
HEALTH, NUTRITION AND POPULATION SECTOR SUPPORT PROGRAM

Government of the People's Republic of Bangladesh

PROGRAM FOR RESULTS

Environmental and Social System Assessment (ESSA)

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DRAFT

ACRONYMS AND ABBREVIATIONS

BP	Bank Procedures
CHT	Chittagong Hill Tract
DG	Director General
DLI	Disbursement-linked indicator
DOE	Department of Environment
EA	Environmental Assessment
ECA	Environmental Conservation Act
ECC	Environmental Clearance Certificate
ECR	Environment Conservation Rules
EH&S	Environmental Health & Safety
ESA	Environmental Systems Assessment
ESSA	Environmental and Social Systems Assessment
GOB	Government of Bangladesh
IDA	International Development Association
IFC	International Finance Corporation
OP	Operational Policy
PAP	Program Action Plan
PDO	Program Development Objective
PforR	Program-for-Results
PIC	Project Implementation Committee
WB	World Bank

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EXECUTIVE SUMMARY

The Government of Bangladesh (GOB) and partners have pursued a sector-wide approach (SWAp) since 1998, adopting a series of multi-year strategies, programs and budgets for management and development of the health nutrition and population (HNP) sector, with support from both domestic and international financing. The government is currently implementing its third sector program and is in the latter stages of finalizing its Fourth Sector Program, covering the 5.5 year period (between January 2017 and June 2022) with an estimated cost of US\$14.8 billion. The Fourth Sector Program's overall objective is "to ensure that all citizens of Bangladesh enjoy health and well-being by expanding access to quality and equitable healthcare in a healthy and safe living environment." The budget for the program comes through two channels: (i) the revenue (non-development) budget which covers recurrent costs but also some capital costs allocated directly to different institutions; and (ii) the development budget which largely covers capital costs, but also some recurrent costs allocated to different Operational Plans, each implemented by a line directorate in the Ministry of Health and Family Welfare (MOHFW).

As Bangladesh builds on significant progress in the HNP sector and pursues progress towards the Sustainable Development Goals (SDGs), it will face important challenges. These can be characterized in three ways: (i) foundational financing and system development priorities; (ii) the unfinished agenda relating to the Millennium Development Goals; and (iii) emerging challenges. The MOHFW considers the Fourth Sector Program as a first, foundational, program towards the achievement of the SDGs by 2030. The government's Fourth Sector Program builds on a successful history of the previous sector programs, with well-established planning and consultation processes as well as monitoring and coordination mechanisms. It encompasses three components: (i) Governance and Stewardship, (ii) HNP Systems Strengthening, and (iii) Provision of Quality HNP Services.

Like previous sector programs, it is expected that a significant proportion of development partner (DP) support will be channeled through on-budget financing, including through co-financing of the World Bank operation. The World Bank will use Program-for-Results (PforR) as its financing instrument, to support the government in meeting the sectoral challenges through relevant parts of its Fourth Sector Program. The PforR Results Areas are aligned with the government program components with a focus on those aspects that will contribute to meeting these challenges. The Program Development Objective (PDO) of the PforR is to strengthen the HNP sector's core management systems and improve delivery and utilization of essential HNP services, with a focus on selected geographical areas. In supporting part of the government's Fourth Sector Program, which is national in scope, the proposed PforR will benefit, directly and indirectly, the entire 160 million population of Bangladesh, including 50 million in Sylhet and Chittagong divisions, which are of particular focus for several indicators. The PforR includes a set of 21 disbursement-linked indicators (DLIs) that will assist the MOHFW in achieving measurable results. Twelve of these DLIs are focused on improving service delivery including maternal and child health and nutrition services in Chittagong and Sylhet (two out of the seven administrative divisions of Bangladesh).

In accordance with the World Bank Policy PforR Financing, the World Bank team carried out an Environment and Social Assessment (ESSA) which provides a comprehensive review of relevant government systems and procedures that address environmental and social issues associated with the PforR. The ESSA describes the extent to which the applicable government environmental and social policies, legislations, program procedures and institutional systems are consistent with the six 'core principles' of the World Bank's Policy for PforR Financing and recommends actions to address the gaps and to enhance performance during Program implementation.

The assessment used various approaches to review the environment and social systems that are relevant to the Fourth Sector Program. It includes analysis of information/ data on previous assessments and reports on the status of different aspects of healthcare system and its management of environmental and social issues (e.g. medical waste management, gender disparity, access to health care by vulnerable groups) and national consultations with key stakeholders related to the HNP sector. The risks have been identified using the Environmental and Social Risk Screening Format included in the World Bank’s Policy for PforR Financing that determined the boundary of assessment. It also covers the likely environmental and social effects, the environmental and social context, institutional capacity, and the reputational and political risk. Based on the findings, the recommended measures to strengthen system performance for environmental and social management are presented in the following table.

Table 1: Measures to strengthen social and environmental systems management

Objective	Measures
Environmental systems management:	
Strengthen policy and legal framework	Under the existing regulatory framework, the health facilities that generate medical waste are not sufficiently held accountable for proper handling and managing of such waste. At the upazila level, the health facilities can be made more accountable by ensuring proper record-keeping, assigning a focal person for supervision of medical waste management (MWM) activities, and constructing burial pits for sharps and infectious wastes.
Strengthen institutional capacity and compliance	Improve health care waste management, particularly focused on the Upazila Health Complex and below, by ensuring: <ul style="list-style-type: none"> • use of color-coded bins in health facilities in accordance with Medical Waste Management Rules 2008; • segregation of waste in all facilities by using the established color coding system and recordkeeping of medical waste generated; • storage of waste in designated temporary storage areas before disposal; • destruction of sharps before its final disposal in in-house deep-burial pits as per existing HCWM guidelines; and • availability and visibility of information, education and communication materials on health care waste management in health facilities.
Strengthening implementation	<ul style="list-style-type: none"> • Monitoring and reporting on the implementation of MWM, particularly focused on the Upazila Health Complex and below. • Capacity building for health workers on MWM, particularly focused on the Upazila Health Complex and below.
Budget Allocation	Sufficient budget needs to be allocated to ensure adequate in-house management (construction of burial pits) and capacity building for MWM.
Social systems management:	
Systems for social management and mainstreaming gender, equity, voice and accountability (GEVA)	<ul style="list-style-type: none"> • Citizens’ oversight system functioning in the Community Clinics needs to be enhanced in many of the Upazila health Offices, Upazila Health Complexes, Upazila Family Planning Offices and Family Welfare Centers to facilitate enhanced participation in health service governance by citizens. • Five of the DLIs under the PforR will support gender inclusiveness. DLI # 9 aims at deploying female midwives at upazila health complexes, which will contribute to the expected result of making the services more woman-friendly for institutional delivery. DLI # 13 will increase readiness of health facilities to provide family planning services to married couples right after a child’s birth; DLI # 14 will increase capacity of health facilities to provide emergency obstetric care; DLI # 16 aims at developing a school-based adolescent girl health program; while DLI # 17 will improve nutrition services for mothers and pregnant women. • GEVA-related activities need to be incorporated in and implemented by the relevant operational plans with a specific focus on issues relating to physical and

Objective	Measures
	<p>mental disability, geriatrics and rehabilitation of victims of gender-based violence, as well as addressing the needs of the small ethnic and vulnerable community (tribal people). The one-stop crisis centers need to be strengthened further.</p> <ul style="list-style-type: none"> • There is a need to identify health impacts of and related mitigation measures to deal with the effects of climate change including sea-level rise, increase in salinity, frequent storm surges, and rise in temperature.
Budget	The MOHFW will ensure that sufficient budgets are allocated to implement the GEVA-related activities. A Program Action Plan (PAP) will be developed that will include relevant ESSA actions. The PAP will be legally binding.
Technical guidance and implementation capacity	The Health Economics Unit will continue to work with stakeholders to identify barriers faced by vulnerable groups and provide technical input to the relevant line directorates to implement GEVA-related activities. The PforR will support the MOHFW in collected gender disaggregated data (through DLI # 11), which can be used for policy decisions.
Systems for information disclosure and stakeholder consultation	DLI # 1, which focuses on strengthening the Grievance Redressal Mechanism of the MOHFW, will enable availability of information on grievances received and addressed and thereby improve transparency and disclosure. The MOHFW will use its existing citizen engagement mechanisms to seek feedback and continue with stakeholder consultations on mainstreaming GEVA and social inclusion activities.

SECTION I: BACKGROUND

1.1 Introduction and Context

1. Bangladesh, with a population of 160 million and gross national income per capita in 2015 of US\$1,316, has benefited from annual economic growth of over 6 percent during the past decade. The country has achieved a number of Millennium Development Goal (MDG) targets. Similarly, Bangladesh has experienced substantial improvements in key health, nutrition and population (HNP) outcomes, including several HNP-related MDG targets. Child and maternal mortality, as well as fertility rates, have decreased substantially since 2000, while progress on child under-nutrition has been evident but slower.

2. In 2014, Bangladesh crossed the per capita income threshold for World Bank classification as a lower middle-income country. Bangladesh has embraced the Sustainable Development Goals (SDGs) for 2030, including SDG 3, which focuses on ensuring health and promoting well-being. A specific objective is to achieve universal health coverage, which encompasses assuring access to HNP services without causing financial hardship.

1.2 Health Sector in Bangladesh

3. The HNP system in Bangladesh can be characterized as “pluralistic” in that community-level and facility-based services are delivered by the government, non-governmental organizations (NGOs), and private for-profit providers. At the same time, the government service delivery system is the most important instrument for the government to work towards its development goals in the HNP sector, encompassing around 225,000 staff, 18,000 primary health care facilities, 430 local-level (Upazila) facilities offering inpatient care, and 130 secondary and tertiary hospitals across the country. It may be noted that at present at the micro level, some 12,895 Community Clinics (CCs) are operating to provide health care to the rural populace.

4. The government and partners (DPs, NGOs, Private-for Profit Providers) have pursued a sector-wide approach (SWAp) since 1998, adopting a series of multi-year strategies, programs and budgets for management and development of the sector, with support from both domestic and international financing with the vision of providing effective PHC including Nutrition and Family Welfare support to the citizens of the country in general and the VG and IP including the adolescent, elderly and the children in particular. The GOB has completed the third HNP Sector Development Program that covered the period 2011-2016. The HPNSDP worked on creating conducive conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health. The program focused on ensuring quality and equitable health care for all citizens by improving access to and utilization of health, under two main components, namely: (i) improve health services, such as maternal and child health, and support the service delivery system including primary health care, and (ii) strengthening health systems such as governance and human resources.

5. The government is currently going through with its third HNP sector program and moving along with its fourth HNP program, covering the period January 2017 to June 2022. The fourth HNP program’s objective is to “ensure quality and equitable healthcare for all citizens of Bangladesh by gradually achieving Universal Health Coverage” with a higher-level goal of improving the health and well-being of all Bangladeshi citizens (echoing SDG 3). The Ministry

of Health and Family Welfare (MOHFW) considers it as a first, foundational, program towards the achievement of the SDGs by 2030.

6. As Bangladesh builds on significant progress in the HNP sector and pursues progress towards the SDGs, including the target of universal health coverage, it will face challenges as mentioned below.

7. **Unfinished Agenda:** There is an unfinished agenda relating to reproductive, maternal and child health and nutrition, as well as communicable disease control. For example, adolescent health requires attention. The median age at first marriage is young (16.1 years), leading to high fertility in the 15-19 year age group (113 births per 1,000 women), which also contributes to higher risk of maternal mortality. Maternal and child nutrition present continuing challenges. In 2004, 32 percent of women aged 15-49 were under-nourished and this declined significantly to 18 percent in 2014, although continuing progress is needed. Again, there are significant socio-economic and regional inequalities in nutritional status.

8. Progress is slower with child malnutrition. As in 2004, 51 percent of under-five children were stunted; this status declined to 36 percent in 2014. In addition, although the prevalence of child undernutrition has been declining, improvement over time has been slow (with an average annual decline of one percentage point since 2000), so that over one-third of under-5 children (or over 6 million) are stunted. (NIPORT *et al.*, 2016) Similarly, although diagnosis and treatment of tuberculosis has steadily improved over time, it is estimated that the government program identifies only around half of all incident cases. (WHO, 2015)

9. **Rapid demographic transition leading to increase in life expectancy:** At the same time, Bangladesh has experienced a rapid demographic transition through large drops over the past two decades in child mortality and fertility combined with increased life expectancy (Under 5 mortality rate MDG 4 – 46 per 1000 live births, which is a 68 percent reduction against the target of 66 percent (BDHS 2014). Total fertility rate (TFR) of women reduced from 5.1 in the 1980s to current TFR at 2.21). This is accompanied by an epidemiological transition whereby non-communicable diseases such as cardio-vascular disease, hypertension, diabetes and cancer, represent a growing proportion of the causes of death and disability. In 2013, as non-communicable diseases were estimated to cause 70 percent of deaths, compared to 20 percent caused by communicable diseases and maternal, neonatal and nutritional conditions. (The burden of injuries was estimated at around 10 percent). (IHME, 2015)

10. **Persistent socio-economic and regional disparities.** There are persistent socio-economic and regional disparities in HNP outcomes and access to services, so that improving equity will be integral to progress towards universal health coverage. For example, estimated prevalence of stunting among under-5 children in 2014 was 49.2 percent among the lowest quintile of households ranked by socio-economic status, compared to a (still high) rate of 19.4 percent among the highest quintile. Fertility is highest in Sylhet and Chittagong divisions, with estimated total fertility rates of 2.9 and 2.5 respectively, compared to the national estimate of 2.3. (NIPORT *et al.*, 2016)

11. **Vulnerability due to Climate Change.** Due to its geographic location, population density, low capacity and resource constraints, Bangladesh is highly vulnerable to climate change, including its health impacts namely fever, diarrhea, and ARI among children under the age of five, hypertension due to water salinity caused by coastal flooding, malnutrition due to both increased food insecurity and high disease incidence (the two-way causation between nutrition

and childhood illnesses, and mental disorders, have already become more prevalent in recent years and could be attributed to climate change (Mani and Wang, 2014).

12. **Urbanization and Out-of-pocket Spending on Healthcare.** The population of Bangladesh is becoming increasingly urbanized. Although by administrative measures, 30 percent of the population lives in urban areas, other indicators suggest this proportion is at least 45 percent. (Ellis and Roberts, 2016) Urban populations rely to a great extent on private for-profit health services or private clinics and pharmacies. Indeed, it is estimated that 63 percent of total health expenditure in the country in 2012 was out-of-pocket spending by households (Government of Bangladesh, 2015a).

13. **Low GOB Spending on Healthcare.** Government health spending as a proportion of GDP has remained under 1 percent over the past decade, among the lowest in the world. International financing accounts for about 23 percent of government health spending, but as Bangladesh transitions to middle-income status, international support can be expected to decline. (Vargas *et al.*, 2016) At the same time, between fiscal years 2014-15 and 2016-17, the Government's allocation to the Ministry of Health and Family Welfare (MOHFW) increased from 4.3 percent to 5.1 percent, leading to an increase of 37.7 percent in absolute (Taka) terms. The 2016-17 HNP budget (01 July 2016 to 30 June 2017) of about US\$2.24 billion is equivalent to US\$14 per capita.

14. **Governance and Capacity challenges.** As the Government works towards its development objectives, it will need to address governance and system capacity challenges. The government health service delivery system is hampered by weaknesses in governance and accountability leading to absentee doctors and HRH from workplaces, human resource allocation and management, supply chain management, and information systems. (Ahmed *et al.*, 2015)

15. **Weaknesses in health systems and public sector management inefficiencies contribute to the low quality of care and inequities in health outcomes.** Various binding constraints contribute to poor public sector management in health. These include: weaknesses in public financial management, poor resource allocation to sector priorities, deficit of qualified health workers and inefficiencies in human resource management, inadequate oversight by the MOHFW due to low capacity, weak information systems from decentralized units where service delivery occur, poor accountability at most levels, and inadequate and fragmented mechanisms for citizen engagement despite being a key priority area under the MOHFW's Fourth Sector Program Strategy.

1.3 Government's Fourth Sector Program

The GOB's 7th Five Year Plan and Fourth Sector Program (July 2016-June 2021) are the primary instruments to guide the health sector for the next five years. It adopts the vision and mission set forth by the National Health Policy and carries the ethos of Constitutional provision to guarantee access to basic health services as a fundamental right of every citizen. It articulates nation's commitment towards achieving Universal Health Coverage and provides the basis for garnering required resources and investments. The Fourth Sector Program's objectives, results framework, and strategies are described in a Strategic Investment Plan that was developed on the basis of wide consultation of stakeholders and approved in April 2016. (Government of Bangladesh, 2016a) The Strategic Investment Plan will be operationalized by a Program Implementation Plan and 29 Operational Plans. The Fourth Sector Program's overall objective is "to ensure that all citizens of Bangladesh enjoy health and well-being by expanding access to

quality and equitable healthcare in a healthy and safe living environment.” The Ministry of Health and Family Welfare (MOHFW) considers it as a first, foundational, program towards the achievement of the SDGs by 2030. The Fourth Sector Program will build on a successful history of the previous sector programs, with well-established planning and consultation processes as well as monitoring and coordination mechanisms. It will encompass three components: (i) Governance and Stewardship, (ii) HNP Systems Strengthening, and (iii) Provision of Quality HNP Services.

16. Both the documents (Fourth Sector Program and the 7th Five Year Plan) incorporate institutional and systemic reforms alongside a renewed focus on delivering more effectively and efficiently so that the poorest and most marginalized populations access services. It envisions for equitable service utilization, strengthening service delivery and demand generation to the underprivileged population, including the urban poor. It also calls for greater partnerships with local level institutions and community groups to empower women, promote supportive cultural practices and curb gender-based violence in the society. There is a strong focus on improving institutional arrangements that affect service delivery—including human resources, procurement and supply chain management, contract management systems, budget planning, execution and reporting, as well as expanding citizen engagement to improve transparency and accountability. It also focuses on ensuring that services and financial protection mechanisms are targeted to population in greatest need.

1.4 The Scope of ESSA

17. The ESSA provides a comprehensive review of relevant government systems and procedures that address environmental and social issues associated with the Program. The ESSA describes the extent to which the applicable government environmental and social policies, legislations, program procedures and institutional systems are consistent with the six ‘core principles’ of the World Bank’s Policy for PforR Financing and recommends actions to address the gaps and to enhance performance during Program implementation.

- **Core Principle 1:** General Principle of Environmental and Social Management. This core principle aims to promote environmental and social sustainability in Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the Program’s environmental and social impacts.
- **Core Principle 2:** Natural Habitats and Physical Cultural Resources. This core principle aims to avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the Program.
- **Core Principle 3:** Public and Worker Safety. This core principles aims to protect public and worker safety against the potential risks associated with: (i) construction and/or operation of facilities or other operational practices under the Program; (ii) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.
- **Core Principle 4:** Land Acquisition. This core principle aims to manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement, and assist affected people in improving, or at the minimum restoring, their livelihoods and living standards.
- **Core Principle 5:** Small Ethnic and Vulnerable Communities (a terminology used by the GOB as it does not use the term “Indigenous Peoples”). This core principle aims to give due consideration to the cultural appropriateness of, and equitable access to, Program benefits, giving special attention to the rights and interests of the small ethnic and vulnerable communities (tribal people) and to the needs or concerns of vulnerable groups.

- **Core Principle 6: Social Conflict.** This core principle aims to avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.

18. Specific objectives of ESSA are as follows:

- To identify the potential environmental and social impacts/risks applicable to the Program interventions
- To review the policy and legal framework related to management of environmental and social impacts of the Program interventions
- To assess the institutional capacity for environmental and social impact management within the Program system
- To assess the Program system performance with respect to the core principles of the PforR instrument and identify gaps in the Program's performance
- To include assessment of monitoring and evaluation systems for environment and social issues
- To describe actions to fill the gaps that will input into the Program Action Plan (PAP) in order to strengthen the Program's performance with respect to the core principles of the PforR instrument

1.5 Approach to ESSA

19. The assessment team used various approaches to review the environment and social systems that are relevant to Fourth Sector Program. It included analysis of information/ data on previous assessments and reports on the status of different aspects of healthcare system and its management of environmental and social issues (e.g. medical waste management, gender disparity, access to health care by vulnerable groups) and national consultations with all key stakeholders related to healthcare system management.

20. The data gathered from these multiple sources were processed to allow for triangulation. National level consultations are to be organized with stakeholders for feedback on the implementation of provisions to enhance transparency and accountability and other related environment and social issues. One of the key purposes of the consultations was to provide detailed local information and views on experiences related to healthcare waste management from the key relevant stakeholders.

SECTION II: PROGRAM DESCRIPTION

2.1 The GOB's Fourth Sector Program

21. The government and partners have pursued a sector-wide approach (SWAp) since 1990, adopting a series of multi-year strategies, programs and budgets (1998-2003, 2003-11, and 2011-16) for management and development of the sector, with support from both domestic and international financing. The government is currently implementing its third HNP sector program and is in the latter stages of planning its Fourth HNP Program, covering the 5.5 year period between January 2017 and June 2022. The program's objectives, results framework, and strategies are described in a Strategic Investment Plan that was developed on the basis of wide consultation of stakeholders and approved in April 2016. (Government of Bangladesh, 2016) The Strategic Investment Plan will be operationalized by a Program Implementation Plan and 27 Operational Plans (OPs). The Fourth HNP Program's overall objective is, "To ensure that all citizens of Bangladesh enjoy health and well-being by expanding access to quality and equitable healthcare in a healthy and safe living environment." The Ministry of Health and Family Welfare considers it as a first, foundational, program towards the achievement of the SDGs by 2030.

22. The government's Fourth HNP Sector Program will build on a successful history of the previous sector programs, with well-established planning and consultation processes as well as monitoring and coordination mechanisms. The government's Fourth HNP Sector Program will encompass three components: (i) Governance and Stewardship, (ii) HNP Systems Strengthening, and (iii) Provision of Quality HNP Services.

23. The total estimated cost of the government's Fourth HNP Sector Program is US\$14.8 billion, which covers the entire government HNP sector budget over a 5.5 year period (or about US\$2.7 billion per year). The budget for the program comes through two channels: (i) the revenue (non-development) budget which covers recurrent costs but also some capital costs allocated directly to different institutions; and (ii) the development budget which largely covers capital costs, but also some recurrent costs allocated to different Operational Plans, each implemented by a line directorate in the MOHFW. Like previous sector programs, it is expected that, under the SWAp, a significant proportion of development partner (DP) support will be channeled through on-budget financing, including through co-financing of this proposed World Bank operation.

2.2 Program Development Objectives of the Proposed Program

24. The Program Development Objective (PDO) of the PforR is to strengthen the HNP sector's core management systems and improve delivery and utilization of essential HNP services, with a focus on selected geographical areas.

25. In supporting part of the government's Fourth HNP Sector Program, which is national in scope, the proposed PforR will benefit, directly and indirectly, the entire 160 million population of Bangladesh, including 50 million in Sylhet and Chittagong divisions

2.3 Program-for-Results Scope¹

¹ In this document, the government program is referred to as such, while the part of the government program supported by this financing operation is referred to as the "Program-for-Results (PforR)."

26. As Bangladesh builds on significant progress in the HNP sector and pursues progress towards the SDGs, it will face important challenges. These can be characterized in three ways: (i) foundational financing and system development priorities; (ii) the unfinished MDG agenda; and (iii) emerging challenges. The PforR will support the government in meeting these challenges through relevant parts of its Fourth HNP Sector Program. The PforR Results Areas are aligned with the government program components with a focus on those aspects that will contribute to meeting these challenges.

2.4 Program-for-Results Financing

27. The total budget over the 5.5 year period of the government's Fourth HNP Sector Program is estimated at US\$ 14.8 billion.

28. The proposed PforR will be financed by the government from domestic sources, and by US\$300 million from the 17th round of IDA, allocated to Disbursement-Linked Indicators (DLIs). Like previous World Bank financing operations supporting Bangladesh's HNP sector programs, the proposed PforR will serve as a platform for co-financing by other DPs, anticipated to total US\$200 million. Such co-financing, to be finalized during the first year of implementation, will be linked to the DLIs and results.

2.5 Disbursement-Linked Indicators

29. The three components of the government's Fourth HNP Sector Program, encompassing governance and stewardship, system development, and service delivery, will lead to results that are reflected by the PDO - improvements in HNP system management as well as service delivery, utilization and equity. The PforR will contribute to these results by supporting the government in meeting key challenges as it builds the foundation for achieving the SDGs, specifically through supporting results that will contribute to (i) foundational priorities, (ii) unfinished aspects of the MDG agenda, and (iii) emerging challenges. The DLIs under each Results Area have been selectively chosen to reflect work towards meeting these three cross-cutting challenges. The DLIs are listed in the table below.

30. **Results Area 1. Governance and Stewardship.** The DLIs supporting this Results Area reflect work necessary for improving accountability and use of the greater public resources that will be necessary for achieving progress towards the SDGs in the medium term. The DLIs were chosen to reflect the government's efforts to enhance the accountability and responsiveness of the HNP service delivery system as well as on improve the efficiency and allocation of government health spending. Citizen feedback will be encouraged through development of the Ministry of Health and Family Welfare's grievance redress system (GRS) in follow-up to its establishment under the third HNP sector program. In the area of health financing, one DLI reflects improved budget execution by all Operational Plans while another represents an initial step towards greater management authority at the service delivery level through improved allocation and expenditure of discretionary funds for repair and maintenance.

31. **Results Area 2. HNP Systems Strengthening.** The DLIs under this Results Area reflect

work to develop core management systems in preparation of further expansion and improvement of HNP services in order to achieve progress towards the SDGs. The DLIs reflect improvements in the major management systems: financial management, asset management, procurement, human resource management, and the information system. One DLI reflects development of the Financial Management and Audit Unit in the Ministry of Health and Family Welfare and strengthening of the internal audit function, while another reflects further implementation of an asset management system that was initiated under the current sector program. Several DLIs reflect improvements in procurement and supply chain management, specifically implementation by the Ministry of Health and Family Welfare of the government’s e-procurement system and establishment of a system to track medicine stocks at the service delivery level. Two DLIs reflect improvements in human resource management, with direct impact on maternal health care in particular, relating to posting of specialists at district-level hospitals and posting of midwives at *Upazila* Health Complexes. The DLI measuring improvement in the information system reflects better coordination of information management at the service delivery level, as well as an effort to better understand gender dynamics through reporting of gender disaggregated service delivery data.

32. **Results Area 3. Provision of Quality HNP Services.** The DLIs supporting this Results Area are reflections of work to address the unfinished MDG agenda as well as emerging challenges. Many of these DLIs focus on improved HNP service delivery and utilization in two divisions, Sylhet and Chittagong divisions, where indicators are below national averages. This will help focus attention and resources in order to reduce disparities. A number of DLIs relate to improved service delivery and utilization of family planning, maternal and child health services. These focus on improved post-partum family planning services, delivery care, and child immunization. Several DLIs focus on strengthening maternal and child nutrition services. In addition, a DLI will reflect the unfinished agenda in the area of communicable disease control, specifically addressing tuberculosis. Generally, these DLIs will reflect the government’s efforts to improve supply and increase utilization of the Essential Service Package.

Table 2: List of DLIs

Results Area 1. Governance and Stewardship
1. Citizen feedback system is enhanced
2. Budget execution across programs is increased
3. Spending on repair and maintenance at the service delivery level is increased
Results Area 2. HNP Systems Strengthening
4. Financial management system is strengthened
5. Asset management system is implemented
6. Procurement process is improved using information technology
7. Institutional capacity is developed for procurement and supply chain management
8. Medicine stock tracking system is developed and implemented
9. Availability of midwives for maternal care is increased
10. Availability of specialist human resources for first-referral care is increased
11. Information systems are strengthened, including gender-disaggregated data
Results Area 3. Provision of Quality HNP Services
12. Utilization of maternal health care services is increased
13. Post-partum family planning services are improved
14. Emergency obstetric care services are improved

15. Immunization coverage and equity are enhanced
16. School-based adolescent health and nutrition services are developed
17. Maternal nutrition services are expanded
18. Infant and child nutrition services are expanded
19. Communicable disease control is improved
20. Non-communicable disease services are developed
21. Coordination on urban health services is improved

33. In addition, several DLIs reflect work on emerging challenges, specifically in the areas of adolescent health and nutrition services, non-communicable diseases, and urban HNP services. These DLIs focus on assessment, planning and initial implementation; this work will lead to definition of results reflecting further implementation to be supported by possible additional financing.

34. The proposed project will not support any major civil construction (only minor maintenance or repairs). There will be no new construction, land acquisition or any activities resembling category “A” projects.

2.6 Institutional and Implementation Arrangements

35. The MOHFW is responsible for implementation of the HNP sector program as a whole, including the part of the sector program to be supported by the PforR. The ministry encompasses a number of entities, including those that will implement the part of the sector program to be supported by the PforR: the Directorate General of Health Services, Directorate General of Family Planning and Directorate General of Health Economics Unit. There are 29 Line Directors responsible for development and implementation of Operational Plans. Operational Plans, including budgets, have been developed for the 5.5 year implementation period of the Fourth HNP Sector Program, and together constitute the Program Implementation Plan that is to be approved by the Executive Committee of the National Economic Council, chaired by the Prime Minister. The PforR will support Operational Plans that will contribute to the results measured by the DLIs; that is, those that are largely focused on system planning and management and on basic HNP service delivery (at the *Upazila* level and below).

36. Government health facilities are situated at different administrative levels: national, division, district, *Upazila*, union, and ward. The PforR will support system development activities at all levels, and service delivery results at the *Upazila* level and below. Services are delivered by both the Directorate General of Health Services and the Directorate General of Family Planning, operating through parallel systems. The lowest level facility is the Community Clinic, serving at the ward level as the first point of contact for primary health care services, including immunization, family planning, and health education. One Community Clinic is intended to serve 6,000 people; currently, 13,094 Community Clinics are functioning. At the union level, three kinds of facilities, each of which include physicians on staff, provide outpatient care: rural health centers, union sub-centers, and Union Health and Family Welfare Centers. At the *Upazila* level, services are provided by *Upazila* Health Complexes, with inpatient capacity of 30 to 50 beds. Some of these facilities provide first-referral (secondary) care including comprehensive emergency obstetrical care. At the district level, district/general hospitals of different sizes (100 to 250 beds) provide secondary care, while some districts also have government medical colleges providing tertiary care. In addition, at the district level are situated 10-20 bed Maternal and Child Welfare Centers providing family planning as well as maternal care services. The government also manages a number of tertiary and specialized hospitals at the division and national levels.

37. The SWAp arrangements include a Local Consultative Sub-Group for Health that meets every six months and is jointly chaired by the Secretary of the Ministry of Health and Family Welfare and the Chair of the HNP Development Partner Consortium. The HNP Development Partner Consortium is the forum for coordination of development partners in the sector, with a Chair and Co-Chair elected every two years. The Ministry of Health and Family Welfare, in collaboration with development partners, leads an Annual Program Review in the third quarter of every calendar year. Thematic task groups, with membership from the Ministry of Health and Family Welfare and from development partners, review implementation progress of the sector program in a variety of technical areas, and this will include monitoring DLIs and the Program Action Plan of the PforR. A Planning Working Committee, chaired by the Joint Chief of the Planning Wing of the MOHFW, was set up to support preparation of the Fourth Sector Program and will continue to function as a DLI Monitoring Committee tasked with monitoring achievement of the DLIs and supporting Line Directors in implementation.

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SECTION III: NATIONAL ENVIRONMENTAL AND SOCIAL POLICY, INSTITUTIONAL AND MANAGEMENT SYSTEMS

38. This section describes the existing environmental and social management system of the GOB along with an overview of the policy and legal framework. This includes a profile of the key institutions and their role with respect to management of environmental and social aspects of the Program.

3.1 Institutional Framework for Environmental and Social Management

3.1.1 Government Agencies

39. The main Government institutions with key responsibilities for environmental and social management in the health sector are described below.

Ministry of Health and Family Welfare (MOHFW)

40. The MOHFW plays a pivotal role in improving the health of the people including mental, physical and social wellbeing, for overall national development with the increased participation of the private sector and non-government institutions in the implementation of programs. The ministry envisions creating conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of people health. It is a vision that recognizes health as a fundamental human right and therefore the need to promote health and reduce suffering in the spirit of social justice.

41. Under the Ministry, there are four Directorates and a good number of Divisions/bodies with specific charter of duties. Amongst those, Directorate General of Health services (DGHS) and Directorate General of Family Planning (DGFP) are primarily involved with service delivery while National Institute of Population Research and Training (NIPORT) develops capacity of human resources and generates evidence for improving health, population and nutrition programs and policies in Bangladesh.

42. DGHS Controls the following operation of the healthcare facilities:

- Licensing authorities for the healthcare facilities
- Inspections and auditing of the healthcare facilities
- Public hospitals management
- Proving the logistic support, training, and
- Managing human resources in Health Service

43. DGFP is responsible for the following operations:

- Management Information Systems
- Family Planning Field Services Delivery
- Clinical Contraception Services Delivery
- Maternal, Child, Reproductive and Adolescent Health
- Planning, Monitoring and Evaluation of Family Planning
- Information, Education and Communication (IEC)
- Procurement, Storage and Supplies Management- FP

Gender, Equity, Voice and Accountability (GEVA):

42. The GOB has made it a priority to eliminate discrimination against women and girls and promote gender equity. The MOHFW addressed the issue under the third sector program and reviewed the existing Gender Equity Strategy and revised various gender related issues including human resource planning, development and management at facility level, housing, promotion for women workforce, etc. MOHFW's priority interventions for GEVA includes:

- Mainstreaming GEVA issues in all components of the sector program and ensuring adequate budget for these (at central and local levels)
- Improving coordination on GEVA issues through assigning and strengthening the Gender, NGO and Stakeholder Participation Unit (GNSPU) as the focal point.
- Ensuring inclusion of GEVA and accountability issues in the objectives, activities and indicators of all operational plans and in the overall results framework.

43. The Gender Equity Strategy developed by GoB has been finalized. Meanwhile, the GNSPU of Health Economics Unit (HEU) under MOHFW with addition of a gender expert have developed "Activities of Gender Equity Action Plan (2014-2024) with six Strategic Objectives to strengthen gender aspects of the program, including health sector response to victims/ survivors of gender-based violence. The objectives are:

- **Strategic Objective 1:** Introduce gender-sensitive policies, plans and evidence-based approaches: To ensure policies, strategies, operational plans and other programs adhere to the principles of gender equity and effective practice. The activities include: Ensure plans and programs are in line with the GOB's commitment to achieve gender equity., Ensure collection of adequate and relevant gender disaggregated information and use gender responsive indicators for monitoring and evaluation processes., Ensure regular gender auditing process in every health facilities, Ensure gender responsive health budget in every operational plan , Ensure development of gender sensitive information and communication materials, etc.
- **Strategic Objective 2:** Ensure equitable access and utilization of services using a life-cycle approach -aiming to protect the health of young girls, adolescents and elderly women within a rights-based approach. The activities include strengthening maternal and child health services including adolescents, reproductive health, geriatric health and nutrition services, updating training modules, materials, guidelines (including counseling and communication) to provide services to socially excluded population (i.e. transgender, people with disabilities, small ethnic and vulnerable community, etc.), conducting training of trainers for health service providers and enhance gender sensitive family planning and counseling services.
- **Strategic Objective 3.** To ensure gender mainstreaming in all programs with MOHFW and other ministries and organizations through equitable planning and budgeting. Advocacy with policymakers to change, develop and/or enforce laws and policies that promote gender equality and human rights. The activities involve incorporation of Gender equity with concerned ministries & organizations so that mainstreaming of the gender perspective is in legislative drafting, budget preparation and other activities with major implications for gender equality.
- **Strategic Objective 4.** To ensure gender balanced human resources (service providers) in health sector with appropriate skills to deliver gender sensitive, non-discriminatory

services. The activities include ensuring the development of gender sensitive human resources who are capable in providing quality services to all, irrespective of individual's sex, ensuring the development of gender balanced human resources who are capable in providing quality services to all, irrespective of individual's sex, and ensuring that gender sensitive policies are practiced in HR dealings.

- **Strategic Objective 5.** To ensure involvement of key stakeholders- representatives of civil society and other stakeholders, particularly women, men, girls and other socially excluded communities, on planning, implementing and reviewing health and family welfare services and gender equity strategy. The activities include dialogue with civil society, stakeholders, NGOs on gender mainstreaming so that ownership and acceptance of an intervention or practice is increased.
- **Strategic Objective 6.** To ensure effective stewardship by the government ministry responsible for health. The activities include ensuring governance and stewardship in health sector program.

44. The GNSPU is committed to provide required attention to adolescent friendly and Sexual and Reproductive Health and Rights (SRHR) services and gender-based violence. (Health, Population and Nutrition Sector Development Program (HPNSDP), Midterm Review, August–October 2014 Joint Aide Memoire).

45. However, GNSPU lacks required technical expertise and human resource to implement the activities to Gender Equity Strategy. Moreover, due to inadequate manpower, and minimum expertise of the Line Directorates, GNSPU is yet to start the basic works including Gender Reporting, Gender Auditing etc. The Planning Wing at the MOHFW need to incorporate such programs developed under 'Gender Equity Action Plan (2014-2024) in the PIP and OP and allot required budget to make the GNSPU effective, while MOHFW may be requested to address the HRH issue of GNSPU.

National Institute of Population Research and Training (NIPORT)

46. National Institute of Population Research and Training (NIPORT), working under MOHFW, develops human resource and generates evidence for improving health, population and nutrition programs and policies in Bangladesh. NIPORT is the only training institute under the MOHFW that provides residential training for program personnel. NIPORT has well-equipped training facilities from national level to the Upazila level. In addition to the facilities at NIPORT head office in Dhaka, there are 12 Family Welfare Visitors' Training Institutes (FWVTIs) at the division or the district levels, 20 Regional Training Centers (RTCs) at the Upazila level and 31 Field Training Centers (FTCs) attached to FWVTIs. The FWVTIs and RTCs are geographically located in such a way so that the trainees can easily reach the centers, participated the training courses and stay there comfortably. The research division of NIPORT is housed within the head office.

Ministry of Environment & Forest (MoEF)/Department of Environment (DoE)

47. MOEF is the responsible ministry to deal with environmental issues. The Department of Environment (DoE) working under MOEF is responsible for the following tasks that have linkage with the ESSA. These are:

- Inspections of the waste management facilities at the time of the renewal of the licenses.
- Implementation of the Medical Waste (Management & Treatment) Rules 2008.

Ministry of Local Government, Rural Development and Cooperatives (MoLGRDC)

48. MoLGRDC along with City Corporations and Poursavas are responsible for the following:
- Providing waste management services including medical waste management.
 - Providing public health, waste management (conservancy) and water supply in the urban areas
 - City Corporation and Poursava run Satellite Clinics in the earmarked areas.
 - Local Government Division (LGD) is responsible for Urban area PHC.

49. In Bangladesh, the City Corporations/MoLGRDC are responsible for out-house management of medical waste. At present the out-house management system is operational in five cities (World Bank, 2014). In these cities, there is agreement between city corporation and service providers, e.g. NGOs. These NGOs are responsible for collection, treatment and disposal of waste and are registered with the DoE as per the medical waste (Management and Treatment) rule 2008. They do not pay any fees to the city corporations and do not get any financial support from city corporations. They meet the expenses through the service charges it collects directly from the healthcare facilities with whom it enters into a service contract for transport, treatment and disposal of the medical waste.

3.1.2 Other Government Stakeholders

Bangladesh Medical Research Council (BMRC)

50. Bangladesh Medical Research Council (BMRC) was established in 1972 by order of the President as an Autonomous Body under MOHFW. The objectives, rules & regulations of the Council were formulated by resolution of the MOHFW in 1974 & 1976. As per resolution of the Government, BMRC is the focal point for Health Research. The objectives of BMRC are to identify problems and issues relating to medical and health sciences and to determine priority areas in research on the basis of health care needs, goals, policies and objectives. BMRC has a General Body with 54 members representing post-graduate medical institutes, medical colleges, universities, learned societies, medical institutions, health related organizations, various divisions and departments of ministries dealing with medical education, services and research. The General Body elects the Executive Committee. It is headed by the Chairman, Executive Committee, elected from among the members of the General Body. The Mission of the Council is to create effective and quality health care facilities for the whole population of the Country by promoting health research through strengthening of research facilities, training and dissemination of research results. The main activities of the Council include: organization and promotion of scientific research in various fields of Health Science, training of manpower in the field of health research and dissemination of research results for proper utilization.

Bangladesh Medical and Dental Council

51. The Bangladesh Medical & Dental Council (BM&DC) is a statutory body with the responsibility of establishing and maintaining high standards of medical education and recognition of medical qualifications in Bangladesh. It registers doctors to practice in Bangladesh, in order to protect and promote the health and safety of the public by ensuring proper standards in the practice of medicine.

Bangladesh Nursing and Midwifery Council (BNMC)

52. BNMC is the Regulatory Body and Focal Point from which all activities relating to nursing are managed. This includes all involved in nursing and midwifery education and practices. Though regulation of Nursing education and practices is the responsibility of the BNMC, the council works closely with the Directorate of Nursing services (DNS) under MoHFW in regulating Nursing and Midwifery Services.

3.1.3 NGOs and other Stakeholders/Programs

In addition to the GOB efforts, there are UN agencies and NGOs that are working in providing HNP services/interventions in different hard to reach areas including the tribal areas. These NGOs and programs are important entry points to enhance compliance with social safeguards best practices. Main agencies and NGOs include UNDP, UNICEF and BRAC. Among these, recently completed Chittagong Hill Tracts Development Facility (CHTDF) of UNDP worked in 15 Upazilas of the CHT in close collaboration with the HDC and the MOHFW. The strategies include a network of female outreach workers or Community Health Service Workers (CHSWs) who are recruited and posted in their own remote para after two months of Residential training. They provide basic health care including diagnosis and treatment of malaria, mobilize communities for immunization, family planning services and refer cases to satellite clinics and other health facilities. There are satellite clinics that provide an important link between community health service provided at the community level and the services delivered through government health facilities at the upazila and district levels.

53. CHTDF covered Rowangchari, Thanchi, Alikodom, Ruma and Lama Upazilas of Bandarban Hill District, Rajastali, Langudu, Barkal, Billaichari, Juraichari and Baghaichari (for Baghaichari 2 mobile teams) upazilas of Rangamati Hill District and Matiranga, Panchari and Laxmichari and Mahalchari upazilas of Khagrachari Hill District.

3.2 Policy and Legal Framework

54. Bangladesh has a number of policies, instruments and laws that support environmental and social management and the environmental and social assessment processes. The ESSA reviewed the existing regulations and policies, their legal and practical applicability at the program level as well as the institutional capacity, and the effectiveness of implementation in practice. GOB has enacted various Acts and Regulations relating to clean environment, public health protection, and health care waste management.

3.2.1 Policy and Legal Framework for Environmental Safeguard

55. The GOB's environmental laws and policies are deemed adequate for both protection and conservation of resources, although enforcement capacity needs to be improved significantly. The assessment highlights that the Program may generate medical waste and GOB has comprehensive laws and policies for management of medical waste.

National Environmental Policy 1992

56. The concept of environmental protection through national efforts was first recognized and declared in Bangladesh with the adoption of the Environment Policy, 1992 and the Environment Action Plan, 1992. The major objectives of Environmental policy are to i) maintain ecological balance and overall development through protection and improvement of the environment; ii) protect country against natural disaster; iii) identify and regulate activities, which pollute and degrade the environment; iv) ensure environmentally sound development in all sectors; v) ensure sustainable, long term and environmentally sound base of natural resources; and vi) actively remain associate with all international environmental initiatives to the maximum possible extent.

Bangladesh Environmental Conservation Act (ECA), 1995 amended 2002

This umbrella Act includes laws for conservation of the environment, improvement of environmental standards, and control and mitigation of environmental pollution. It is currently the main legislative framework document relating to environmental protection in Bangladesh, which repealed the earlier Environment Pollution Control ordinance of 1977.

57. The first sets of rules to implement the provisions of the Act were promulgated in 1997 (see below: "Environmental Conservation Rules 1997"). The Department of Environment (DoE) implements the Act. A Director General (DG) heads DoE. Under the Act, operators of industries/projects must inform the Director General of any pollution incident. In the event of an accidental pollution, the Director General may take control of an operation and the respective operator is bound to help. The operator is responsible for the costs incurred and possible payments for compensation.

Environment Conservation Rules (ECR) 1997 amended 2003

58. These are the first set of rules, promulgated under the Environment Conservation Act 1995. Among other things, these rules set (i) the National Environmental Quality Standards for ambient air, various types of water, industrial effluent, emission, noise, vehicular exhaust etc., (ii) requirement for and procedures to obtain Environmental Clearance, and (iii) requirements for IEE/EIA according to categories of industrial and other development interventions. Any proponent planning to set up or operate an industrial project is required to obtain an "Environmental Clearance Certificate" from the Department of Environment (DoE), under the Environment Conservation Act 1995 amended in 2002. The wastewater generated from healthcare facilities are subjected to the discharge standards set in ECR 1997.

Environment Court Act, 2000

59. The aim and objective of the Act is to materialize the Environmental Conservation Act, 1995 through judicial activities. This Act established Environmental Courts (one or more in every division), set the jurisdiction of the courts, and outlined the procedure of activities and power of the courts, right of entry for judicial inspection and for appeal as well as the constitution of Appeal Court.

Bangladesh Labor Act, 2006

60. This Act pertains to the occupational rights and safety of factory workers and the provision of a comfortable work environment and reasonable working conditions. In the Chapter VI of this law safety precaution regarding explosive or inflammable dust/ gas, protection of eyes, protection against fire, works with cranes and other lifting machinery, lifting of excessive weights are described. And in Chapter VIII, provision of safety measures like appliances of first aid,

maintenance of safety record book, rooms for children, housing facilities, medical care, group insurance etc. are illustrated.

Medical Waste (Management and Treatment) Rules 2008

61. The Medical Waste (Management and Treatment) Rules 2008 forms the base of management of all medical waste in the country. The rules are applicable only to waste management facility/operators i.e. those involved in transportation, treatment and disposal of medical waste. The law provides for guidance on the collections, storage treatment and disposal of medical waste for management facilities/operators. The institutions or agencies involved in collection, transport, storage, have to obtain authorization from the DoE.

Manual for Hospital Waste Management 2001

62. DGHS has developed a manual for hospital waste management in 2001 which was later updated. The manual is aimed for the hospital managers, health providers, policy makers and all the administrators, with an interest for and with responsibility to ensure hospital wastes are disposed of efficiently and economically as far as possible with a minimal environmental and health impact.

Guidelines on Infection Prevention and Control (IPC) and Biosafety 2016

63. WHO Bangladesh has supported the development of updated guidelines on infection prevention and control (IPC) and biosafety for health care providers. The guidelines focus on measures to ensure patient safety as well as the safety of health care and laboratory personnel.

GOB 7th 5-year Plan (FYP)

64. Under the 7thFYP, the government aims to attain a number of broad goals, including good governance in environmental sustainability, addressing population growth, ensuring the sustainability of cities with improved infrastructure, production and economic activity with minimal degradation, meeting national air and water quality standards, protecting endangered species, sustainable conservation of the Sundarbans Mangrove Forest and reducing potential economic losses from natural disasters. Among the array of activities that will be implemented under 7th FYP, it is mentioned that the GOB will take the following steps to counteract the harmful effects of pollution due to medical wastes:

- a. GOB will take measures to improve medical waste management in the country by delivering specific disposal training and with strict enforcement of separate collection & disposal systems.
- b. GOB will establish environmentally acceptable treatment centers for infectious wastes in each divisional city.
- c. Strict compliance of Medical Waste Rules along with in-house and off-the-house management should be established.

3.2.2 Policy and Legal Framework for Social Safeguard

65. The GOB's health related laws and policies are quite adequate to ensure social safeguards' compliances following relevant core principles of OP 4.9 (core principles 1 and 5)². To improve the access of disadvantaged and marginalized groups to basic and quality health care services; policy makers, international partners, political actors and NGOs have expressed strong commitments to gender equality and social inclusion. Accordingly, the issues of gender including women, children, the adolescent, small ethnic and vulnerable community (tribal people) have been brought to the fore in development discourses, and also reflected in various acts, policies, strategies and programs, including in the health sector.

Constitution of the People's Republic of Bangladesh, 04 November 1972

66. Bangladesh's Constitution defines the rights of every citizen to have access to medical care where the State is responsible for the provision of Basic Necessities for the citizens. Article 15 (1) notes that it shall be a fundamental responsibility of the State to ... "the provision of the basic necessities of life, including food, clothing, shelter, education and medical care". Articles 18, 19, 27,28 (2), 28 (4), and 29 (3) (a) also addresses issues relating equal rights of citizens irrespective of gender gives equal opportunity irrespective of cast, creed and religious beliefs.

ILO Convention on Indigenous and Tribal Peoples, 1989 (No.169)

67. Bangladesh has ratified several international human rights treaties, including ILO Convention on Indigenous and Tribal Populations, 1957 (Convention No. 107), and its accompanying Recommendation 104 (which supplements with detailed guidelines the broad principles contained in Convention 107). Though there is no specific policy regarding the healthcare of indigenous and Tribal population, in April 2011 MOHFW has developed a program named "Tribal/Ethnic Health Population and Nutrition Plan for the Health, Population and Nutrition Sector Development Program (HPNSDP) 2011 to 2016". The program has just been completed and it needs to be assessed how far the program has been put to practice.

Gender Equality and Social Inclusion in Health Plans and Policies

68. In the health sector, the GOB has been formulating and implementing various policies and programs such as the National Health Policy 2011; Bangladesh Population Policy 2012; Bangladesh National Nutrition Policy 2015; Seventh Five Year Plan, FY 2016-FY 2020, Accelerating Growth, Empowering Citizens, Tribal/Ethnic Health Population and Nutrition Plan for the Health, Population and Nutrition Sector Development Program (HPNSDP) 2011 to 2016 and 1st to Fourth Sector Programs- all of which have focused on improving the health status of disadvantaged and marginalized populations, and improving the access and use of health services by disadvantaged and marginalized groups. Specifically, these guidelines emphasize creating a favorable environment, enhancing capacity of service providers, improving the health-seeking behavior of disadvantaged populations based on a rights-based approach, ensuring adequate budget and monitoring arrangements, grievance redress mechanisms, and effective governing and implementation of health services including from the private and non-state actors.

National Health Policy (NHP) 2011

²National Health Policy 2011; Bangladesh Population Policy 2012; Bangladesh National Nutrition Policy 2015;Seventh Five Year Plan, FY 2016-FY 2020, Accelerating Growth, Empowering Citizens

69. National Health Policy (NHP) 2011 views access to health as a part of recognized human rights. In order to achieve good health for all people, equity, gender parity, disabled and marginalized population access in health care need to be ascertained. However, NHP 2011 tends to cover everything without any clear direction of priority setting. National Health policy 2011 and the subsequent plans of action will be the most important and relevant policy document to comply with core principles 1, 3, 5 and 6 (gender, vulnerable groups and IPs and Social Conflicts).

Bangladesh Population Policy 2012 (BPP)

70. This policy addresses important gender issues and is thus relevant to social safeguard considerations. Specifically, this policy aims to reduce maternal and child mortalities and undertaking steps to improve maternal and child health through ensuring safe motherhood; ensure gender equity and women's empowerment and strengthening program to reduce gender discrimination in family planning, maternal and child health initiatives; adopt short, medium and long term plan by involving concerned ministries for transforming population into human resources; easy availability of information on reproductive health including family planning at all levels (MOHFW 2012). However, BPP 2012 was silent about much talked integration of health and family planning programs for synergistic and effective outcomes by avoiding duplication and wastage.

Bangladesh National Nutrition Policy (NNP) 2015

71. The Policy aims at improving nutritional status of the people particularly mother, adolescent girl and child; and accelerating national development through improvements of lives. The goal of the NNP 2015 is to improve the nutritional status of the people, prevent and control malnutrition and to accelerate national development through raising the standard of living. The policy addresses nutrition of the Vulnerable Groups, particularly pregnant and lactating mothers, adolescent girls and children. Besides, it also strengthens nutrition-specific direct and indirect nutrition interventions

SECTION IV: POTENTIAL ENVIRONMENTAL AND SOCIAL IMPACTS OF THE PROGRAM

72. This section presents the environmental and social benefits, risks and impacts of the Program. The risks have been identified using the Environmental and Social Risk Screening Format included in the World Bank's Policy for PforR Financing that determined the boundary of assessment. It also covers the likely environmental and social effects, the environmental and social context, institutional capacity, and the reputational and political risk

4.1 Environmental Risks and Opportunities of the Program

4.1.1 Analysis of Existing Situation of Medical Waste Management

73. Although medical wastes account for a very small fraction (about 1%) of the total solid wastes generated in Bangladesh (World Bank, 2002), if it is not handled properly and gets mixed with domestic solid waste, the whole waste stream becomes potentially hazardous. A report by International Committee of Red Cross (2011) states that 75% to 90% of the hospital wastes are similar to household refuse and municipal waste and do not entail any particular hazard. The other 10% to 25% is called hazardous medical waste or special waste. According to the Dhaka City Corporation's research report, 3700 metric tons of wastes are generated per day in Dhaka City and about 200 tons are hospital waste of which 40 tons are infectious wastes (Bangladesh Observer, 2000). Estimated amounts of hazardous wastes in Bangladesh, tons/ year, 2009-2015 (HPNSDP 2011-2016) are shown in the following table (which includes all facilities that do not fall under the scope of the PforR):

Hazardous waste	Y-2009	Y-2010	Y-2011	Y-2012	Y-2013	Y-2014	Y-2015
Dhaka	1275	1313	1353	1392	1435	1478	1522
Chittagong	663	683	703	724	746	769	792
Rajshahi	920	948	976	1005	1035	1066	1098
Khulna	388	400	412	424	437	450	463
Barisal	270	278	286	295	304	313	322
Sylhet	292	301	310	319	329	339	349
MCWC	161	166	171	176	181	187	192
Total Public HCFs	3969	4088	4211	4337	4467	4601	4739
Private HCFs	4239	4366	4497	4632	4771	4914	5062
Total	8208	8454	8708	8969	9238	9515	9801

74. Medical Waste Management (MWM) has been previously identified as a significant challenge in the health sector in Bangladesh as highlighted in several reports and assessments (The Environmental Assessment and Action Plan for HPNSDP in 2011-10, EMP implementation status report of 2014 etc.). The major findings from the assessment are the following:

- The Medical Waste Generators by and large do not maintain any proper record of the different streams of MW generated. Inadequate number of color-coded bins, often improperly placed, results in different waste streams getting mixed.
- The segregation of waste is delegated to the ward boys and the sweepers who do not have formal training. The nurses or the ward-in-charge who has received MWM training are not being able to supervise or transfer their knowledge adequately resulting in MWM practices not being implemented.
- There is lack of uniformity in color-coding and segregation procedures among the facilities.

- Needles and syringes were not destroyed before disposal. The needle cutters were not functional (blades becoming blunt after one or two uses) and more often the needle-cutters are usually kept inside the cupboards and are not used. It was also observed that bins used for sharps are not properly designed as per international standards. There is a general reluctance of destroying the sharps and needles.
- The IEC materials were not visible at the appropriate places in the facilities.
- The waste trolleys have become defunct and instead the trolleys used for ferrying patients were used for transporting the waste from the wards.
- The temporary storage of the different streams of Medical Waste is not done properly at the HCFs especially in the Public Hospitals.
- The use of PPE such as gloves, masks, boots, etc. is partial. The employees/waste pickers also do not undergo immunization at regular periods, as is required under the Infection Control guidelines.

75. Under the previous sector programs, the DGHS has taken initiatives to address some of these issues related to medical waste management in the health sector. In this regard, the DGHS has developed an online record-keeping, reporting and monitoring system for in-house waste management, conducted training on MWM at various levels, explored the feasibility of different out-house waste management options in several hospitals in the country. DGHS has also developed new IEC materials promoting awareness campaign on MWM. However due to weak institutional capacity, inadequate monitoring and lack of awareness and enforcement, the issues associated with Medical waste management are still persisting.

4.1.2 Potential Environmental Risks

76. The PforR focuses on improving health service delivery in primary level healthcare facilities in Sylhet and Chittagong. Improving health services would entail generation of medical waste which will have risks associated with it regarding its handling and treatment. Some general risks associated with medical waste is described below.

77. According to the risks, medical waste can be divided into five categories (MWM, ICRC, 2011)

1	Sharps	➤ Waste entailing risk of injury
2	<ul style="list-style-type: none"> i. Waste entailing risk of contamination ii. Anatomical waste iii. Infectious waste 	<ul style="list-style-type: none"> ➤ Waste containing blood, secretions or excreta entailing a risk of contamination. ➤ Body parts, tissue entailing a risk of contamination ➤ Waste containing large quantities of material substances and cultures entailing the risk of propagating infectious agents

3	<ul style="list-style-type: none"> i. Pharmaceutical waste ii. Waste containing heavy metals iii. Chemical waste 	<ul style="list-style-type: none"> ➤ Spilled/unused medicines expired drugs and used medication receptacles. ➤ Batteries, mercury waste (broken thermometers or manometers, fluorescent or compact fluorescent light tubes) ➤ Waste containing chemical substances leftover laboratory solvents, disinfectants, photographic developers and fixers
4	Toxic waste	<ul style="list-style-type: none"> ➤ Waste containing radioactive substances; urine or excreta of patients treated.

78. Medical wastes cause numerous health risks directly or indirectly. There is risk of spread of infection through poorly managed (i) sharp waste (e.g., hypodermic needles, scalpels etc.); (ii) chemical waste (e.g., reagents, solvent etc.); pathological waste (e.g., human tissues, body parts, fetus, etc.); (iii) infectious waste (e.g., blood and body fluids etc.); (iv) pharmaceutical waste (e.g. outdated medications, etc.); and (v) waste with high heavy metal content (e.g., batteries, thermometers etc.). Unhygienic and unsanitary conditions at healthcare facilities can increase the risk and potential for patients to get Hospital Acquired Infections.

79. Poor infection control and occupational health and safety practices due to lack of usage of Personal Protective Equipment (PPE) and lack of training, awareness and understanding of health risks of such poor practices can contribute to increased risk of infection in healthcare facilities. When the workers expose to the hospital environment and do not use appropriate personal protective equipment (PPE) they become vulnerable to different diseases.

80. Additional poor practices with regard to general (non-infectious) waste, such as inadequate storage, poor collection and untimely disposal can attract stray animals and rag pickers and become breeding grounds for vector-borne, water-based and fecal-oral infections. There is also the risk of contamination of water bodies through inadequate disposal of drug waste, expired pharmaceuticals, heavy metals such as mercury, phenols and disinfectants which can potentially affect a larger community beyond the hospital workers and rag-pickers.

81. The PforR will finance a slice of the GOB's Fourth Sector Program to support provision of services at the upazila and below levels. Such activities will generate healthcare waste and the improper management of this may pose significant environmental risk. In Bangladesh, at the upazila level the low amount of waste generated does not encourage outhouse facilities to be developed as it is not financially viable. Moreover, although the policies and regulations related to HCWM are there, the healthcare waste management and monitoring/enforcement institutions are weak at the central level. The institutional limitations are percolated downwards and also likely to be reflected in the primary healthcare facilities. The volume of waste generated in these facilities will be low and therefore the negative impact will be not be as high as in district hospitals.

82. Activities planned under the proposed PforR will not include any physical interventions such as construction, rehabilitation or renovation works. Hence, negative environmental effects, any loss or conversion of natural habitats, any changes in land or resource use, are not anticipated.

4.1.3 Potential Environmental Benefits and Opportunities

83. The PforR provides an opportunity to enhance systems to ensure provision of safe, clean and hygienic health services while also providing an opportunity to improve measures for waste recycling and minimization. This may reduce the disease burden associated with infection and improve the quality of life. It may also reduce the risk of vector-borne diseases from solid waste dumping sites and pollution of water bodies, which could have a community-wide impact. In-house management should be the only discourse in this case and specific set of activities should follow starting from waste segregation and application of medical waste management guidelines. Since currently the medical waste is inadequately managed in healthcare facilities primarily due to weak institutional monitoring mechanism and inadequate enforcement of existing rules and guidelines, there is scope for improving the scenario and thereby generate a visible positive outcome from this project. Activities associated with the service-delivery related DLIs can increase the use of syringes and sharps, recyclable fluid bags, and consequently increase sharp wastes, recyclable wastes, infectious wastes as well as increase the risk of infection and contamination. Through effective implementation of HCWM activities in line with the GOB's MWM 2008, the risks can be adequately mitigated. Specific activities will include capacity building of relevant personnel, proper segregation of waste, disposal of sharps and introducing deep burial pits for sharps and infectious wastes/body parts.

4.2 Social Risks and Opportunities of the Program

84. Bangladesh has made very good progress in expanding coverage of basic HNP services, but there is a considerable challenges and problems in providing access to services to ethnic minorities, women and other vulnerable groups. Specific regions/districts are also lagging behind the others in this respect. For example, there is a geographical disparity in the proportion of one-year old children covered with all recommended vaccinations as this proportion was 61.1 percent in Sylhet division and 69.4 percent among the lowest socio-economic quintile countrywide in 2014, while the aggregate national percentage was 83.8. Similarly, the proportion of married women (aged 15-49) who currently use modern contraceptive methods increased from 47.3 percent in 2004 to 54.1 percent in 2014. The proportions were 47.2 percent in Chittagong division and 40.9 percent in Sylhet division. (NIPORT *et al.*, 2016).

85. With regard to maternal health care, the proportion of deliveries cared for in health facilities has risen from 12 percent in 2004 to 37 percent in 2014 (NIPORT *et al.*, 2016), but this level is an insufficient basis to assure continuity of care from delivery to emergency obstetric care in order to prevent maternal mortality. Indeed, along with increasing utilization of facility-based delivery care, referral and transport systems as well as capacity for emergency obstetric care, including necessary staff, need to be put in place. Inequalities are also evident, as only 22.6 percent of deliveries in Sylhet division were in a health facility in 2014. (NIPORT *et al.*, 2016)

86. The health and nutrition of adolescents are not adequately addressed, with a variety of repercussions for young women in particular, as well as for their children. Although the incidence of marriage at young ages is slowly decreasing, in 2014, 59 percent of women aged 20 to 24 years were married before the age of 18. Compared to overall averages, young women have higher fertility, experience higher infant mortality, and are more likely to be under-nourished. (NIPORT *et al.*, 2016)

87. Maternal and child nutrition also present continuing challenges. In 2004, 32 percent of women aged 15-49 were under-nourished and this declined significantly to 18 percent in 2014, although continuing progress is needed.

88. Shortage of adequate human resources is another major problem in the Health sector and Bangladesh ranks lowest in the Doctors/Nurses/Dentists per 10,000-population (6.02) amongst Pakistan, India and Sri Lanka (WHO Global Health Workforce Statistics, 2014 update³). According to a WHO estimate, Bangladesh has a shortage of more than 60,000 doctors, 280,000 nurses and 483,000 technologists. This shortage affects the access to health services among ethnic minorities and other vulnerable groups including women.

89. Ethnic and vulnerable communities comprise about less than 1% (3 million) of the population of Bangladesh living mainly in the Chittagong Hill Tracts (CHT) and in rural communities in Mymensingh, Sylhet, Dinajpur and Rajshahi. There are 45 recognized distinct ethnic groups living in 28 districts of Bangladesh. Of the 45 tribes, 13 are living in 3 CHT districts: Khagrachari, Rangamati and Bandarban. The largest groups are the Chakmas, Marmas, and Tripuras. The other 32 ethnic communities are scattered in 25 districts. There is a good concentration of Khasia and Monipuris in Sylhet division. These small ethnic and vulnerable communities have distinct identities, specific racial backgrounds, different languages, and distinct heritage and culture. They differ in their social organization, marriage customs, birth and death rites, food and other social customs from the people of the rest of the country.

90.

91. Small and ethnic vulnerable community (tribal people) have their own practices and may not be able to access mainstream services. Specifically, small and ethnic vulnerable community groups in CHT live in small clusters in hard to reach areas that are often difficult to cover by the health facilities. The areas they inhabit, especially in CHT, are less likely to have improved infrastructure (like roads, schools, water supply and sanitation, health care facilities) due to the difficult geographic terrain. In two districts, Rangamati and Khagrachari, many of the small ethnic and vulnerable people live on hilltops that dot the vast expanse of waters. For them small country boats are the only means of transportation. The PforR will support the GOB in improving maternal and child HNP services in Sylhet and Chittagong, as well as strengthen health systems. Based on the available data, there is no evidence of any discrimination or barrier to access healthcare specifically for the small ethnic and vulnerable communities. In the following sub sections, relevant DLI specific risks are identified and discussed.

92. Effective Grievance Redressal System (GRS). The GOB is committed to effective Grievance Redressal System (GRS) in its service delivery and has made arrangements of grievance and complaints using phones and SMS and web based platforms. However, the system is yet to be fully developed and made functional. At service provision and decision making levels, limited information on grievances and complaints are available resulting extremely limited or no action to redress grievance. DLI 1 will support the MOHFW in strengthening its GRS, thereby enhancing greater responsiveness and transparency to the public.

93. Ensuring gender friendly HNP services: There is a shortage of female medical personnel. Owing to religious bindings, social taboos etc., women and girls including adolescents prefer

³<http://www.who.int/hrh/statistics/hwfstats>

interacting with female doctors. A large number of female doctors do not stay in the remote areas citing family restrictions, poor schooling facilities for children, security at the workplace etc. to address this, DLI 9 aims at increasing the number of upazila health complexes with at least two midwives on staff.

94. Inadequacy of essential specialists at the District level public hospital: There is a shortage of specialist doctors at the district hospitals. Being the referral healthcare facility (from the community and upazila level facilities), the district hospitals cater to a large number of people who belong to the lower wealth quintiles particularly women, adolescent girls, children, elderly, the mentally sick including autistic patients as well as tribal people. DLI 10 intends to increase the number of essential specialists at the district level public hospitals.

95. Lack of effective Reporting System in the Healthcare System. The information systems are fragmented in the MOHFW and there is a need to avoid duplication of data. DLI 11 focuses on number of CCs reporting to District Health Information System 2 (DHIS 2) on an agreed format with gender disaggregated data. This will assist in formulating gender specific and gender sensitive policies.

96. With regard to social safeguards, the results areas to be supported by the PforR would have positive impacts through its support to civic engagement, increasing voice and accountability, as part of the proposed Results Area on strengthening governance and stewardship. It will also strengthen the focus on improving equity by linking disbursement with improved results in the low performing Upazila of Sylhet and Chittagong Divisions, which are also home to Bangladesh's small ethnic and vulnerable communities (tribal groups).

97. The PforR will directly benefit the ethnic minorities groups, women and other vulnerable groups who would seek services from these local health service providers. This support will take forward the government's Gender Equity Strategy and Action Plan (2014–2024) that has strategic objectives to strengthen gender aspects of the program, including health sector response to victims/ survivors of gender-based violence. This strategy aims to introduce gender-sensitive policies, plans and evidence-based approaches; ensure equitable access and utilization of services using a life-cycle approach aiming to protect the health of young girls, adolescents and elderly women within a rights-based approach; and mainstream gender in all programs of MOHFW with a specific focus on gender-sensitive planning and ensuring gender-balanced human resources. Specifically, the PforR will support implementation of the Strategy by ensuring that gender disaggregated data is inserted in DHIS2 by the community clinics (DLI # 11). This DLI has the potential to monitor and influence gender related discussions and policy decisions. A number of DLIs will help increase access to health services for women. Improved service delivery will in turn result in rights awareness and demand for better services amongst the small ethnic and vulnerable community groups, women, the adolescents and children in the geographic divisions of Sylhet and Chittagong that also houses the IP. DLI # 9 aims at deploying female midwives at upazila health complexes, which will contribute to the expected result of making the services more woman-friendly for institutional delivery. DLI # 13 will increase readiness of health facilities to provide family planning services to married couples right after a child's birth; DLI # 14 will increase capacity of health facilities to provide emergency obstetric care; DLI # 16 aims at developing a school-based adolescent girl health program; while DLI # 17 will improve nutrition services for mothers and pregnant women.

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SECTION V: OPERATIONAL PERFORMANCE AND INSTITUTIONAL CAPACITY ASSESSMENT

98. The World Bank’s Policy for PforR Financing requires that all PforR operations to ‘Operate within an adequate legal and regulatory framework to guide environmental and social assessment at the Program level’. Drawing on the information and analysis presented in the preceding sections, the analysis presented here assesses the Program systems’ consistency with each of the six Core Principles outlined in the Bank Policy Program for Results Financing.

Core Principle 1: General Principle of Environmental and Social Management

Environmental and social management procedures and processes are designed to (a) promote environmental and social sustainability in Program design; (b) avoid, minimize or mitigate against adverse impacts; and (c) promote informed decision-making relating to a program’s environmental and social effects.

Program procedures will:

- Operate within an adequate legal and regulatory framework to guide environmental and social impact assessments at the program level.

Incorporate recognized elements of environmental and social assessment good practice, including (a) early screening of potential effects; (b) consideration of strategic, technical, and site alternatives (including the “no action” alternative); (c) explicit assessment of potential induced, cumulative, and trans-boundary impacts; (d) identification of measures to mitigate adverse environmental or social impacts that cannot be otherwise avoided or minimized; (e) clear articulation of institutional responsibilities and resources to support implementation of plans; and (f) responsiveness and accountability through stakeholder consultation, timely dissemination of program information, and responsive grievance redress measures.

Applicability

Core Principle 1 is applicable for the environmental and social management for the health sector improvement program. The healthcare waste management will be the key issue in environmental management to promote sustainability of the proposed program and adequate safeguard measures should be in place to avoid adverse impacts of infectious and hazardous waste.

With regards to social safeguards, the IPs, women and others VGs will be the key focus of the Program. The THNNP (developed by the GOB during the 3rd sector program period) and other measures to enhance access to services by VGs will enable compliance of Core Principle 1

Analysis

- Adequate legal provisions are there to safeguard against adverse impacts of pollution activities (Environment conservation Act 1995, ECR 1997) and for the management of medical waste (MW Rules 2008). The Department of Environment is mandated to take necessary actions for violations of the provisions of the abovementioned acts and rules. Additionally, there are HCWM guidelines issued by DGHS that basically addresses operational procedures for handling and disposal of various types of medical wastes. So the program will operate within an adequate legal framework to guide environmental impact assessment.
- Since the activities will involve small-scale renovation and no new civil works, there is no requirement for explicit environmental screening and EIA.
- IEC materials and technical resources/manuals, modules of training for MWM are available, online record-keeping, reporting and monitoring system for in-house waste management have been developed by DGHS. These can aid in mitigating adverse environmental impacts from handling healthcare wastes.
- There is lack of clear articulation of institutional responsibilities and resources to support healthcare waste management. Weak institutional capacity, including insufficient allocation of financial and human resources in medical waste management could offset the progress and improvement in the quality of health service delivered; and could potentially result in unacceptable health and performance indicators. The proposed PforR will not support any

structural measures (incinerators, development of out-house HCWM facilities in Sylhet and Chittagong).

- Stakeholders have been consulted with regarding the risks associated with the project. ESSA report will be disclosed according to the disclosure policy of the World Bank.
- The program will develop a grievance redress mechanism
- The THNNP has not been implemented yet and there is a lack of human resources who are sensitive and aware of special needs of the tribal population

Core Principle 2: Natural Habitats and Physical Cultural Resources

Environmental and social management procedures and processes are designed to avoid, minimize and mitigate against adverse effects on natural habitats and physical cultural resources resulting from program.

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Not applicable. The proposed program investments would neither impact nor convert critical natural habitats, does not generate any adverse impact on terrestrial flora. The program will not support civil works. There will not be any adverse impacts on physical cultural resources.

Core Principle 3: Public and Worker Safety

Environmental and social management procedures and processes are designed to protect public and worker safety against the potential risks associated with (a) construction and/or operations of facilities or other operational practices developed or promoted under the program; (b) exposure to toxic chemicals, hazardous wastes, and otherwise dangerous materials; and (c) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

Applicability:

The Program will not support new construction and major civil works and therefore there are no issues associated with public and worker safety during construction activities. Also, no reconstruction or rehabilitation will take place in natural hazard-prone areas. But Core Principle 3 will be applicable because medical waste generation under the proposed program may expose a certain group of people to toxic, hazardous and radioactive material.

Analysis:

The following poor operational practices and non-compliance issues related to HCWM can create safety concerns for workers (nursing staff, ward boys) and general public (patients, people living in surrounding area, scavengers and rag-pickers):

- Poor practices related to infection control and management of healthcare waste, including inadequate segregation, and unmethodical methods of collection, storage and disposal.
- lack of awareness of healthcare staff and workers with regard to occupational safety and infectious waste management practices, inadequate transfer of knowledge to ward boys and sweepers from the healthcare staff
- Involvement of unauthorized persons in waste handling, pilferage, reluctance to destroy/dispose the needles/sharps, improperly designed sharps bins, lack of uniformity of color-coding of bins among healthcare facilities creating confusion, lack of visibility of IEC materials, defunct waste trolleys, lack of adequate PPEs available in large government hospitals -in public healthcare facilities
- improper disposal of medical waste exposes general public to infection-related risks.

Core Principle 4: Land Acquisition

Land acquisition and loss of access to natural resources are managed in a way that avoids or minimizes displacement, and affected people are assisted in improving, or at least restoring, their livelihoods and living standards.

Not applicable. The Program will not support any activities such as civil works that will require land acquisition. In the absence of any civil works, the risk of impacts on loss of land/asset/ formal and informal livelihood etc., from land acquisition is not likely. This principle therefore does not apply to the Program as no land will be acquired and there will be no economic or physical displacement.

Core Principle 5: Small Ethnic and Vulnerable Community

Due consideration is given to cultural appropriateness of, and equitable access to, program benefits giving special attention to rights and interests of small ethnic and vulnerable community (tribal people) and to the needs or concerns of vulnerable groups.

- Undertakes free, prior, and informed consent if small ethnic and vulnerable community (tribal people) are potentially affected (positively or negatively) to determine whether there is broad community support for the program.
- Ensures that small ethnic and vulnerable community (tribal people) can participate in devising opportunities to benefit from exploitation of customary resources or tribal knowledge, the latter (tribal knowledge) to include the consent of the small ethnic and vulnerable community (tribal people).

Gives attention to groups vulnerable to hardship or disadvantage, including as relevant the poor, the disabled, women and children, the elderly, or marginalized ethnic groups. If necessary, special measures are taken to promote equitable access to program benefits.

Analysis:

While considering the applicability of this Core Principle, the analysis found that this principle is relevant. There is a need to ensure that vulnerable and marginalized groups, including small ethnic and vulnerable community (tribal people), are included in the planning process (especially needs prioritization), implementation and monitoring of program activities; Specifically, in such participation and subsequent decision making, adopting the principles of “free, prior, and informed consent” of small ethnic communities should be institutionalized. Moreover, other vulnerable groups have access to program benefits; and that the needs of vulnerable groups are considered with respect to the Programs impacts. The ESSA analysis of vulnerable groups focused on small ethnic and vulnerable communities living in both Hill Tracts and plain districts of Chittagong and Sylhet divisions. In addition, the problems faced by senior citizens, sexual and gender minorities, and people living in remote regions, poor, unreached groups, and underserved areas have also been discussed with the stakeholders.

Findings indicate that the legal and policy framework as well as the political commitments to gender and social inclusion have laid down the foundation addressing gender and social exclusion issues in the health sector and integrating GEVA and social inclusion into systems and services. An initial institutional structure for GEVA and social inclusion mainstreaming has also been established at the ministry level. However, weak institutional capacity, including insufficient allocation of financial and human resources to reach vulnerable groups; incipient stages of GEVA and social inclusion mainstreaming; shortage of skilled workers, drug stocks, ancillary health facilities, referral services, and other services required by vulnerable groups; centralized programming which undermines localized management of resources according to the local priorities and needs; high opportunity cost (e.g., wage loss) while seeking care and high out of pocket expenditure; harmful cultural practices and stigma associated with particular services (e.g., family planning); inability of women to make independent decisions on matters related to their own health, especially sexual and reproductive health; inappropriate attitude and behavior of health service providers; inconveniently located or distant health facilities, are some of the factors that impede effective health service delivery to vulnerable groups despite the fairly strong institutional and policy framework for mainstreaming GEVA and social inclusion.

According to present healthcare system of the GOB, there is top down approach from the MOHFW up to the Upazila level where effective functionality of the service providers at different tiers are

governed by the official oversight. Only at the community level, there is citizen oversight at the CCs. This means that GRS and peoples' participation is most effective at the CCs.

GoB has articulated relevant Policies for addressing the small ethnic and vulnerable community and the VG healthcare issues following Core Principle 5. GoB is focused on Tribal HNP Plan (THNPP), thus providing the interface for effective implementation of HNP program in tribal areas and for tribal people. Internal administrative and regulatory mechanisms need to be flexible to allow oversight of the UHC and related facilities.

The hierarchy in the tribal areas is based on traditional leadership. The 'Headman' leads a village/ cluster of dwellings while the Karbari commands number of villages through the Headman among small ethnic and vulnerable communities in Chittagong Hill Tracts areas. The small ethnic and vulnerable communities are respectful to the leadership chain and that addresses the issues of the VG amongst them.

The small ethnic and vulnerable communities inhabited areas being different from other parts of Bangladesh, demand that being different from other areas of Bangladesh, a mechanism should be developed allowing more people's participation including the adoption of free prior and informed consent principle. In Hill districts, the Hill District Council may active play a supervisory role of the UHC and related Family Planning facilities to ensure effective delivery of healthcare services.

Access to Healthcare is a major concern for the small ethnic and vulnerable communities due to geographical and cultural practices. Since they reside in difficult terrain, most of the moves are on foot and this impedes the movement of the children, pregnant women and the elderly to the CC and the UHC for seeking PHC. However, GoB is working to connect the Unions with the Upazila through the road network. A modality is needed where Health Assistants and FWAs may be asked to visit villages on regular interval thus covering inaccessible areas. Here the focus should be to take PHC to the doorsteps of the inhabitants rather than they reach the CC and the UHC.

The healthcare personnel from the plains are often disinterested to work in the small ethnic and vulnerable communities inhabited areas owing to limited civic facilities and comparatively difficult living condition from the plains. MoHFW may come up with attractive packages/ incentives/ service privileges for the ones working in this region.

While the small ethnic and vulnerable community residing at CHT are important, there are also small ethnic and vulnerable communities living in plain land of Sylhet division. The GOB needs to make similar service provisions and practice of "free, prior and informed consent" of these plan land small ethnic and vulnerable communities (e.g. Khasias and Monipuris).

Core Principle 6: Social Conflict

Avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.

Not Applicable: The Program will not entail social conflict in fragile states, post-conflict areas or areas subject to territorial disputes. However, the Program seeks to address issues of distributional equity thus risking social conflicts between groups that have captured health-care resources thus far and vulnerable groups who have been marginalized from accessing health care services. In this regard, the ESSA did not consider the Program with regards to Core Principle 6 but issues of distributional equity and cultural sensitivities are covered under the analysis of system with respect to the main considerations of Core Principle 5.

SECTION VI: RECOMMENDED MEASURES TO STRENGTHEN SYSTEMS PERFORMANCE

99. The Program ESSA analysis presented in preceding sections identified the potential risks, opportunities and analyzed the compatibility of the program with respect to the Core principles. Based on the above findings, this section outlines recommended actions for improving the social and environmental management systems, where appropriate. These options for improvement of the environmental and social management system (ESMS) have been discussed with the implementing agencies.

Measures to strengthen system performance for environmental and social management

Objective	Measures
Environmental systems management:	
Strengthen policy and legal framework	Under the existing regulatory framework, the health facilities that generate medical waste are not sufficiently held accountable for proper handling and managing of medical waste. At the upazila level, the health facilities can be made more accountable by ensuring proper record-keeping, assigning a focal person for supervision of medical waste management (MWM) activities, and constructing burial pits for sharps and infectious wastes.
Strengthen institutional capacity and compliance	Improve health care waste management, particularly focused on the Upazila Health Complex and below, by ensuring: <ul style="list-style-type: none"> • use of color-coded bins in health facilities in accordance with Medical Waste Management Rules 2008; • segregation of waste in all facilities by using the established color coding system and recordkeeping of medical waste generated; • storage of waste in designated temporary storage areas before disposal; • destruction of sharps before its final disposal in in-house deep-burial pits as per existing HCWM guidelines; and • availability and visibility of information, education and communication materials on health care waste management in health facilities.
Strengthening implementation	<ul style="list-style-type: none"> • Monitoring and reporting on the implementation of MWM, particularly focused on the Upazila Health Complex and below. • Capacity building for health workers on MWM, particularly focused on the Upazila Health Complex and below.
Budget Allocation	Sufficient budget needs to be allocated to ensure adequate in-house management (construction of burial pits) and capacity building for MWM.
Social systems management:	
Systems for social management and mainstreaming gender, equity, voice and accountability (GEVA)	<ul style="list-style-type: none"> • Citizens' oversight system functioning in the Community Clinics needs to be enhanced in many of the Upazila health Offices, Upazila Health Complexes, Upazila Family Planning Offices and Family Welfare Centers to facilitate enhanced participation in health service governance by citizens. • Five of the DLIs under the PforR will support gender inclusiveness. DLI # 9 aims at deploying female midwives at upazila health complexes, which will contribute to the expected result of making the services more woman-friendly for institutional delivery. DLI # 13 will increase readiness of health facilities to provide family planning services to married couples right after a child's birth; DLI # 14 will increase capacity of health facilities to provide emergency obstetric care; DLI # 16 aims at developing a school-based adolescent girl health program; while DLI # 17 will improve nutrition services for mothers and pregnant women. • GEVA-related activities need to be incorporated in and implemented by the relevant operational plans with a specific focus on issues relating to physical and mental disability, geriatrics and rehabilitation of victims of gender-based violence, as well as addressing the needs of the small ethnic and vulnerable

	<p>community (tribal people). The one-stop crisis centers need to be strengthened further.</p> <ul style="list-style-type: none"> • There is a need to identify health impacts of and related mitigation measures to deal with the effects of climate change including sea-level rise, increase in salinity, frequent storm surges, and rise in temperature.
Budget	The MOHFW will ensure that sufficient budgets are allocated to implement the GEVA-related activities. A Program Action Plan (PAP) will be developed that will include relevant ESSA actions. The PAP will be legally binding.
Technical guidance and implementation capacity	The Health Economics Unit will continue to work with stakeholders to identify barriers faced by vulnerable groups including small ethnic and vulnerable communities and provide technical input to the relevant line directorates to implement GEVA-related activities. The PforR will support the MOHFW in collected gender disaggregated data (through DLI # 11), which can be used for policy decisions.
Systems for information disclosure and stakeholder consultation	DLI # 1, which focuses on strengthening the Grievance Redressal Mechanism of the MOHFW, will enable availability of information on grievances received and addressed and thereby improve transparency and disclosure. The MOHFW will use its existing citizen engagement mechanisms to seek feedback and continue with stakeholder consultations on mainstreaming GEVA and social inclusion activities.

6.3 The Grievance/Complaint Redress Mechanism

GoB believes in free flow of information and people's right to information. In view of ante 'The Right To Information Act, 2009 Bangladesh' came into effect on 6 April, 2009. The right to information shall ensure that transparency and accountability in all public, autonomous and statutory organizations and in private organizations run on government or foreign funding shall increase, corruption shall decrease and good governance shall be established. In the ICT domain, GoB has developed a dedicated web portal (http://www.grs.gov.bd/home/index_english) where the aggrieved ones could ventilate complains and seek remedial measures. All the ministries including MOHFW have also developed GRS mechanism within the ministry to ensure better accountability and transparency. However, owing to the very nature and social standing of the VG and small ethnic and vulnerable communities, most prefer not to complain against any wrongdoing by the HRH fearing repercussion. At the same time, the DGHS and DGFP personnel do not have a functional system to address the complaints received. The DGHS and DGFP need to improve their internal mechanisms to avert wrongdoings by the HRH and establish a functional GRS. The Program needs to sensitize MOHFW on this aspect. The realization of DLI 1 will accelerate these activities.

Communities and individuals who believe that they are adversely affected by a World Bank supported project may submit complaints to existing project-level grievance redress mechanisms or the 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 that determines whether harm occurred, or could occur, as a result of WB non-compliance with its 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 respond⁴.

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⁴For information on submitting complaints to the World Bank's corporate Grievance Redress Service (GRS), <http://www.worldbank.org/GRS>.
For information on submitting complaints to the World Bank Inspection Panel: www.inspectionpanel.org.

ANNEX I: STAKEHOLDERS CONSULTATION

The ESSA process includes extensive stakeholder consultations and disclosure of the ESSA Report following the guidelines of the World Bank’s Access to Information Policy. Feedback from stakeholders has been instrumental in designing and revising the Program Action Plan, indicators, and technical manual.

As the main objective of stakeholders’ consultations was to assess the institutional capacity and present practices of the GOB with regards to compliance with the social and environmental safeguards of the World Bank policies, relevant government officials at the Ministry and different directorate levels as well as development partners, and NGOs were consulted through focused group discussion and individual level interviews. In these interviews, the government officials mentioned that the GOB has made considerable progress in health sector with regards to access to services for vulnerable groups including small ethnic communities. However, the opined that the main problem that the sector faces is the acute shortage of HRH at every level of service delivery starting from specialist doctors to midwives and nurses. Second, due to lengthy process of public procurement system of the GOB, it becomes difficult to make arrangements for necessary medicines and supplies in a timely fashion. Thirdly, the ministry lacks adequate HRH to maintain GRS.

The development partners commented that, while in general the government is committed to inclusion of service recipients in health sector, often innovations towards such inclusion face bureaucratic resistance from service providers. The shortage of skilled manpower and huge number of patients, it often becomes very difficult to make the health services citizen-friendly.

The NGOs and academics that were interviewed opined that they should be included in policy dialogues more frequently than that are practiced now. Research and evidence based policy making should be integrated in healthcare provisions.

In additional to stakeholders’ consultations for ESSA, as part of preparation of the Government’s program, the Ministry of Health and Family Welfare held several consultations in each geographic divisions of the country including Chittagong and Sylhet, to elicit feedback from people on the scope and priorities of the Government’s program. During these workshops, tribal health issues were discussed.

All stakeholders interviewed agreed that GEVA has substantially improved the inclusion and gender mainstreaming in health sector and the 2014-2024 Gender Equity and Action Plan needs to be implemented to ensure compliance with international best practices including World Bank policies. Adequate monetary and human resources should be made available to this end.

The list of key stakeholders is detailed in table below:

Persons met	Organization
1. Brigadier General AhmedulKabir, Ex Chief Engineer, Health Engineering Department	MOHFW; now Bangladesh Army
2. Mr. Kh. AnisurRahman, MBA	PRISM Bangladesh Foundation
3. Professor A.B.M. Abdul Hannan(Former Director, DGHS)	Registrar, Bangabandhu Sheikh Mujib Medical University, Dhaka
4. Professor FerdousArfina Osman, PhD, Department of Public Administration	Dhaka University

5. Dr. Ayesha Afroz Chowdhury, SrAsst Chief, GNSPU	MOHFW
6. MdAshadul Islam, DG HEU and Chairperson GEVATG	MOHFW
7. ShereenAkhter, SrAsst Chief, Planning Wing	MOHFW
8. Marcella Lizana Bobadilla, Lead DP	SIDA
9. Dr. Zahirul Islam,	SIDA
10. MsSathyaDoraiswamy	UNFPA, Bangladesh
11. Dr. ShaminaSharmin, Maternal Health Specialist	UNFPA, Bangladesh
12. Akiko Sakaue, Gender Analyst	UNFPA, Bangladesh
13. Dr. Ueda Naoko	JICA
14. Mushfiqna Z Satiar, Adviser SRHR and Gender	Embassy of the Kingdom of Netherland
15. Dr. Riad Mahmud	UNICEF
16. MsRoshniBasu	UNICEF
17. Mr. Moniruzzaman	WHO
18. Dr. Tomas Zapata	WHO
19. Miranda Beckman	USAID
20. MsSaima Khan	USAID
21. Dr. HalidaAkhter, Chief of Party	USAID-DFID NGO Health Service Delivery Project
22. Dr. Shelina Ahmed, Health and Population Adviser	DFID
23. Dr. S.A.J.M. Musa	UNFPA
24. Dr. BushraBinteAlam, Lead DP of SMTG	WB, Dhaka
25. Mr. Hasib E Chowdhury	WB, Dhaka
26. Mr. MM Reza, CTA, PMMU	MoHFW
27. Mr. Mohammad Mesbahuddin, APR Consultant	MoHFW
28. Mr. A Waheed Khan, P&CA, PMMU	MoHFW
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ANNEX II: REFERENCES

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