



Project Information Document (PID)

Appraisal Stage | Date Prepared/Updated: 23-Jan-2020 | Report No: PIDA27493



BASIC INFORMATION

A. Basic Project Data

Country Bangladesh	Project ID P171648	Project Name Health and Gender Support Project for Cox’s Bazar district	Parent Project ID (if any)
Region SOUTH ASIA	Estimated Appraisal Date 19-Jan-2020	Estimated Board Date 19-Mar-2020	Practice Area (Lead) Health, Nutrition & Population
Financing Instrument Investment Project Financing	Borrower(s) The People’s Republic of Bangladesh	Implementing Agency Ministry of Health and Family Welfare, Government of Bangladesh	

Proposed Development Objective(s)

Improve the access to and utilization of HNP and GBV response services among the host and the displaced Rohingya population in Cox’s Bazar district.

Components

- Component 1: Strengthening integrated HNP & GBV response services in all tiers of health care and in the DRP camps
- Component 2: Strengthening government system’s capacity to deliver enhanced services in CXB
- Component 3: Stewardship, Management and Coordination
- Component 4: Contingent Emergency Response Component

The processing of this project is applying the policy requirements exceptions for situations of urgent need of assistance or capacity constraints that are outlined in OP 10.00, paragraph 12.

Yes

PROJECT FINANCING DATA (US\$, Millions)

SUMMARY

Total Project Cost	150.00
Total Financing	150.00
of which IBRD/IDA	150.00
Financing Gap	0.00



DETAILS

World Bank Group Financing

International Development Association (IDA)	150.00
IDA Grant	150.00

Environmental and Social Risk Classification

Substantial

Decision

The review did authorize the team to appraise and negotiate

Other Decision (as needed)



B. Introduction and Context

Country Context

- Bangladesh has enjoyed relatively high and stable growth over the last two decades, accompanied by fast poverty reduction.** Gross Domestic Product (GDP) grew well above the average for developing countries at around 6 percent per annum since 2000. The poverty rate dropped by a half from 48.9 percent in 2000 to 24.5 percent in 2016.¹ With per capita Gross National Income (Atlas method) at USD1,944 in 2019, Bangladesh has been a lower middle-income country since 2015. Macroeconomic fundamentals have been sound, with inflation under control (5-6 percent) and fiscal deficit at a relatively low level. Growth in manufacturing exports and remittance flows, as well as slow import growth, has kept the external balance, with a comfortable level of foreign exchange reserves (equivalent to 5.8 months of imports as of June 2019).
- Despite robust growth, the pace of poverty reduction and job creation has slowed down.** While the annual GDP per capita growth rate increased to 5.2 percent in 2010-16, compared with 4.9 percent during 2005-10, the pace of associated poverty reduction slowed, especially in urban areas. With rapid urbanization, the absolute number of urban-poor was higher in 2016 than in 2010. The welfare gap between eastern and western Bangladesh has also reemerged, correlated with different rates of progress in demographic change and educational attainment, as well as slower agricultural growth. The pace of job creation in the formal sector also slowed down. Total employment grew only by 1.8 percent between 2011 to 2016, compared with 3.1 percent per year between 2003 and 2010.
- Bangladesh has been coping with a large influx of people displaced from Myanmar.** Since August 2017, 915,000 displaced people from Myanmar are living in Bangladesh, including 34,172 registered before August 31, 2017. The displaced Rohingya population (DRP) have mostly taken shelter in Cox's Bazar district (CXB), with 613, 272 (September 2019²) residing in the large and congested Kutupalong-Balukhali site in Ukhia Upazilla,³ currently the world's largest refugee camp. In Ukhia and Teknaf Upazillas of CXB, the DRP outnumber the host community almost by a factor of four, with 87 percent settled in unplanned camps and the remaining 13 percent living among the host communities⁴.
- Bangladesh is eligible to access financing under the IDA18 Refugee Sub-Window (RSW) for Refugees and Host Communities.**⁵ Firstly, as of September 2019, Bangladesh is hosting an estimated 915,000⁶ displaced Rohingya people and persons living in refugee-like situations from Myanmar's Rohingya community.⁷ Second, the Government of Bangladesh's (GoB) overall framework for the protection of refugees remains adequate based on practices consistent with international standards. The GoB has continued to keep its borders open throughout the crisis, providing safety, shelter and food to the DRP. In 2018, the GoB and UNHCR signed a MoU on voluntary repatriation which has served as the basis for GoB's treatment of the DRP. The MoU includes commitments to ensure the DRP's free and informed choice to return and provide for their safety and security, among other measures. Two coordinated attempts by Bangladesh and Myanmar to repatriate the DRPs back to Myanmar in November 2018 and August 2019 ultimately did

¹ World Bank Poverty Assessment (2019) based on Bangladesh Bureau of Statistics upper poverty line.

² Population Map: UNHCR

³ Upazillas are the sub-district administrative units. Unions are sub-Upazilla administrative units.

⁴ Inter Sector Coordination Group, Situation Report: Rohingya Refugee Crisis, Cox's Bazar, 24 May 2018.

⁵ A country is eligible if (i) the number of UNHCR registered refugees, including persons in refugee-like situations, it hosts is at least 25,000 or 0.1% of the country's population; (ii) the country adheres to an adequate framework for the protection of refugees; and (iii) the country has an action plan, strategy, or similar document that describes concrete steps, including possible policy reforms, that the country will undertake towards long-term solutions that benefit refugees and host communities, consistent with the overall purpose of the RSW.

⁶ 905,822 refugees identified in camps according to the Refugee Relief & Repatriation Officer (RRRC) and UNHCR Registration (including 34,172 registered before August 31, 2017). 9,176 refugees estimated in host communities in Teknaf and Ukhia upazillas (sub-districts) according to UNHCR Family Counting. Inter Sector Coordination Group (ISCG) Situation Report (September 2019).

⁷ The Government of Bangladesh uses the term "Forcibly Displaced Myanmar Nationals", this document refers to the "displaced Rohingya population" (DRP).



not materialize due to the fact that the DRPs chose not to return before the Government of Myanmar addresses key conditions related to their safety, security and basic rights.

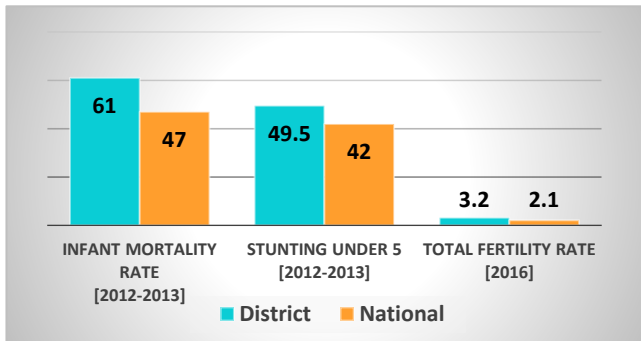
5. **Bangladesh is considered one of the most disaster-prone and climate-vulnerable countries in the world, and subsequently, social vulnerability to disasters and climate change is also high.** Bangladesh faces considerable development challenges posed by its low and flat topography and vulnerability to floods, torrential rains, erosion, storms and tidal surges due to severe cyclones and landslides. Its vulnerability is exacerbated by climate change induced increase in frequency and intensity of extreme weather events, and sea-level rise. Bangladesh is ranked the 6th most climate vulnerable country among 181 countries. Damages and losses associated with a single extreme event impose substantial costs on the national economy.

Sectoral and Institutional Context

6. **Bangladesh has embraced the Sustainable Development Goals (SDGs) for 2030, including SDG 3, which focuses on ensuring health and promoting well-being for all.** Bangladesh's performance against the Millennium Development Goals was impressive relative to the South Asia Region's average for most indicators. A specific SDG objective is to achieve universal health coverage, which encompasses assuring access to Health, Nutrition and Population (HNP) services without causing financial hardship (7th Five Year Plan, Government of Bangladesh).

7. **There has been significant progress in the HNP indicators nationally.** As per the Bangladesh Demographic Health Survey⁸, the proportion of infants fully immunized rose from 73 percent in 2004 to 86 percent in 2017-18⁹, and the proportion of married women using modern contraceptives increased from 47 percent to 54 percent over the same period. However, inequalities persist, for example, 49 percent of stunted under-five children were found among the lowest quintile of socioeconomic status.

Figure 1: HNP Indicators (District and National)



8. **CXB has poorer HNP indicators relative to national averages.** For example, the estimated total fertility rate of 3.2 children per woman (2016) in the district contrasts with the national rate of 2.1. The Multiple Indicator Cluster Survey (2012-2013)¹⁰ found higher infant mortality rate (61 in CXB compared with the national rate of 47 per 1000 live birth); and higher prevalence of stunting among under-five children (49.5 percent in CXB compared with 42 percent at the national level).

9. **Shortage of human resources (HR) and inappropriate skill-mix have led to the constraints in the provision of HNP services in CXB.** In CXB, only about half of the medical professionals' positions are filled.¹¹ HR shortages can be attributed to issues of distribution, deployment and retention, as well as protracted recruitment timelines through the government system. The limited HR available are almost entirely focused on the crisis, leading to inadequate attention for the routine services for the host population. Other constraints include poor conditions of health facilities; inadequate supplies of medicine and commodities and weak health care waste management systems. The MOHFW's administrative capacity, both at district and national levels, has been overstretched due to the crisis. At the same time,

⁸ Bangladesh Demographic Health Survey provides national and division level data only

⁹ Bangladesh Demographic Health Survey

¹⁰ District segregated Data is available in MICS only. The latest MICS is of (2012-2013)

¹¹ MOHFW, Health Bulletin 2016, Cox's Bazar Civil Surgeon Office.



the host population has experienced an increased exposure to infectious diseases, in a situation where high poverty levels already undermine nutritional status and access to health services.

10. **The prevalence of Gender Based Violence (GBV) is high within the host community in Chattogram division¹².** A survey (2015) on violence against women found that 48 percent¹³ of ever-married women in Chattogram division experienced violence. In addition, the provision of GBV response services as part the health system has been limited; approximately 85 percent of the host communities have limited access to GBV response service provision¹⁴. Vital gaps include clinical management of rape, psychosocial support/mental health, and age-appropriate GBV response services for adolescents. In CXB, GBV response services are provided at one One-Stop Crisis Center (OCC) and two One-Stop Crisis Cells¹⁵, that are not adequate to cover the total need for service provision.

11. **The DRP's needs for HNP services are more acute because of their living conditions prior to their arrival, which have been exacerbated by the conditions in the camps.** The DRP includes a large number of women, children and other vulnerable groups, who had poor access to and knowledge about HNP services in the past. Low immunization rates (less than 4 percent) prior to their arrival in Bangladesh makes the DRP children more vulnerable to infectious diseases, as illustrated by the diphtheria outbreak. These contagious diseases pose a risk of spreading to the host population. In addition to water-borne diseases such as cholera, there are seasonal risks of dengue and malaria.

12. **Displaced Rohingya women and girls continue to be vulnerable to GBV.** Approximately 52 percent of the DRP are women and girls, and most have been subjected to GBV prior to fleeing to Bangladesh. While more women are now stepping out of the confines of their homes, stringent social norms, fear of sexual assault, and rising Intimate Partner Violence (IPV) remain as risks.¹⁶ The women friendly spaces (WFS) provide safe spaces, counselling services, limited HNP services, and outreach services. But this support is inadequate to cover the GBV response needs of the DRP.

13. **The World Bank Group (WBG) supports the Government of Bangladesh (GOB)'s Fourth Health, Population and Nutrition Sector Program,(4th HPNSP), 2017-2022,** through the US\$565 million Health Sector Support Project (HSSP) (Credit of US\$500 million, Global Financing Facility of US\$15 million approved in July 2017, and a subsequent Additional Financing (AF) Grant in the amount of US\$50 million approved in June 2018 from the RSW) following a Sector-wide Approach (SWAp). Since 1998, the government and Development Partners (DPs) have pursued this approach, adopting a series of multiyear strategies, programs, and budgets for management and development of the sector, with both government and development partner financing.

14. **Given the evolving nature of the refugee crisis, the World Bank response took a phased approach.** Under phase I, the Bank, through the IDA 18 Sub-window for Refugees and Host Communities¹⁷ is focusing on early recovery interventions and resilience building activities for DRP. These interventions consist of two ongoing additional financing projects in the health and education sectors (US\$50m and US\$25m respectively), and a dedicated Emergency Multi-Sector Rohingya Crisis Response Project (\$165m) to improve disaster and social resilience of DRPs which also includes the construction of 16 new WFS. The phase 1 Health AF focuses on providing health services to the DRP, including GBV response and mental health services through 10 WFS; and also addresses some system challenges in the camps. It also

¹² Cox's Bazar is a district in Chattogram division

¹³ Violence Against Women (VAW) Survey 2015, Bangladesh Bureau of Statistics

¹⁴ Joint Response Plan (2019)

¹⁵ There are currently two one-stop crisis cells – one in Teknaf attached to the UzHC, and one in Ukhia which is mainly for the Rohingya refugees.

¹⁶ UN agencies and local non-government organizations (NGOs) report high levels of GBV among the Rohingya women <https://reliefweb.int/sites/reliefweb.int/files/resources/briefing-violence-against-rohingya-women.pdf>

¹⁷ The Bank made available about half a billion dollars in grant-based support on an exceptional basis



supports a few existing facilities in Ukhia and Teknaf upazillas accessed by the DRPs. The DRPs access those MOHFW facilities, for basic services and are often referred to facilities for higher levels of care. The District Sadar Hospital (DSH) has designated Wards (both female and male) for the DRPs.

15. **Going forward, under phase II, Bank support will adopt a regional development approach to cover the whole of CXB district**, focusing on three areas: strengthening CXB's economy; improving productivity and human capital of both refugees and host communities; and improving social cohesion between DRPs and host communities. The proposed USD 150 million Health and Gender Support Project (HGSP) is one of three operations to be financed in Phase II from the IDA18 regional sub-window for refugees and host communities. The other two operations will focus on social protection (USD 100 million), and further strengthening climate and social resilience (USD 100 million). In parallel, several ongoing Bank projects with national scope have a footprint in CXB region¹⁸, among them: (i) the Multi-Purpose Disaster Shelter Project (MPDSP), supporting disaster preparedness across Bangladesh; (ii) the Sustainable Forests and Livelihoods Project that aims to improve forest management and increase benefits for forest-dependent communities in targeted sites; (iii) the Municipal Governance and Services Project (MGSP), aimed at improving municipal governance and basic urban services; and (v) the Bank is also supporting analytical work that will inform the medium-term planning process.

C. Proposed Development Objective(s)

Development Objective(s) (From PAD)

16. **The project development objective is to improve the access to and utilization of HNP and GBV response services among the host and the displaced Rohingya population in Cox's Bazaar district.**

Key Results

- Number of MOHFW facilities in CXB providing 24/7 normal delivery
- Number of children (0-11 months) in CXB who have received three doses of pentavalent vaccines (disaggregated by gender, host and DRP¹⁹)
- Number of women and girls utilizing GBV response services from the health facilities in CXB (disaggregated by host and DRP)

D. Project Description

17. **WBG grant financing of US\$150 million through the proposed project** will ensure: i) provision of HNP and GBV response services to the DRPs (as opposed to catering to "emergency" needs); ii) response to the "additional" needs of the host population emanating from the resource diversion that has occurred due to the influx; iii) adoption of a more systematic approach to deal with the needs of the DRPs and the host; and iv) provisions for responding to future emergencies through a Contingent Emergency Response Component (CERC). The proposed project will be implemented by Ministry of Health and Family Welfare (MOHFW) building on the experience of the SWAp. It will be closely linked with the ongoing HSSP and the AF to HSSP and has been designed in coordination with other DPs. Multiple rounds of consultations have taken place with all the stakeholders involved to avoid duplication and for a better

¹⁸ These projects provide capacity and financial support to local governments, not specifically focusing on the DRPs

¹⁹ For the DRPs children, it will be the count of all 11-month-old children of the third year of HGSP as for the first two years the immunization cost is being financed through the AF of HSSP.



coordinated approach. Furthermore, USAID, GAC and others may participate through parallel financing for specific activities (under discussion) targeting the host population to complement the interventions proposed under the WBG project. The proposed HGSP will adopt a multi-pronged approach targeting the provision of appropriate HR, readiness of facilities for service delivery, and expansion of services in underserved areas, among others. It will be implemented over a period of three years (2020-2023).

18. **Component 1: Strengthening integrated HNP & GBV response services ²⁰in all tiers of health care and in the DRP camps (US\$100 million).** This component will support strengthening of HNP and GBV response services, through: a) provision of the requisite HR, b) improvement of the physical facilities and c) strengthening behavior change communication, to enable the delivery of quality services for the host and the DRP. For the host population, the service packages to be delivered at the various tiers of health facilities will comprise of a combination of selected elements of MOHFW's Essential Services Package (ESP)²¹, and the GBV Health Response Protocol (see Table 1). Various constraints like HR shortages and inadequate skill-mix, have led to gaps in the optimum delivery of the ESP. Mental health services, psychosocial support and counselling for survivors of GBV, have been identified as areas that have not received adequate attention in the ESP. The proposed project will expand access to and strengthen the provision of HNP and GBV response services at district level and below i.e., DSH, Upazilla Health Complexes (UzHC), Mother and Child Welfare Center (MCWC), Union Health and Family Welfare Center (UH&FWC) and Community Clinic (CC). It will finance the operationalization of the OCC at the DSH with 24/7 GBV response services, and the strengthening of existing cells at two UzHCs, which are barely functioning. In addition, two more one stop cells will be established at two other hard to reach upazillas.

19. **In the camps, the proposed project will finance the following gaps in services :** (i) mental health including psychosocial counselling; (ii) immunization coverage (procurement of Non-GAVI vaccines for the third year, and parallel co-financing of procurement of GAVI Vaccines from 2020), along with vaccination campaigns and related expenses; (iii) tuberculosis (TB) control (mass screening followed by active and passive screening and treatment of identified cases); (iv) Voluntary Counseling and Testing (VCT) including Antiretroviral Therapy (ART) for HIV/AIDS; and (vi) further strengthening of preventive, promotive and clinical nutrition services. The proposed HGSP will build on the efforts of the AF and other DPs and strengthen service delivery by supporting the 35 WFS with required HR and infrastructure renovations to deliver the enhanced HNP and GBV response services to the DRP.

20. **The proposed project will also strengthen care for women, and children suffering from undernutrition** targeting the first 1,000 days of life; emerging diseases like dengue and other climate sensitive diseases (including water and vector borne diseases like diarrhea, dengue and others) for both host and DRP. This integrated modality of service delivery (of HNP and GBV response services) may be expected to be scaled up nationally once it is successfully implemented through the proposed project.

²⁰ GBV response services for DRP will be provided through the WFS in the camps along with the psychosocial at the Health and Family Welfare Centers at the camps. GBV response services for the host will be provided through the OCC at DH, Cells at selected UzHC and primary response at CC and UH&FWC (like emergency contraceptive pills and first aid).

²¹ MOHFW has an approved ESP package. The project will support the provision of ESP package that the government intends to provide with the inclusion of psychosocial counselling and GBV response (following MOHFW's approved protocol for GBV response). The interventions were prioritized in consultation with the government for the different tiers of health facilities given the evolving situation in CXB with the influx of DRP.



Table 1: Proposed ESP and GBV response services at all tiers of health service delivery in CXB²²

WARD LEVEL	UNION LEVEL	UPAZILLA LEVEL	DISTRICT LEVEL	
CC	UH&FWC	UzHC	MCWC	DSH
<p><u>Essential services</u></p> <ul style="list-style-type: none"> RMNCAH: Ante natal care (ANC), Post Natal Care (PNC), Family Planning (FP), Immunization Nutrition: Growth Monitoring and Promotion (GMP), Adolescent and Maternal nutrition, counselling and assessment Non-Communicable Diseases(NCDs): screening Limited Curative care BCC 	<p><u>Essential services</u></p> <ul style="list-style-type: none"> RMNCAH: ANC, PNC, Normal delivery, Essential Newborn Care, Newborn resuscitation, sepsis, Integrated Management of Childhood Illnesses (IMCI), Immunization and FP, Nutrition: Infant and Young Child Feeding (IYCF), GMP, Adolescent and maternal nutrition and counselling, NCDs: screening Limited curative care BCC 	<p><u>Essential services</u></p> <ul style="list-style-type: none"> RMNCAH: Sexual and Reproductive Health services (SRH), ANC, PNC, CEmONC, Essential Newborn Care, Newborn resuscitation, sepsis, IMCI, Immunization, FP and Menstrual Regulation (MR) Nutrition: IYCF, Care of LBW babies, Adolescent and Maternal nutrition and counselling, GMP, management of SAM Communicable Diseases (CD): diagnosis and treatment NCDs: screening, diagnosis and management, Mental health services Inpatient and emergency care Diagnostic services BCC 	<p><u>Essential services</u></p> <ul style="list-style-type: none"> RMNCAH: SRH, ANC, PNC, CEmONC, Essential Newborn Care, Newborn resuscitation, Immunization, FP and MR Nutrition: IYCF, Care of LBW babies, Adolescent and Maternal nutrition and counselling, GMP Mental health services Diagnostic services BCC 	<p><u>Essential services</u></p> <ul style="list-style-type: none"> RMNCAH: SRH, ANC, PNC, CEmONC, Essential Newborn Care, Newborn resuscitation, sepsis, IMCI, Immunization, FP and MR Nutrition: IYCF, Care of LBW babies, Adolescent and Maternal nutrition, GMP, assessment and management of SAM CDs: diagnosis and treatment NCDs: screening, diagnosis and management Inpatient and emergency care Mental health care Diagnostic services BCC <p><u>Additional services</u></p> <ul style="list-style-type: none"> SCANU ICU Coronary Care Unit Blood Transfusion services VCT including ART for HIV/AIDS cases
<p><u>GBV response services</u></p> <ul style="list-style-type: none"> Documentation Provision of ECP Manage minor injuries Referral GBVIMS 	<p><u>GBV response services</u></p> <ul style="list-style-type: none"> Documentation Counselling Provision of ECP Manage minor injuries Follow-up with the survivor Referral GBVIMS 	<p><u>GBV response services</u></p> <ul style="list-style-type: none"> Documentation Counselling Provision of ECP Management of injuries Follow-up with the survivor Referral GBVIMS 	<p><u>GBV response services</u></p> <ul style="list-style-type: none"> Documentation Counselling Provision of ECP Manage minor injuries Follow-up with the survivor Referral GBVIMS 	<p><u>GBV response services through OCC</u></p> <ul style="list-style-type: none"> Clinical Management of Rape DNA testing Documentation Surgical intervention and injury management In patient services Psychosocial Counselling Follow-up with the survivor Casework and follow up counselling GBVIMS – maintaining and collating data across all tiers

(a) Human Resources

21. **Availability of adequate human resource with required skill mix is essential for effective service delivery, lack of which has been a binding constraint in CXB.** Improvements in the delivery of HNP and GBV response services will entail support for required HR, which will be contracted to complement the existing workforce to ensure strengthened and quality services at different facilities by filling in vacancies,

²² Adapted from MOHFW: Essential Health Service Package (ESP), August 2016, and MOHFW: Health Response To GBV: Protocol for Health Care Providers, September 2017



providing staff required to match services in upgraded facilities²³, and to cater to additional needs due to the influx. The OCC at the DSH, and one stop cells at selected UzHCs, will be provided with relevant number of staffs, to make round the clock treatment for GBV survivors more accessible to women and girls in CXB.

(b) Physical facilities

22. **Renovation and refurbishment of physical facilities has been determined based on the detailed assessment of the existing facilities in all eight upazillas of the district.** The renovations will be done using with climate resilient designs to reduce vulnerability of health facilities to natural disasters. The facilities will include solar power for energy efficient lighting, back-up generators, safe water supply and sanitation facilities (segregated toilets for male/female). The civil works will include provision of ramps, rails and appropriate signage where required, to make the facilities disability friendly and universally accessible. The project will fund renovation of accommodation for medical staff to improve HR retention and ensure 24/7 services. The proposed project will finance the continued operations of 35 WFS including minor renovation where required with climate resilient design.

(c). Behavior Change Communication (BCC)

23. **The objective of Behavior Change Communication (BCC) intervention is to improve awareness, attitudes and encourage healthier lifestyles and care-seeking behaviors.** The project will finance the preparation of a comprehensive BCC strategy by integrating the existing strategies being used to address HNP and Gender issues. Various communication and information materials will be developed and disseminated through mass media, social media, print media, billboards and posters. Community-based activities such as street theatre, inter-personal communication and counselling, will be done using culturally sensitive materials, in the local dialect. BCC materials will be provided to address gender issues, inclusion and participation of the communities, while ensuring that men and boys are also engaged, along with women. Community volunteers, health workers and support groups will be mobilized to raise awareness on the benefits of care-seeking practices and to increase the utilization of services provided through the proposed project. In the camps the project will increase access and utilization of services through the community network of case workers, volunteers, religious leaders, majhis and other community leaders. The WFS and their associated volunteer networks will undertake awareness raising and orientation workshops for majhis and religious leaders on gender and GBV issues. These workshops will also cover training on climate and disaster risk resilience; community-based early warning systems of disease outbreaks, cyclones, flood and other natural disasters.

24. **Component 2: Strengthened government system's capacity to deliver enhanced services in CXB (US\$45 million).** This component will finance supporting systems to make service delivery in CXB fully functional. These will include: (a) human resource management and capacity development; (b) supply chain and store management system; (c) management information system; (d) healthcare waste

²³ Some facilities have increased the bed capacity without increasing the technical and support staff required for service provision.



management system; (e) referral system; (f) community/citizens' engagement, participation and Grievance Redressal Mechanism.

(a) Human Resources Management and Capacity Development (HRM&D)

25. **CXB includes remote and hard-to-reach areas where deployment and retention of HR remains a constant challenge.** The problem is further aggravated by inadequate skill-mix, and scarcity of required support staff. In the DSH, there has been an increase in the number of beds, to cater to the increased demand, without sanctioning the corresponding level of HR. Furthermore, at the upazilla level and below, medical staff positions are currently not filled, thereby making 24/7 service provision difficult. The proposed project will support HNP and GBV response services through enhanced HRM&D of the existing and contracted staff at the health facilities, OCC and Cells, to address the issue of skill-mix

26. **Capacity of all categories of health workers will be enhanced** by providing necessary training using standard protocols and training packages as applicable for different types and levels of healthcare. Training on standard protocols for HNP, GBV management, waste management etc. will be provided at regular intervals for relevant staff at all tiers of health facilities. A standardized protocol for HNP and GBV response services will be developed and implemented at the WFS funded by the project. The proposed project will train the Community Support Groups (CSGs) and community volunteers to promote HNP and GBV preventive activities within the communities. In the DRP camps, majhis/religious leaders and community volunteers will be oriented with HNP, gender and GBV issues. The project will also support the capacity building of MOHFW to increase their understanding of climate change adaptation and mitigation issues, such as the deployment of early-warning systems; and to improve the planning for relocation efforts in the event of climate and geophysical hazards.

(b) Supply chain and store management system

27. **This sub component will ensure the availability of essential medicines, other medical supplies and equipment** such as blood pressure machines, glucometers and weighing machines, digital X-ray machines and any other requirements based on need assessments. Systems will be developed in different types of facilities for store management, including inventory management, planning and timely replenishments of stocks. The project will support procurement and supply of medicines and commodities to avoid stock-outs, and to respond to the expected increase in utilization of services as a result of project interventions. Relevant support will be provided for facilities to manage the stocks for medicine and commodities. This supply-chain strengthening support will build on the logistic management system that is currently being followed by Director General of Family Planning (DGFP) and being rolled out at Director General of Health Services (DGHS). Through a parallel mechanism, USAID will provide Technical Assistance to support the implementation of the Logistic Management Information System.



(c) Management Information System (MIS)

28. **Management Information System will be strengthened to monitor activities of the proposed project.** District Health Information System2 (DHIS2) in CXB will be expanded to cover all the facilities at different tiers, focusing on coverage of services. This system will support data collection, recording and generating reports from all the facilities providing HNP services through the project financing enabling the health managers to analyze the data for decision-making. Non-identifying and confidential data for GBV response services will be collected from all levels of the health facilities, the OCC and cells, which will be collated by the OCC. Data from the WFS will be reported by the assigned UN agency. All GBV related data will be managed using the Global Gender Based Violence Information Management System (GBVIMS).

(d) Healthcare Waste Management System (HCWM)

29. **Health facilities produce waste that pose risks not only to the environment, but also to the service providers and recipients.** With the proposed increase in service delivery by the health facilities in CXB, an increase in the quantity of health care waste is expected. HCWM system will be strengthened through the project to ensure sound practices in all health facilities, adhering to safety protocols and procedures. This will include supply of logistics at different tiers of health facilities for segregation of wastes at source, transportation, storage and final disposal. The transportation and treatment of biomedical waste will be supported under the proposed project to reduce the environmental and health risks.

(e) Referral System

30. **The project will establish a structured referral pathway.** Referrals are currently conducted in an informal and undocumented manner. The referral pathway will be strengthened by establishing clear procedures, in accordance with the protocol developed for the proposed project. Patients from the host community requiring higher level of care will be referred to appropriate tier of health facility. DRPs will also avail higher level services as required, outside the camps. Referred GBV survivors will be accompanied by a volunteer to the next tier of recommended care. The referral will be based on the level of service required by care seekers. There are already established GBV referral pathways operating within the DRP camps in collaboration with UN agencies and non-governmental organizations (NGOs), which the project will build upon. If the GBV survivors wish, the health facility will refer them to an NGO for legal assistance.

(f) Community /Citizens' Engagement and Participation

31. **Citizen's engagement with a focus on community participation is a key element of the project to improve service delivery and outcomes.** Citizen's engagement activities in the host population will involve CSGs, a third of which are women. Initiatives will be undertaken to institutionalize regular



meetings of the CSGs with active participation of all members, focusing particularly on the poor, the marginalized, and women; with documentation of minutes and follow-up of decisions. The CSGs will be supported to orient other community organizations like adolescent groups, mosque/market committees in awareness raising, promotion and prevention of HNP and GBV issues, respectively. Client Charter of rights will be displayed at the facilities. Notification of the availability of essential medicines will be displayed at the upazilla level. In the camps, the system of consultation, communication and feedback that has been established and is being followed under the WBG funded projects for the DRP will continue to be supported in order to avoid creating parallel systems. Stakeholder Engagement Plan (SEP) has been prepared and will be implemented throughout the project implementation period focusing on participatory implementation and monitoring.

32. Grievance Redressal Mechanism (GRM) will serve as an integral part of engaging host and DRPs in the project activities and its implementation. The MOHFW uses a web-based, text message and phone call-based platform for grievance redress and citizens' engagement. The HGSP will build on the existing GRM of HSSP focusing on CXB as per the project scope. The project will train staff at the health facilities across different tiers (where necessary) and use the CSGs at the community level as key proponents of the project GRM. The existing systems will be strengthened and adapted for addressing complaints from the DRPs in the camps. The DRP will be better informed about accessing and using the GRM through awareness raising activities. Project level GRM staff who are familiar with the dialect of the DRPs will be recruited. Activities will include raising public awareness of the system and reporting back to the complainant on issues raised. Actions will also include publicly disclosing information on the system, the grievances received, actions taken while maintaining patient privacy and confidentiality.

33. **Component 3: Stewardship, Management and Coordination (US\$5million). The overall responsibility for project implementation, coordination, monitoring and supervision will be with MOHFW**, in close collaboration with MOWCA. The health ministry has been effectively leading coordination of the HNP sector response involving UN agencies and national and international NGOs.²⁴ This component will finance activities for coordination, monitoring and supervision which will facilitate achievement of results supported under components 1 and 2 of the proposed project. This component will strengthen coordination across relevant ministries and stakeholders, including providing relevant support to committees set up from the national to the union level. Monitoring and coordination activities to be financed under this component will include project related travel and meeting costs; training and coordination workshops and training on the use of the systems developed under the project. The component will also finance training on the HGSP program's operations, including Environmental Social Framework, across the different levels of coordination and supervision. The financing will include development of communication materials, knowledge exchange events, technical assistance support for the policy makers and managers. Project supervision activities to be financed under this component will include equipment, computers, hired vehicles costs including rental of office spaces, communications costs, and incremental project-related operating costs. The proposed project will provide the necessary resources to MOHFW and technical assistance to MOWCA to operationalize these mechanisms.

34. **Component 4: Contingent Emergency Response Component (CERC) (US\$0 million). The**

²⁴ See <https://www.humanitarianresponse.info/en/operations/bangladesh/health>.



objective of this component is to cater to unforeseen health emergency needs. In case of a health emergency in CXB, the Government may request the Bank to re-allocate project funds to this component (which presently carries a zero allocation) to support the response. Disbursements under CERC will be contingent upon the fulfillment of the following conditions: (i) the Government of Bangladesh in conjunction with WHO have determined that a health emergency has occurred and warrants a response, and the Bank has agreed and notified the Government; (ii) the Ministry of Finance has prepared and adopted the Contingent Emergency Response (CER) Implementation Plan that is agreed with the Bank; (iii) The MOHFW has prepared, adopted, and disclosed safeguards instruments required as per Bank guidelines for all activities from the CER Implementation Plan for eligible financing under the CERC; and (iv) the expenditures under the component will be to benefit both the host communities and DRP. The project will provide support to improve surge capacity of MOHFW and MOWCA to ensure rapid response during an emergency, including those induced by climate change and natural disasters.

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

Summary of Assessment of Environmental and Social Risks and Impacts

35. WBG financing of \$150 million will support MoHFW to undertake the following four components under HGSP:
- a. Establishing and scaling up the integrated provision of HNP and GBV response services in all tiers of care (district and below) – USD 95 million. This component will support strengthening of HNP and GBV response services along with the provision of the requisite infrastructure (reparation, renovation, refurbishment of existing health facilities and residential accommodation, where necessary with provision of adequate running water, sanitation and power supply) to enable the delivery of quality services. Services will be strengthened at the district level and below in an integrated manner in the four tiers of the district health system.
 - b. Strengthening support systems capacity for HNP and GBV response service provision – 45 million US\$. This component will finance support systems and capacity-building to make the service delivery infrastructure in Cox’s Bazaar (CXB) district fully functional. These support systems will comprise of HR management and development, system for behavior change communication (BCC), MIS, supervision and monitoring system, community/ citizens’ engagement including grievance redress mechanism (GRM), store/ inventory management system, mechanism to address gender issues and referral system.
 - c. Project Management and Coordination– 10 million US\$. Project management under component 3 will be at five levels – ministry, department, division, district and upazila. The



project will be implemented by the MoHFW in close collaboration with MoWCA, but parts of the project will require implementation support from relevant UN agencies (WHO, UNICEF, UNFPA, IOM), which will be contracted by the MoHFW to provide selected services. Coordination will also take place at five levels.

- d. Contingent Emergency Response Component (CERC) - 0 million US\$. The objective of this subcomponent is to cater to unforeseen health emergency needs. In case of a health emergency in CXB, the Government may request the Bank to re-allocate project funds to this component (which presently carries a zero allocation) to support the response.

36. The key environmental impact of the project is the generation of medical, solid and liquid wastes from health services and, noise, construction waste etc. from minor construction, if not properly managed. The healthcare workers, patients, waste handlers, waste-pickers and general population may be exposed to health risks from medical, solid and liquid waste. The baseline illustrates the need for enhanced capacity induction for the healthcare workers (training and awareness raising) and development and implementation of waste management plans and systems in all tiers of health facilities at CXB to deal with the potential excess generation of medical, solid and liquid waste.

37. Given the present state of waste management system and practice, which is below the expected standards as was found from ESA, the HGSP will require the development and implementation of Medical Waste Management Plan (MWMP) and a Solid and Liquid Waste Management Plan (SLWMP), which have been included in the ESA for each health facility. Trainings, awareness raising, inductions and capacity development of health care workers and waste handlers will be included in the plans and recorded in the ESCP.

38. The project also includes minor civil works and the construction works that may cause noise, vibrations and emissions and generate small amount of waste.

39. Considering the potential increase in generation of medical, solid and liquid wastes in health care facilities and existing poor waste management practices in CXB the Environmental risk is rated Substantial.

40. No land acquisition will be caused by the project. The small-scale construction for renovation and improvement of facilities will be within the existing health complexes where no squatters are located.

41. CXB district has few small ethnic and religious minority communities. The ethnic minority communities in the project sub-districts have been identified through extensive consultation while the ESA was conducted. Since the project will not affect these people, an IPP is not required. No cultural heritage will be adversely affected by this Project.

42. The project is situated in a humanitarian crisis area situation and in rural and peri-urban settings, where the prevalence of possible GBV incidents tend to be higher than that of the other areas of the country. One main component of the project includes provisions of GBV response services. These response services would be adequate to mitigate risks of GBV induced by the project itself in all tiers of care in CXB. The project-specific GBV risks have been rated as "low". No stand-alone project specific GRM for GBV will need to be developed. The project's main GRM (which will be an integral part of the project) will be used to address such complaints. If the project GRC receives complaints on GBV, it will refer the case to the project personnel under component



2 (GBV response services in health facilities). The Project will also augment the already existing GBV response related services at DRP camps (through WFS) being provided by a number of NGOs and International Organizations. The GBV risk rating and subsequent measures has been included in the ESA.

43. The project involves a low scale of civil works which comprises of repair/renovation and reconstruction of existing health facilities. Such scale of infrastructural development activities can be handled by the participation of local communities; thus, the influx of outside laborers is not expected. Furthermore, the project will coordinate closely with government officials and other development organizations involved in GBV response services, which have standard rules and protocols they follow for GBV response. All these factors will benefit the project by reducing the GBV risks for service providers, service recipients and the surrounding communities.

E. Implementation

Institutional and Implementation Arrangements

44. **Implementation of the proposed project will be the responsibility of the MOHFW through its existing structures, in close coordination with MOWCA.** The project will be implemented as part of the 4th HPNSP (2017-2022), which was approved by the Executive Committee of National Economic Council in March 2017. There are 29 Operational Plans in the sector program, which detail activities, implementation plans, and budgets. The HGSP will be reflected in the 30th Operational Plan using government procedures, under the responsibility of the designated Line Director (LD), as is the case with the other Operational Plans. LDs report to the DGHS and DGFP, who in turn report to the Secretaries of the Health Service, and the Medical Education and Family Welfare Divisions under the overall responsibility of the Minister, MOHFW. MOHFW will appoint four UN agencies – IOM, WHO, UNFPA, and UNICEF, to carry out specific tasks given their comparative advantage in similar refugee and fragility related contexts in delivering quality and timely work. The tasks to be carried out by the latter agencies will range from repair and renovation works, HR recruitment, gender and GBV response and prevention services, nutrition, immunization etc. MOHFW will monitor the progress of works under the UN agencies. The UN agency responsible for carrying out the gender and GBV response and prevention activities will coordinate closely with MOWCA.

Table 2: Institutional Arrangement

Ministry level: Secretaries, HSD, ME&FWD for overall implementation, monitoring and supervision, in coordination with Secretary, MOWCA
Directorate Level: DGHS, DGFP for project implementation and monitoring
Divisional level: Divisional Director Health for supportive supervision
District level: CS, DDFP and DDWA for monitoring the project interventions
Upazilla level: Health and Family planning officials for implementation and monitoring of the project within their jurisdiction

45. **The coordination and monitoring between MOHFW and MOWCA will take place at the central, divisional, district and upazilla levels for implementation of the interventions for both the host population and DRP.** The two Secretaries, Health Service Division (HSD) and Medical Education and Family Welfare Division (ME&FWD) of the MOHFW will be overall responsible for project implementation, coordination, monitoring and supervision, in close coordination with the Secretary, Ministry of Women



and Children Affairs (MOWCA)²⁵. DGHS and DGFP will be responsible for overall project implementation and monitoring. The Chattogram Divisional Director will provide supportive supervision to the CXB District level Health managers. The Civil Surgeon (CS) and Deputy Director, Family Planning (DDFP) are the responsible MOHFW officials in CXB, managing and coordinating with different stakeholders in the district. The Deputy Director (DDWA), MOWCA, will coordinate with CS and DDFP with respect to the GBV response. MOHFW has been effectively leading coordination of the HNP sector response involving UN agencies and over 100 national and international NGOs.²⁶ The ongoing AF to HSSP has built on these mechanisms which will be further strengthened as the proposed project will include the host population and integrate GBV response in all tiers of health facilities.

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²⁵ MOWCA is the ministry responsible for the formulation of policies that promote the institutionalization and development of women and children issues.

²⁶ See <https://www.humanitarianresponse.info/en/operations/bangladesh/health>.



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