity and sustainability risks are Substantial.** The Project is the first multi-sectoral engagement in Punjab associated with human capital. While both PSHD and SED had experience of implementing the Bank's Projects, this is the first time for the lead agency - PSPA. At the same time, the Project is building on the PSPA's core functions without creating a parallel structure for Project implementation, while PSHD and SED will rely on PMIUs. To mitigate the risks, the Bank is planning technical assistance and capacity building activities mirroring the Project implementation activities.

d. **Fiduciary risks are Substantial**. Fiduciary assessment shows that there are significant weaknesses in procurement and contract management due to insufficient capacity. As discussed above, the PSPA is implementing a World Bank-financed Project for the first time. Both PHSD and SED have the relevant experience, but there is a need for dedicated FM staff to manage development Projects. Overall, the resources under each sub-component will be directed toward strengthening the FM and procurement capacity in all entities and further support will be provided through periodic training.

## VI. RESULTS FRAMEWORK AND MONITORING

**Results Framework**

**COUNTRY: Pakistan**

**Punjab Human Capital Investment Project**

### Project Development Objectives(s)

The Project Development Objective is to increase the utilization of quality health services, and economic and social inclusion programs, among poor and vulnerable households in select districts in Punjab.

### Project Development Objective Indicators

| Indicator Name | DLI | Baseline | End Target |
|---|---|---|---|
| **Utilization of health services** | | | |
| Percent of pregnant women, among CCT beneficiaries, who delivered a child attended by skilled health personnel (Percentage) | | 52.00 | 65.00 |
| Percent of children between the ages of 12 and 23 months, among CCT beneficiaries, fully immunized as per the age specific protocol (Percentage) | | 65.00 | 75.00 |
| Percent of children children between the ages of 12 and 23 months, among CCT beneficiaries, fully immunized as per the age specific protocol -- female (Percentage) | | 65.00 | 75.00 |
| **Economic inclusion** | | | |
| Percent of economic inclusion beneficiaries who reported an overall income increase due to asset support (Percentage) | | 0.00 | 70.00 |
| Percent of economic inclusion beneficiaries who reported an overall income increase due to asset support -- female | | 0.00 | 70.00 |

| Indicator Name | DLI | Baseline | End Target |
|---|---|---|---|
| (Percentage) | | | |
| **Social inclusion for education** | | | |
| Percent of children who transition from preschool to Grade 1 (Percentage) | | 55.00 | 60.00 |

## Intermediate Results Indicators by Components

| Indicator Name | DLI | Baseline | End Target |
|---|---|---|---|
| **Health services quality and utilization** | | | |
| Number of regular BHUs that are upgraded to 24/7 BHUs (Number) | | 243.00 | 392.00 |
| Share of 24/7 BHUs that implement electronic medical records (EMR) (Percentage) | | 0.00 | 80.00 |
| Share of CCT beneficiary women who are satisfied with health services provided (Percentage) | | 0.00 | 80.00 |
| Number of people who have received essential health, nutrition, and population (HNP) services (corporate) (Number) | | 0.00 | 18,065,000.00 |
| Number of people who have received essential health, nutrition, and population (HNP) services – Female (Number) | | 0.00 | 12,736,500.00 |
| Number of family planning visits at health facilities (Number) | | 0.00 | 2,949,000.00 |
| Number of ANC-1 visits (Number) | | 0.00 | 4,459,000.00 |
| Number of children screened for nutrition at OTP sites (Number) | | 0.00 | 10,657,000.00 |
| **Economic Inclusion** | | | |

| Indicator Name | DLI | Baseline | End Target |
|---|---|---|---|
| Number of households that are enrolled in economic inclusion program (Number) | | 0.00 | 100,000.00 |
| Number of females that are enrolled in the economic inclusion program (Number) | | 0.00 | 50,000.00 |
| Percent (%) of economic inclusion beneficiaries who complete the labor market readiness package and transition to the mentoring phase (Percentage) | | 0.00 | 70.00 |
| **Social Inclusion for Education** | | | |
| Number of schools with ECE classrooms that meet the Quality Standards prescribed in the Punjab ECE Policy 2017 (Number) | | 0.00 | 3,400.00 |
| Number of children attending ECE (Number) | | 25,000.00 | 100,000.00 |
| Number of schools with ECE classrooms where the Head Teacher has received the revised leadership training (Number) | | 0.00 | 2,800.00 |
| **Efficiency and Sustainability** | | | |
| Establishment of unified beneficiary registry and MIS (Yes/No) (Text) | | No | Yes |
| Percent of the CCT beneficiary who receive the benefits payment in a timely manner (Percentage) | | 0.00 | 80.00 |
| Percent of grievances addressed within timely manner (Percentage) | | 0.00 | 70.00 |

| Monitoring & Evaluation Plan: PDO Indicators | | | | | |
|---|---|---|---|---|---|
| **Indicator Name** | **Definition/Description** | **Frequency** | **Datasource** | **Methodology for Data Collection** | **Responsibility for Data Collection** |
| Percent of pregnant women, among CCT beneficiaries, who delivered a child attended by skilled health personnel | Numerator is the number of births delivered in BHUs: data from CCT MIS<br>Denominator is the total number of pregnant CCT beneficiaries who gave births over the past three months: data from CCT MIS<br>Baseline numbers from baseline data conducted in two districts | Quarterly | Baseline from MICS<br>Updates should come from CCT MIS | Administrative data | PSPA |
| Percent of children between the ages of 12 and 23 months, among CCT beneficiaries, fully immunized as per the age specific protocol | Numerator: number of children between the ages of 12 and 23 months, among CCT beneficiaries, fully immunized<br>Denominator: number of children between the ages of 12 and 23 months among CCT beneficiaries.<br>Full immunization should be defined by age group. By 23 months, full immunization would include BCG, OPV 0-III, IPV, Hep B, Pneumococcal I-III, Rotavirus I-II, Pentavalent I-III, Measles I. | Quarterly | Baseline from MICS<br>Updates should come from CCT MIS | Administrative data | PSPA |

| | | | | | |
|---|---|---|---|---|---|
| Percent of children children between the ages of 12 and 23 months, among CCT beneficiaries, fully immunized as per the age specific protocol -- female | | | | | |
| Percent of economic inclusion beneficiaries who reported an overall income increase due to asset support | Nominator: number of economic inclusion beneficiaries who report income increase due to asset support and other supplementary service including coaching and mentoring<br>Denominator: number of economic inclusion beneficiaries who received asset support | Annual reporting | Administrative data | Frequent coaching with data collection and observation | PSPA |
| Percent of economic inclusion beneficiaries who reported an overall income increase due to asset support -- female | | | | | |
| Percent of children who transition from preschool to Grade 1 | Nominator: number of children who are enrolled in primary school<br>Denominator: number of children who have graduated from ECE | Annual | School information system | Administrative data | SED |

| Monitoring & Evaluation Plan: Intermediate Results Indicators | | | | | |
|---|---|---|---|---|---|
| **Indicator Name** | **Definition/Description** | **Frequency** | **Datasource** | **Methodology for Data Collection** | **Responsibility for Data Collection** |
| Number of regular BHUs that are upgraded to 24/7 BHUs | Cumulative number of normal BHUs that are upgraded to 24/7 BHUs and functional as per department-notified criteria: sufficient skilled birth attendants posted, labour room toilet, delivery light, delivery table, electricity connection, backup power, water supply, blood pressure apparatus, emergency tray with 14 essential medicines/supplies. | Annual/Bi-Annual | Administrative data from PHFMC | Administrative reporting | PHFMC |
| Share of 24/7 BHUs that implement electronic medical records (EMR) | Numerator: cumulative number of project supported 24/7 BHUs that transmit service delivery data through EMR<br>Denominator: total number of 24/7 BHUs | Bi-annual | Administrative reporting from EMR | EMR | PHFMC |
| Share of CCT beneficiary women who are satisfied with health services provided | Multiple indicators reflecting clients satisfaction in health services would be developed. | Year 3 and 5 of project | Customer satisfaction survey | Survey | Third party entity |
| Number of people who have received essential health, nutrition, and population | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| (HNP) services (corporate) | | | | | |
| Number of people who have received essential health, nutrition, and population (HNP) services – Female | Cumulative number of (i) pregnant women who received at least one ANC, (ii) girls under five screened for nutrition at OTP sites, and (iii) women of reproductive age who visited BHUs and RHC for family planning counseling | Bi-annual | Administrative data | DHIS | PHFMC |
| Number of family planning visits at health facilities | Cumulative number of women of reproductive age who visited BHUs and RHCs for family planning counselling | Bi-annual | Administrative data | DHIS | PHFMC |
| Number of ANC-1 visits | Cumulative number of pregnant women who visited BHUs and RCHs for at least one ANC. | Bi-annual | Administrative data | DHIS | PHFMC |
| Number of children screened for nutrition at OTP sites | Cumulative number of children under five screened for nutrition at OTP sites | Bi-annual | Administrative data | DHIS | PHFMC |
| Number of households that are enrolled in economic inclusion program | Cumulative number of beneficiary households enrolled in the economic inclusion program | Quarterly | Program MIS | Administrative reporting | PSPA |
| Number of females that are enrolled in the economic inclusion program | Cumulative number of female beneficiary households enrolled in the economic inclusion program | Quarterly | Program MIS | Administrative reporting | PSPA |

| | | | | | |
|---|---|---|---|---|---|
| Percent (%) of economic inclusion beneficiaries who complete the labor market readiness package and transition to the mentoring phase | Numerator: number of beneficiary households who complete the labor market readiness package Denominator: total number of benefiiary households enrolled in the economic inclusion program | Quarterly | Program MIS | Administrative reporting | PSPA |
| Number of schools with ECE classrooms that meet the Quality Standards prescribed in the Punjab ECE Policy 2017 | Cumulative number of schools that meet ECE Quality Standards, set out in the ECE policy, including Physical Environment: (i) classroom paint (ii) age-appropriate furniture (iii) ECE learning materials kit; Trained ECE Workforce under PHCIP: (iv) trained ECE teacher (v) revised ECE teachers' guide (vi) trained ECE caregiver (vii) trained HT (viii) trained SC member | Bi-annual | PMIU monthly monitoring | Administrative reporting | SED |
| Number of children attending ECE | Number of children enrolled in ECE class | Annual | PMIU monthly monitoring | Administrative reporting | SED |
| Number of schools with ECE classrooms where the Head Teacher has received the revised leadership training | Cumulative number of schools where Head teachers have completed the designated training | Annual | PMIU monthly monitoring/ QAED | Administrative reporting | SED |

| | | | | | |
|---|---|---|---|---|---|
| Establishment of unified beneficiary registry and MIS (Yes/No) | The project will support the establishment of a Unified Beneficiary Registry to provide decision support and analytics through a central beneficiary database of SP initiatives across the province. | Annual | Progress Reports | Progress Reports | PSPA |
| Percent of the CCT beneficiary who receive the benefits payment in a timely manner | Numerator: number of beneficiaries paid within the agreed time frame (30 days or other cutoff defined in the operations manual, from compliance verification to the tansfer of benefits to the beneficiary's bank account)<br>Denominator: total number of CCT beneficiaries | Quarterly | Administrative data | Administrative data from the program MIS | PSPA |
| Percent of grievances addressed within timely manner | Numerator: number of grievances on project delivery, resolved within the agreed time frame (8 weeks or other cutoff defined in the operations manual) since the grievance being registered with PSPA<br>Denominator: total number of grievances on project delivery registered with PSPA | Quarterly | Administrative data | Administrative reporting | PSPA |

## ANNEX 1: Implementation Arrangements and Support Plan

**COUNTRY: Pakistan**
**Punjab Human Capital Investment Project (PHCIP)**

1. The following GoPb's Departments / agencies will manage, coordinate, and be responsible for Project implementation: PSPA, PSHD, and SED. PSC will provide additional oversight for Project activities.

**FM Arrangements**

2. **FM Staffing:** Each IE will hire/appoint a mandatory FM specialist, within 3 months of Project effectiveness. The PSPA will manage sub-components 1.2, 2.1 and Component 3; SED will manage sub-component 2.2; and PHFMC representing PSHD will manage sub-component 1.1. All hiring will need to be in accordance with the Terms of Reference (ToRs), for respective positions acceptable to the Bank. The PSPA, as lead agency, will engage with an audit firm for a Project-wide internal audit that covers all three IEs. The ToRs of the internal audit function should also be acceptable to the Bank.

3. **Annual Budgeting and Planning:** FM staff will be responsible for the budgeting and planning for their respective Project components in coordination with technical staff at all IEs. The Project's Planning Commission (PC-I), along with procurement plans prepared by each entity of GoPb, provides estimates for all activities. Based on the PC-I and procurement plans, the Project's budget will be reflected in the province's ADP. All IEs will prepare an annual budget for Project operations (for their respective components), in accordance with the GoPb's budget rules and regulations and submit to P&D, for inclusion in the ADP. Technical staff at agencies will provide details of planned activities and their associated costs to respective FM staff. All IEs will prepare an annual work plan and a cash plan that will provide quarterly break up of planned activities and associated costs. Annual Work Plans and Budgets for PHCIP will guide the Project implementation activities, and the process will be led by Project Director (PD) of PHCIP, at the PSPA, with the participation of PMIUs of all IEs along with other key implementation partners. Once finalized, the annual work plan and budget will be approved by the PSC.

4. **Quarterly Budgeting and Planning:** The quarterly work plan with planned activities and associated costs will be further discussed by the PCC. The Committee's quarterly planning will be the main instruments for day to day activities, monitoring, and course correction, if needed, during the specific quarter of the Project.

5. **Disbursement*:*** Three segregated Designated Accounts (DAs), one each for the PSPA, SED, and PHFMC, in US Dollars will be established at the National Bank of Pakistan for receipt of funds from the Bank. The DAs will be opened and operated by the respective agencies, in accordance with the provisions of "Revised Accounting Procedure for Revolving Fund Account (Foreign Aid Assignment Account)", dated August 2, 2013 issued by the Finance Division. Disbursements will be report-based where advance equivalent to six months forecast will be provided to DA and subsequent bi-annual IFRs will be the basis of documentation of the expenditures. Subsequent IFRs will also provide forecast for the following six months, based on which the amount of funds to be disbursed will be determined.

6. **Six-monthly and Annual Progress Reports*:*** PD PHCIP at the PSPA, based on information received from IEs, will be responsible for preparing consolidated semi-annual progress reports, against the approved annual workplans and Project targets. All IEs and partners will contribute to the report regarding their assigned tasks. Six-monthly progress reports will have essential details about targets and achievements, and explanations for any variations and issues. Annual Progress reports will then be based on six-monthly reports and consolidate to cover the entire period of a year.

7. **Auditing:** The Office of the Auditor General of Pakistan (AGP) will conduct annual audit of the Project, which is acceptable to the Bank. The Directorate General Audit in Punjab, as representative of AGP, will carry out the audit of the Project in accordance with the ToRs that have been agreed between the Bank and AGP. The audit will cover the IEs include physical verification of assets procured from the loan proceeds. For each financial year closing on June 30, acceptable audited financial statements for the overall Project (combined) will be submitted to the Bank by December 31, i.e. within six months of the close of the financial year.

8. **Accounting and reporting:** Finance Managers will maintain separate books of accounts for their respective components under the Project. Payment vouchers will be prepared for each transaction, with each voucher showing the relevant accounting codes, disbursement category, and Project component. The Finance Managers will work with the Accountant General Punjab to include the transactions of the Project in the national FM Information System (FMIS) from Project effectiveness. The following manual registers (in Excel) will be maintained:

    - Cash book (also in hard form, complying with government rules).
    - Assets register – will include details of assets procured from the loan, unique identification number, location of the asset, and custodian of the asset.
    - Invoice register – will include date of invoice/bill receipt and date of payment to supplier/ contractor. This will be used to monitor payment processing time.

9. **Procurement** shall be aligned with principles of procurement stated in Procurement Regulations and shall follow a fit-for purpose approach to deliver Value for Money (VfM). There will be a possibility of outsourcing financial intermediation functions and use blockchain capability for better traceability of outflows. The PPSD has been developed by the PSPA in consultation with PSHD and SED and in agreement with the Bank, considering the volume of items to be procured, prevailing market conditions, activity level risks etc. The PPSD spells out the appropriate procurement strategy for the respective component of the Project. PPSD is a live document and it is to be updated at least annually. As an output of the PPSD exercise, initial Procurement Plan has been prepared. The World Bank's Standard Procurement Documents (SPD) shall be used for Open International Competition. Goods works and non-consultancy services following Open National Competition shall be initially procured using Bank's relevant standard procurement documents. Upon finalization of the customized suite of standard procurement documents; aligned with the Bank's procurement Regulations, by Punjab Procurement Regulatory Authority (PPRA), these SPDs shall be employed.

10. **Procurement Responsibility:** Government's capacity to deliver will be strengthened through the establishment of the PMIU, including FM and procurement specialists located within IEs.

**Table A1: Procurement Risk Analysis**

| No. | Risk Description | Description of Mitigation | Risk Owner |
|---|---|---|---|
| 1 | Insufficient pre-procurement needs assessment | • Conduct a thorough & detailed cost analysis, resource & inventory levels, technology etc.<br>• Ensure consistency of cost estimates with market rates | All entities |
| 2 | Deficient Statement of Requirements (SoR) | • Reduce unnecessary restrictions or unjustified constraints, which eventually disrupt and delay the procurement cycle<br>• Flexibility in defining specifications and allow equivalent/ better goods to be offered<br>• Selection and award criteria clearly defined and disclosed in advance | All entities esp. SED for HCIP |

| No. | Risk Description | Description of Mitigation | Risk Owner |
|---|---|---|---|
| 4 | Low capacity of PSPA to procure and manage contracts | • Ensure availability of hired resources<br>• Invest in skill development and training programs for effective control over procurement process & contract delivery | PSPA |
| 6 | Lack of participation | • Conduct market engagement briefings prior to issuing bidding documents<br>• Avoid inappropriately transferring too much risk to suppliers<br>• Prepare procurement packaging and lot sizing | All entities |
| 7 | Unreasonable procedure for evaluation and analysis of bids | • Impart training to the evaluation committee before the procedure of examining the bids in initiated<br>• Clear understanding of evaluation SOP across the board<br>• Mandatory signing of any conflict of interest (COI) documents by all committee members<br>• Avoid unnecessary delays in evaluating bids and award of tender<br>• Evaluation criteria should be quantifiable and be able to achieve VfM | All entities |
| 8 | Risks at the time of award | • Methodically verify certificates submitted through bids by suppliers<br>• Strong record keeping and data management | All entities |
| 9 | Variations in price/ exchange rate risk | • Provide adequate provisions in the contract for price variations/ fluctuations, as appropriate<br>• Ensure price adjustment mechanism is included in the contract | All entities |
| 10 | Fraud and Corruption | • Automated procurement functions with document cross-checking<br>• Complete transactional information along with audit trail for every transaction is imperative | All entities |
| 11 | Slow decision making | • Decision making and procurement accountability should be included in the POM and PC-I where possible. | All entities |
| 12 | Legal issues for foreign bids | • Legal advisor consultation is recommended for any foreign firms intending to participate in procurement regarding taxation, GBV, incorporation | SED, PHFMC |

**Table A2: Recommended Procurement Approach for the Project**

| No. | Attribute | Medicines / Commodities USD 11,350,054 | Waste Management USD 7,294,140 | Social Mobilization USD 7,191,347 | MIS (IT software /hardware) USD 4,423,077 | Surveys & Evaluations USD 4,169,695 |
|---|---|---|---|---|---|---|
| 1 | Selection Method | RFB | RFB | LCS or QCBS | RFB | LCS or QCBS |
| 2 | Selection Arrangement | Single stage, 1 envelope | Single stage, 2 envelopes | Open, two envelopes | Open, 2 envelopes, single stage | Framework agreement |
| 3 | Market Approach | Open, National/ International | Open, National/ International competition | Open, two envelopes | Open, 2 envelops, single stage | Open, National, International competition |
| 4 | Pre / Post Qualification | Post Qualification | Pre-Qualification | Shortlisting | NA | Shortlisting |
| 5 | Evaluation Method | Lowest evaluated cost | Rated Criteria | Rated Criteria | Lowest evaluated cost | Rated Criteria |

11. **Project Steering Committee (PSC):** For effective coordination between PSPA and multiple IEs and partners, and to better integrate and synergize Project's interventions with other existing pro-poor initiatives of the government, a PSC will be constituted. The convener and Chair of the PSC will be the Vice Chairperson of PSPA with the Chairperson of P&D, as co-chairs of the Committee. Membership will comprise the Chief Executive Officer (CEO) of PSPA, along with the Secretaries of PSHD and SED, members of Social Sectors of P&D Board, two representatives from implementation partners and NGOs, and PD – PHCIP at PSPA. The main responsibilities of the PSC include: the approval of the Project's annual work plans/budgets, provision of approvals and policy guidance on any emerging operational issues, oversight of the Project through progress reviews of six-monthly reviews, and guidance for remedial actions for improved performance.

12. **Project Coordination Committee (PCC):** The PCC will be notified, headed by PD – PHCIP at PSPA, to guide the inter-agency and inter-departmental coordination for Project implementation. The rest of the membership will consist of designated PD/Activity Managers, within each implementation entity, and section heads of PHCIP in the PSPA. The PCC will meet at least once every month, but more often if needed, to discuss progress on quarterly work plans (based on PSC approved Annual Work Plan), streamline headquarter and field coordination issues, review progress, identify impediments and initiate corrective actions. They will also review and approve the modifications in PC-I that are within the competence of Principal Accounting Officer. PCC will also approve modifications in the POM.

13. **Governance and Anticorruption.** All the contract opportunities and contract awards will be widely published on the IES website, and when required in United Nations Development Business (UNDB). Other actions are (a) alerting IE's officials/staff about any fraud and corruption issues; (b) alerting bidders against adopting fraud and corruption practices; (c) awarding contracts within the initial bid validity period, and closely monitoring the timing; (d) informing the Bank's Integrity Vice Presidency ; (e) preserving records and all documents regarding public procurement; (f) publishing contract award information in UNDB online, IES website, within two weeks of contract award; (g) ensuring timely payments to the suppliers/contractors/consultants and imposing liquidated damages for delayed completion; and (h) enforcing a procurement filing system.

**Project Management and Implementation**

14. PSPA through PD – PHCIP, would serve as the lead implementing agency with the function of overall coordination, planning, and reporting. Each component's implementation arrangements are as follows:

*PSHD's activities*

15. Project activities under the component for quality health services will be managed by a newly established PMIU working under the jurisdiction of the PHFMC, at the provincial level, with service delivery responsibilities devolved to the district administration. PMIU's staffing will include: Program manager, FM and procurement specialists, environmental safeguard specialist, monitoring officer and assistants. However, the component will use the already existing systems at provincial level as well as district levels to ensure various activities (e.g. EPI, IRMNCH&NP, non-communicable diseases, tuberculosis, and hepatitis control, etc.). These activities will continue to be the responsibility of these programs and ensure that the interventions under their respective programs are fully integrated in Project districts. The PMIU work in close coordination with the Director General - Health and PDs of all other programs for a streamlined and integrated service delivery. In addition, the PMIU of PHFMC will focus on:

- Overseeing and ensuring that the proposed activities are implemented in a timely manner in accordance with approved guidelines and policies
- Tracking and reviewing performance of each district and guiding the districts to improve their performance where required
- Overseeing the implementation of financial affairs of the Program and timely utilization of funds
- Ensuring that the quality of service delivery is uniform across all districts and to providing support to weak districts
- Coordinating with other programs to ensure timely implementation of activities
- Overseeing the hiring of staff for all facilities of Project districts as in any other districts
- Ensuring the provision of contraceptives and nutrition commodities

Meanwhile, the District Health Authority, will be the main implementation unit of the Project at the local level and will be responsible for:

- Ensure availability of staff against sanctioned positions (regular, as well as contractual)
- Ensure that the staff is trained on approved training manuals and follow the guidelines/clinical standards and protocols
- Ensure that the health facilities comply with the minimum service delivery standards notified by the Punjab Healthcare Commission
- Ensure appropriate utilization of budget in line with approved guidelines

*SED's activities*

16. Project activities under SED including ECE and early grade learning will be managed by the existing PMIU of PESP III. However, given the additional activities and responsibilities, staffing will be augmented by establishing a new special Foundational Learning Cell. The Foundational Learning Cell will consist of Program Manager, FM and procurement specialists, Education and curriculum specialists, other technical staff including M&E officer and training coordinator, and filed officers, to manage and monitor the activities under PHCIP.

*PSPA's activities*

*17.* In order to play a role of the lead agency of the Project and oversee the overall coordination and management of Project activities under the leadership of PD – PHCIP, PSPA will strengthen its planning unit to be led by

Additional Director Planning. Project wide environmental and social safeguard specialists, M&E specialists, and program officers will be supporting the unit. For managing specific component activities, administrative functions and staffing (e.g., FM and procurement specialists, administrative officers and clerks) and programmatic functions and staffing (e.g., communication specialists, GRM officer, field officers) in PSPA would be augmented. In addition, investments in IT infrastructure and IT staffing will be significantly strengthened.

*18.* One of most prominent responsibilities of PSPA in implementing Project activities is social mobilization. Social mobilization is key to informing potential beneficiaries and communities about relevant programs in their features, requirements, and benefits. Information campaign is one of key instruments for social mobilization, but the scope of social mobilization is far broader than information dissemination and awareness enhancement. It should involve right activities to help potential beneficiaries build confidence, overcome social norms, and understand the expected results in addition to providing correct information. To support the enrollment of target beneficiaries and delivery of various Project interventions in an effective manner, PSPA through PD PHCIP will engage the services of social mobilization partner(s) for all target districts. Recruitment will be completed in the inception phase through a competitive process. Main considerations will be existing presence and social capital of the agency in the target districts, institutional capacity, past track record of work done in the target area and costs.

**Implementation Support Plan**

19. Implementation support aims to enhance the quality of the client's delivery of Project activities and address and mitigate critical issues and risks which may affect implementation or achievement of Project objectives. It will consist of formal implementation support missions; additional technical missions during the first 18 months of Project implementation; regular technical meetings (including virtual meetings) and field visits by the Bank between missions; and regular reporting and monitoring of FM, procurement and environmental and social safeguards. Formal missions will be carried out quarterly during the first year of implementation, and every six months in subsequent years. Formal missions can take place jointly with DFID to ensure close coordination among key development partners. The implementation support plan should reflect the stage of each activity, risks associated Project activities and mitigation measures to address these risks, phased approach for Project activities, specific demands and needs based on regular assessments and technical discussions.

20. Several Bank team members are based in Islamabad and will be able to provide ongoing and continued on-demand implementation support. Local consultants based in Lahore will also provide additional coordination and support to implementing agencies during the first year of implementation. The resources available through TAWEEL will be used to provide opportunities for further technical assistance and capacity building.

21. During the first six months since effectiveness, implementation support would be most in need. Implementation support during this time will focus on the start-up of PMIUs and the development of Operational Manuals. Setting up PMIUs and recruitment of key staffs should be prioritized, and initial capacity building and training will be supported. Also, while Component 1 Operational Manual has been already developed jointly by PSPA and PSHD, Operational Manuals for sub-components 2.1 and 2.2 should be prepared by PSPA and SED, respectively.

22. From the first six to 18 months, during the 1st phase of operation in two districts in Punjab, robust implementation support would be required to initiate various procurement, technical activities, and operational adjustment of the Operational Manuals. The functionality of key IT investments, M&E mechanisms, safeguards plans, fiduciary and procurement activities, should be assessed during this period.

23. Next 3.5 years, during the scale up and continued operation, implementation support can focus on sustainability and efficiency of activities. The volume of support may be reduced compared to the first 2 periods.

## ANNEX 2: Summary of Human Capital Challenges and Relevant Interventions in Punjab

**COUNTRY: Pakistan**
**Punjab Human Capital Investment Project (PHCIP)**

| Life-cycle Stage | Key Human Capital Challenges | Intervention | World Bank Support |
|---|---|---|---|
| Early childhood (ages 0 to 4) | • High fertility, poor maternal and child health and nutrition<br>• Low quality and utilization of key health, nutrition, and population services<br>• Poor access to improved water and sanitation<br>• Low availability, quality, and enrollment in ECE; poor school readiness | • Integrated Reproductive, Maternal, Newborn, and Child Health & Nutrition Program (IRMNCH&NP)<br>• Prime Minister's Health Initiative<br>• Expanded Program on Immunization (EPI)<br>• Water, sanitation and hygiene (WASH) support<br>• ECE support | • Punjab HSRP (concluded in 2018)<br>• National Immunization Support Project (ongoing)<br>• Punjab Rural Sustainable Water Supply and Sanitation Project (planned)<br>• PESP III (ongoing) |
| School age (ages 5 to 10) | • Low enrollment, retention, and completion<br>• Poor learning outcomes | • GoPb's regular school support<br>• BISP's WeT | • PESP III (ongoing)<br>• National Social Protection Program support for the BISP (ongoing) |
| Adolescence (ages 11 to 18) | • School dropout, early marriage, early childbearing<br>• Poor learning outcomes<br>• Poor school to work transition | • GoPb's Zevar-e-Taleem ZeT (CCTs for secondary school attendance for girls) | • PESP III (ongoing) |
| Youth (ages 19 to 29) | • High NEET<br>• Poor job quality and low levels of earnings | • GoPb's various TVET programs<br>• Higher education | • Punjab Skills Development Project (ongoing)<br>• Pakistan Higher Education Development Project (ongoing) |
| Older adults (ages 30 to 64) | • Low female labor force participation<br>• Poor job quality and low levels of earnings | • GoPb's Women Income Growth and Self-reliance Programme (WINGS) (upcoming; supported by the UK's DFID)<br>• GoPb's Southern Punjab Poverty Alleviation Project (ongoing; supported by IFAD) | • Various sectoral Projects (e.g., smart agriculture, jobs and competitiveness, tourism, etc.). |
| Elderly (ages 65 and above) | • Health challenges and limited social insurance opportunities and savings | • GoPb's disability allowance through Khidmat cards | |

## ANNEX 3: Technical Details of Project Sub-components 1.2 and 2.1

**COUNTRY: Pakistan**
**Punjab Human Capital Investment Project (PHCIP)**

### Sub-component 1.2 – CCT Program Conditionalities

The CCT aims to increase the utilization of key health service packages by pregnant women and children living in poverty. The operational manual for the CCT (originally planned for piloting in two districts in Punjab: Bahawalpur and Muzaffargarh) developed jointly by the PSPA and PSHD, describes the details of operational procedures and implementation arrangements. The CCT would finance quarterly cash transfers to eligible pregnant and lactating women (PLW), incentivizing them to fulfill their co-responsibilities, such as quarterly antenatal care visits, skilled birth and registration, quarterly growth monitoring and immunization of children under 2 years of age, as well as participate in self-help sessions for better early childhood development (See table A3 for conditionalities).

**Table A3. CCT Program's conditionalities**

| Quarter | Co-responsibilities | Timeline | Amount (PKR) |
|---|---|---|---|
| Pregnant Women | | | |
| 1 | ANC I: Health Checkup to identify high risk pregnancies and referral. Check Weight, BP, HB, glycemia. Iron and folic acid supplementation. Counseling on maternal and child care. | 1st Trimester (1 to 3 months of Pregnancy) (Before 12 weeks) | 1,000 |
| 2 | ANC II: Health Checkup to identify high risk pregnancies and referral. Check Weight, BP, HB, glycemia. Iron and folic acid supplementation. Counseling on maternal and child care.<br><br>TT1 | 2nd Trimester (4 to 6 month of Pregnancy) (Around 26 weeks) | 1,000 |
| 3 | ANC III: Health Checkup to identify high risk pregnancies and referral. Check Weight, BP, HB, glycemia. Iron and folic acid supplementation. Counseling on maternal and child care.<br><br>TT II (4 weeks after TTI) | 3rd Trimester (Around 32 weeks) | 1,000 |
| 4 | ANC IV: Health Checkup to identify high risk pregnancies and referral. Check Weight, BP, HB, glycemia. Iron and folic acid supplementation. Counseling on maternal and child care, especially birth spacing | 3rd Trimester (Around 36-38 weeks) | 1,000 |
| 5 | Safe delivery through Skilled Birth Attendant | 9th month of Pregnancy | 3,000 |
| Children (under 2 years) | | | |
| 1 | BCG and OPV-0 (after birth in case not done earlier)<br>Penta-I, Pneumo-I, OPV-I and Rotavirus I (After 6 Weeks)<br>Screening and referral<br>Counseling on maternal and child care, especially birth spacing | During first 3 months | 1,000 |
| 2 | Penta-II, Pneumo-II, OPV-II and Rotavirus-II (After 10 Weeks)<br>Penta-III, Pneumo-III, OPV-III and IPV (After 14 Weeks) | After 3 months | 1,000 |

| | | | |
|---|---|---|---|
| | Screening and referral<br>Counseling on maternal and child care, especially birth spacing | | |
| 3 | Multi Micro nutrients - supplements<br>Screening and referral<br>Counseling on maternal and child care, especially birth spacing | After 6 months | 1,000 |
| 4 | Measles-I<br>Screening and referral<br>Counseling on maternal and child care, especially birth spacing | After 9 months | 1,000 |
| 5 | Multi Micro nutrients – supplements<br>Screening and referral<br>Counseling on maternal and child care, especially birth spacing | After 12 months | 1,000 |
| 6 | Measles-II<br>Screening and referral<br>Counseling on maternal and child care, especially birth spacing | After 15 months | 1,000 |
| 7 | Multi Micro nutrients – supplements<br>Screening and referral<br>Counseling on maternal and child care, especially birth spacing | After 18 months | 1,000 |
| 8 | Screening and referral<br>Counseling on maternal and child care, especially birth spacing | After 21 months | 1,000 |
| Birth registration of children under 2 years of age | | | |
| 1 | Birth Registration Certificate | On submission | 2,000 |

**Sub- component 2.1 – The Economic Inclusion Approach**

1. Economic inclusion programs (also known as graduation programs)[40], refer to multi-sectoral interventions that support and enable households to achieve sustainable livelihoods and increase their incomes and assets, while building human capital and promoting social inclusion. The four foundational pillars of the approach include:
   - **Social Protection** - includes preventive, protective and promotive mechanisms such as consumption support and access to health and education to support basic needs.
   - **Livelihoods Promotion** - ensures regular and diverse income streams for households to support consumption, asset accumulation, and economic empowerment. Interventions include asset or cash transfers for livelihoods or linkages to formal employment, technical and business skills training, and access to markets.
   - **Financial Inclusion** - provides improved income and risk management and financial empowerment. Interventions include access to formal or informal savings facilities, credit and insurance mechanisms, accompanied by financial literacy training.
   - **Social Empowerment** - equips families with a confident mindset and promotes community inclusion and positive behavioral change. Interventions include life skills training, community mobilization, and coaching that cuts across all four pillars.

2. The SP aspect of the pillars, focusing on support for basic consumption as well as health and education needs, comes from the Project's Component 1.2 building on BISP's Unconditional Cash Transfer (UCT). Other pillars including livelihoods promotion, financial inclusion, and social empowerment will come from the Project's sub-

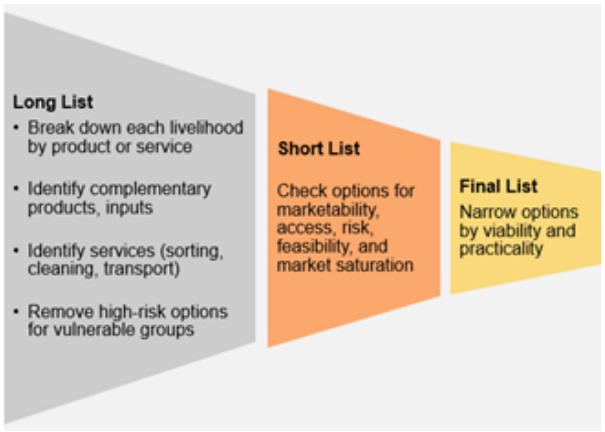
[40] They were pioneered by BRAC, a Non-governmental organization, as its Ultra-Poor Graduation Initiative, and have been adopted by many countries and adapted to the local contexts.

component 2.1 of economic inclusion interventions. which involves tailored support to poor and vulnerable households through:

a) Regular coaching and technical training integrated with an asset transfer, which distinguish this program from other interventions in Pakistan that focus solely on a cash or asset transfer approach, ensures that participants gain the knowledge, skills, and capacity to build sustainable livelihoods. [41]
b) Rigorous and localized market assessment, to mitigate the risks of providing a fixed asset package to all households, which can result in market saturation or limited profits due to mismatch in participant capacity and market factors. It considers participant skill sets, interest, care burden and resources when guiding participants on livelihood selection.

3. Prior to receiving a productive asset, individuals from target households will participate in a LMR component, which will include training on basic literacy and numeracy, social and health awareness, and confidence-building. Given low literacy rates, poor hygiene practices, and lack of self-esteem among the extreme poor, it is critical to address these aspects before households receive assets in order to prepare them to effectively engage in livelihood activities. Basic literacy and numeracy will equip households with record-keeping skills needed to manage a livelihood. Similarly, greater health awareness will promote improved health-seeking behavior, which can reduce the incidence of illness, and consequently time spent away from managing a livelihood. Lastly, through messaging and guidance on developing long-term vision for the future, participants will be able to build a positive mindset, which will form the foundation for their sustained progress.

2. With respect to livelihoods promotion, selecting the right livelihood activities to include in the final list of options requires a careful screening process. The three steps involved in developing the list are:
   a) **Create a long list**: List all livelihoods options possible in the area. This includes products which may be a by-product or additional service needed in a value chain, such as organic fertilizer (a by-product of keeping livestock). This list should be checked for any known risks, such as negative impact on women or children (e.g., by forcing them into labor) or environmental destruction, so that they can be eliminated.




   b) **Assess a short list:** The short list of livelihoods options may contain between 15-30 options and need to be evaluated for their profitability and viability. Using the information in the assessments and by consulting with key informants, the options are examined for viability including:
      - **Marketability:** Is there sufficient demand for each product?
      - **Market Saturation:** What effect does an increase in supply of the product or service have on demand and price?
      - **Market Access:** Where are the buyers for the product or service? Can program participants access these

[41] Research findings from Ghana indicate the importance of complementary interventions in a Graduation program versus a single-instrument model such as a livelihoods program. Banerjee, A. et al. 2017. "Graduation from ultra poverty in Ghana". International Initiative for Impact Evaluation.

buyers?

- **Feasibility:** Can extreme poor households produce the good or service on a regular basis, without harming natural resources?
- **Acceptability:** How acceptable is the option in the context? Does it sufficiently change social norms that are at the root cause of poverty, disempowerment, and inequality?
- **Risk:** What are the risks affecting the livelihood? How do these risks affect production, selling, or marketing of this product or service?

c) **Generate the final list of livelihood options:** Each option in the short list needs to be evaluated for its business potential. Based on the market, production and risk information, calculate the expected:

- **Profit:** How long will it take for the livelihood to generate a profit for each household? How much profit can the household expect for the first 18-24 months? Note that profit is gross income (or sales) minus expenses (costs).
- **Return on Investmen**t: How long will it take for the livelihood to begin generating an income? Note that the recommended time frame is 3-6 months.
- **Other costs and resource requirements**: What are the costs involved in providing this livelihood package and do they fall within the program budget? What other resources, such as space or inputs, are needed?

3. The modality of asset transfer can be either in-kind or cash, depending on the profile of the target households, market opportunities, and procurement regulations of the implementing service providers. Cash transfers for livelihoods are suitable for households that have experience engaging with markets. They are easy to administer, especially among existing program beneficiaries who have a mechanism to receive cash. Moreover, they provide greater autonomy to participants. However, intensive monitoring is required to ensure that the cash is used for productive purposes instead of short-term needs. In-kind transfers are more suited to female participants who tend to have limited mobility and experience engaging in livestock markets. This modality also allows service providers to ensure quality of assets at the time of purchase. However, in-kind transfers are typically subject to procurement process and regulations that can cause delays in program implementation.

4. With respect to the coaching, given the importance of the personalized guidance that extreme poor households require, a cadre of frontline coaches will be mobilized. They should have frequent interactions with participants at the household level, either on a weekly or bi-weekly basis. To ensure proper attention is given to participants, each coach should support between 40-100 households. Caseloads and frequency of household visits will be determined after the target site had been selected and the level of vulnerability of participant households has been assessed.

A POM detailing all the procedures and design features will be developed by the PSPA prior to the implementation of the program.