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Report No: PAD4112

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR 149 MILLION  
(US\$200 MILLION EQUIVALENT)

TO THE

PEOPLE'S REPUBLIC OF BANGLADESH

FOR A

URBAN HEALTH, NUTRITION AND POPULATION PROJECT

August 9, 2023

Health, Nutrition & Population Global Practice  
South Asia Region

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## CURRENCY EQUIVALENTS

(Exchange Rate Effective July 31, 2023)

Currency Unit = BDT

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BDT 108.52 = US\$1

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US\$ 1.34294 = SDR 1

FISCAL YEAR

July 1 – June 30

Regional Vice President: Martin Raiser

Country Director: Abdoulaye Seck

Regional Director: Nicole Kligen

Practice Manager: Feng Zhao

Task Team Leaders: Iffat Mahmud, Mickey Chopra

## ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
AM	Accountability Mechanism of the World Bank
ANC	Antenatal Care
CMSD	Central Medical Stores Depot
COPD	Chronic obstructive pulmonary disease
COVID-19	Novel Coronavirus Disease
CPF	Country Partnership Framework
DA	Designated Account
DGHS	Directorate General of Health Services
DHIS2	District Health Information System Version 2
DPP	Development Project Proposal/Proforma
DSA	Debt Sustainability Assessment
EDCL	Essential Drugs Company Ltd
E&S	Environmental and Social
EPI	Expanded Program on Immunization
ESMF	Environmental and Social Management Framework
FM	Financial Management
FMAU	Financial Management and Audit Unit of the Ministry of Health and Family Welfare
FY	Fiscal Year
GBV	Gender Based Violence
GDP	Gross Domestic Product
GRM	Grievance Redressal Mechanism
GRS	Grievance Redress Service
HNP	Health, Nutrition and Population
HPNSP	Health, Population and Nutrition Sector Program
HR	Human Resources
HSD	Health Services Division
ICT	Information and Communications Technology
IDA	International Development Association
IMF	International Monetary Fund
IUFR	Interim Unaudited Financial Report
LGD	Local Government Division
LGI	Local Government Institution
M&E	Monitoring and Evaluation
MoHFW	Ministry of Health and Family Welfare
MoLGRD&C	Ministry of Local Government, Rural Development and Cooperatives
MWM	Medical Waste Management
NCD	Noncommunicable Disease
NGO	Nongovernmental Organization
NPV	Net Present Value
PDO	Project Development Objective
PIP	Program Implementation Plan
PHC	Primary Healthcare

PMU	Project Management Unit
PPP	Public Private Partnership
PPSD	Procurement Strategy for Development
SEA/SH	Sexual Exploitation and Abuse/Sexual Health
STEP	Systematic Tracking of Exchanges in Procurement
SWAp	Sector Wide Approach
TFR	Total Fertility Rate



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## DATASHEET

### BASIC INFORMATION

Country(ies)	Project Name	
Bangladesh	Urban Health, Nutrition and Population Project	
Project ID	Financing Instrument	Environmental and Social Risk Classification
P171144	Investment Project Financing	Substantial

### Financing & Implementation Modalities

<input type="checkbox"/> Multiphase Programmatic Approach (MPA)	<input type="checkbox"/> Contingent Emergency Response Component (CERC)
<input type="checkbox"/> Series of Projects (SOP)	<input type="checkbox"/> Fragile State(s)
<input type="checkbox"/> Performance-Based Conditions (PBCs)	<input type="checkbox"/> Small State(s)
<input type="checkbox"/> Financial Intermediaries (FI)	<input type="checkbox"/> Fragile within a non-fragile Country
<input type="checkbox"/> Project-Based Guarantee	<input type="checkbox"/> Conflict
<input type="checkbox"/> Deferred Drawdown	<input type="checkbox"/> Responding to Natural or Man-made Disaster
<input type="checkbox"/> Alternate Procurement Arrangements (APA)	<input type="checkbox"/> Hands-on Enhanced Implementation Support (HEIS)

Expected Approval Date	Expected Closing Date
30-Aug-2023	31-Dec-2028

Bank/IFC Collaboration

No

### Proposed Development Objective(s)

To improve delivery of comprehensive primary healthcare services for selected urban areas.

### Components

Component Name	Cost (US\$, millions)
Component 1. Improve urban primary HNP services led by the MoHFW	100.00



Component 2. Improve public health services led by the LGD, MoLGRD&C 100.00

**Organizations**

Borrower: The People's Republic of Bangladesh

Implementing Agency: The Local Government Division of the Ministry of Local Government, Rural Development and Cooperative  
The Ministry of Health and Family Welfare

**PROJECT FINANCING DATA (US\$, Millions)**

**SUMMARY**

<b>Total Project Cost</b>	220.00
<b>Total Financing</b>	220.00
<b>of which IBRD/IDA</b>	200.00
<b>Financing Gap</b>	0.00

**DETAILS**

**World Bank Group Financing**

International Development Association (IDA)	200.00
IDA Credit	200.00

**Non-World Bank Group Financing**

Counterpart Funding	20.00
Borrower/Recipient	20.00

**IDA Resources (in US\$, Millions)**

	Credit Amount	Grant Amount	SML Amount	Guarantee Amount	Total Amount
<b>Bangladesh</b>	200.00	0.00	0.00	0.00	200.00
National Performance-Based Allocations (PBA)	200.00	0.00	0.00	0.00	200.00
<b>Total</b>	<b>200.00</b>	<b>0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>200.00</b>



**Expected Disbursements (in US\$, Millions)**

WB Fiscal Year	2024	2025	2026	2027	2028
Annual	10.00	45.00	45.00	50.00	50.00
Cumulative	10.00	55.00	100.00	150.00	200.00

**INSTITUTIONAL DATA**

**Practice Area (Lead)**

Health, Nutrition & Population

**Contributing Practice Areas**

**Climate Change and Disaster Screening**

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

**SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)**

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



**COMPLIANCE**

**Policy**

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

Yes  No

Does the project require any waivers of Bank policies?

Yes  No

**Environmental and Social Standards Relevance Given its Context at the Time of Appraisal**

E & S Standards	Relevance
Assessment and Management of Environmental and Social Risks and Impacts	Relevant
Stakeholder Engagement and Information Disclosure	Relevant
Labor and Working Conditions	Relevant
Resource Efficiency and Pollution Prevention and Management	Relevant
Community Health and Safety	Relevant
Land Acquisition, Restrictions on Land Use and Involuntary Resettlement	Not Currently Relevant
Biodiversity Conservation and Sustainable Management of Living Natural Resources	Relevant
Indigenous Peoples/Sub-Saharan African Historically Underserved Traditional Local Communities	Not Currently Relevant
Cultural Heritage	Not Currently Relevant
Financial Intermediaries	Not Currently Relevant

**NOTE:** For further information regarding the World Bank’s due diligence assessment of the Project’s potential environmental and social risks and impacts, please refer to the Project’s Appraisal Environmental and Social Review Summary (ESRS).

**Legal Covenants**

Sections and Description



The Recipient shall maintain throughout the period of implementation of the Project, relevant line directorates at the MoHFW, with the composition, mandate, functions, staffing and resources satisfactory to the Association for the implementation of Part 1 of the Project. (Section I.A.1 of Schedule 2)

Sections and Description

The Recipient shall establish within 3 months of the Effective Date and maintain throughout the period of implementation of the Project, a project management unit (PMU) at the LGD, with the composition, mandate, functions, staffing and resources satisfactory to the Association for the implementation of Part 2 of the Project. (Section I.A.2 of Schedule 2)

Sections and Description

The Recipient shall maintain throughout the period of implementation of the Project the Urban Health Coordination Committee with the composition, mandate, functions, staffing and resources satisfactory to the Association, and any revisions thereto shall be done in consultation with the Association. (Section I.A.3 of Schedule 2)

Sections and Description

The Recipient shall maintain throughout the period of implementation of the Project, the Urban Health Working Group, with the composition, mandate, functions, staffing and resources satisfactory to the Association, and any revisions thereto shall be done in consultation with the Association. (Section I.A.4 of Schedule 2)

Sections and Description

The Recipient, through the LGD, shall establish a national level committee headed by the Secretary of LGD with representatives of local government institutions, MoHFW, Ministry of Agriculture, Ministry of Environment, Climate Change and Forest, the Economic Relations Division and the Finance Division of the Ministry of Finance, the Socio Economic Infrastructure Division of Planning Commission, the Implementation Monitoring and Evaluation Division of the Ministry of Planning, the Ministry of Housing and Public Works, and other relevant government agencies, and may also establish committees chaired by the respective mayors for regular monitoring of Part 2 of the Project. (Section I.A.5 of Schedule 2)

Sections and Description

The Recipient, shall prepare and adopt a Program Implementation Plan (PIP) for Part 1 of the Project, and a Development Project Proposal (DPP) for Part 2 of the Project, in form and substance satisfactory to the Association (Section I.B.1 of Schedule 2)

**Conditions**

Type	Financing source	Description
Disbursement	IBRD/IDA	No withdrawal shall be made for payments made prior to the



		Signature Date, except that withdrawals up to an aggregate amount not to exceed SDR 3,730,000 may be made for payments made prior to this date but on or after July 1, 2023, for Eligible Expenditures under Category 1. (Section III. B.1 of Schedule 2)
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## I. STRATEGIC CONTEXT

### A. Country Context

1. ***Bangladesh has made rapid social and economic progress in recent decades and reached lower middle-income status in 2015.*** Stable macroeconomic conditions supported average annual real gross domestic product (GDP) growth of 6.7 percent between 2010 and 2019. Strong labor market gains contributed to a sharp decline in poverty, with the national poverty rate falling from 48.9 to 24.5 percent between 2000 and 2016. However, the pace of poverty reduction slowed in recent years even as growth accelerated, particularly in urban areas and in the west of the country. Annual consumption growth of the bottom 40 percent (1.2 percent) trailed that of the overall population (1.6 percent) from 2010 to 2016.
2. ***A strong post-pandemic recovery was disrupted by rising global commodity prices and synchronous global policy tightening.*** Bangladesh navigated the outbreak of the novel coronavirus disease (COVID-19) pandemic with prudent macroeconomic policies, maintaining positive real GDP growth. An effective stimulus program supported a rapid economic recovery in fiscal year (FY) 2021, as movement restrictions ended. However, worsening external conditions led to a surge in imports in mid-FY22. Inflation accelerated, driven by rising commodity prices and an upward adjustment in administered prices of petroleum products. In the first half of FY23, high inflation weighed on private consumption and fiscal consolidation measures slowed government consumption and investment growth. Merchandise exports remained resilient, growing by 7.1 percent in the first eleven months (July–May) of FY23.
3. ***Real GDP growth is expected to decelerate to 5.2 percent in FY23 before returning to its long-term trend.*** Growth is expected to accelerate in FY24, as inflationary pressure eases and reform implementation accelerates, converging to around 6.5 percent over the medium term depending on the depth of economic reforms implemented. The fiscal deficit is projected to narrow to 3.7 of GDP over the medium term as revenues rise with increasing trade and economic activity, higher incomes, and tax administration reform implementation. A financial account deficit that contributed to external sector pressure in FY23 is expected to moderate in FY24.
4. ***Bangladesh is at low risk of overall and external debt distress in the January 2023 joint International Monetary Fund (IMF)–World Bank Debt Sustainability Assessment (DSA).*** Bangladesh is not currently subject to Debt Limits Conditionality under the Sustainable Development Finance Policy. In its most recent staff report, the IMF stressed the need for Bangladesh to accelerate its ambitious reform agenda to achieve a more resilient, inclusive, and sustainable growth, requiring substantial investments in human capital and infrastructure.
5. ***Bangladesh faces a high level of vulnerability to the effects of climate change.*** The Global Climate Risk Index ranks Bangladesh as the world’s seventh most-affected country in 2000-2019.<sup>1</sup> By 2050, the World Bank estimates that Bangladesh could have 13.3 million internal climate migrants. Addressing these climate risks will support sustainable economic development, ensuring that the vulnerable populations are not left behind.
6. ***The country is rapidly urbanizing, exacerbating pollution levels and straining infrastructure and***

<sup>1</sup> Germanwatch. Global Climate Risk Index 2021.



**social services.** The 2011 census indicated that 23 percent of the population lived in urban areas; with an estimated annual growth in the urban population of 3.3 percent, the proportion of the population currently living in urban areas was 31.5 percent<sup>2</sup> in 2022, rising to a majority by around 2030.<sup>3</sup> Between 2019 and 2021, the rate of internal migration from rural to urban areas increased from 4.3 to 9.6 per 1,000 people.<sup>4</sup> Indeed, given low fertility and rural-urban migration, all future population growth in Bangladesh is expected to be in urban areas. Many rural migrants settle in slums, characterized by overcrowding, environmental pollution, inadequate infrastructure, and poor access to services, including health services. It is estimated that one-third of the populations of city corporations live in slums.<sup>5</sup> Urban local governments, called Local Government Institutions (LGIs), are composed of 12 city corporations (representing about half of the country's urban population) and over 300 municipalities.<sup>6</sup>

## B. Sectoral and Institutional Context

7. ***Bangladesh has made significant progress on health, nutrition and population (HNP) outcomes, both nationally and among the urban population, although significant gaps and inequalities remain in coverage among the urban people.*** Consistent with progress nationwide, key reproductive and child health outcome indicators have improved among urban populations in Bangladesh. In the decade between 2007 and 2017-18, the total fertility rate (TFR) among urban populations declined from 2.4 to 2.0 births per woman. The estimated infant mortality rate in urban areas declined from 50 to 42 deaths per 1,000 live births, while the prevalence of chronic malnutrition (stunting) among under-five children improved from 36 to 25 percent.<sup>7</sup> Coverage of all basic child immunizations remained around 85 percent between 2007 and 2017-18<sup>8</sup>, while the proportion of mothers who delivered in a health facility more than doubled from 31 to 76 percent in urban areas between 2007 and 2022.<sup>9</sup> However, there are significant gaps and inequalities in service provision and quality. For example, in 2016, the Dhaka North and Dhaka South city corporations had the lowest levels in the country of coverage of all basic child immunizations. Furthermore, only 40 percent of pregnant women residing in urban slums received four or more antenatal care (ANC) visits compared to 53 percent in non-slums areas in 2021.<sup>10</sup> The TFR increased by 13 percent in urban slums in seven years (from 2.01 births per woman in 2013 to 2.14 in 2021), while teenage pregnancy was 22.1 percent in urban slums in 2021. This may partly be due to conservative gender norms and limited awareness about health information and available services. Besides, prevalence of child marriage increased substantially in 2020 up to 13 percent as girls discontinued school due to the outbreak of COVID-19.<sup>11</sup> This will have an immediate and lifelong consequence on the health status of adolescent girls and their unborn children as child marriages increase the risk of early and unplanned pregnancy, in turn increasing the risk of maternal complications and mortality.<sup>12</sup> Gender based violence (GBV) remains a particular challenge – in 2018, around 50 percent of women reported intimate partner violence

<sup>2</sup> Bangladesh Bureau of Statistics. Population and Housing Census 2022. Preliminary Report, August 2022, doi: [https://sid.portal.gov.bd/sites/default/files/files/sid.portal.gov.bd/publications/01ad1ffe\\_cfef\\_4811\\_af97\\_594b6c64d7c3/PHC\\_Preliminary\\_Report\\_\(English\)\\_August\\_2022.pdf](https://sid.portal.gov.bd/sites/default/files/files/sid.portal.gov.bd/publications/01ad1ffe_cfef_4811_af97_594b6c64d7c3/PHC_Preliminary_Report_(English)_August_2022.pdf)

<sup>3</sup> United Nations, Department of Economic and Social Affairs, Population Division. 2018.

<sup>4</sup> Bangladesh Sample Vital Statistic 2021 and 2019.

<sup>5</sup> 2013 Bangladesh Urban Health Survey.

<sup>6</sup> In addition, there are over 200 other towns and *Upazila* centers that are under the rural administrative structures.

<sup>7</sup> 2007 and 2017-18 Bangladesh Demographic and Health Surveys.

<sup>8</sup> Ibid

<sup>9</sup> 2022 Bangladesh Demographic and Health Survey.

<sup>10</sup> National Institute of Population Research and Training (NIPORT), Urban Health Survey 2021. Dhaka: NIPORT

<sup>11</sup> <https://www.dhakatribune.com/bangladesh/law-rights/2021/03/28/child-marriage-up-13-during-covid-19-pandemic-in-bangladesh>

<sup>12</sup> <https://www.unicef.org/bangladesh/en/press-releases/10-million-additional-girls-risk-child-marriage-due-covid-19-unicef>



during their lifetime, causing around 14 percent of maternal deaths in Bangladesh. GBV survivors often face difficulties in accessing essential services due to social norms and lack of information/awareness.

8. ***There is a need to achieve further progress among urban populations on maternal and child health and address the growing burden of noncommunicable diseases (NCDs).*** In 2017-18, in urban areas, 49 percent of women aged 35 years and older were measured with elevated blood pressure (hypertension), compared to 43 percent in rural areas. Of the urban women diagnosed with hypertension, only a quarter were being treated with medication; this proportion was only 13 percent among men with hypertension.<sup>13</sup> It is notable that indicators of hypertension and diabetes are more prevalent among urban women than among urban men.<sup>14</sup> For NCDs, effective intervention is prevention and maintenance, which require self-care and lifestyle changes. In 2018, 13 percent of adults aged 18 years and over (both female and male) suffered from diabetes in urban areas, with around 60 percent of the diabetic adults unaware of their elevated blood sugar levels.

9. ***Outbreak of emerging and re-emerging diseases exposes vulnerabilities of the urban population.*** Urban areas of Bangladesh, among the most densely populated in the world, face particular challenges with infectious diseases, notably water-borne diseases, dengue, and COVID-19. Bangladesh had successfully contained dengue incidence since the first official outbreak in 2000 with fatalities kept low. This disease is reemerging with large outbreaks and a high number of deaths recorded in recent years – 86,833 cases and 364 deaths recorded in Bangladesh in 2022. The urban areas bear a bigger brunt of this, for example, in 2019, 101,354 dengue cases were reported with 164 deaths, with half of the total cases and three-quarters of total deaths recorded for Dhaka.<sup>15</sup> Measures for disease and vector surveillance as well as mosquito management in urban areas are insufficient. Climate change and variability, unplanned rapid urbanization, high population densities, insufficient preparedness, including inadequate public health infrastructure and suboptimal vector-control programs, are factors that contribute to the magnitude and severity of dengue outbreaks in Bangladesh.<sup>16</sup>

10. ***Environmental conditions pose a challenge for the urban areas, particularly inadequate management of medical waste and the effects of climate change on human health.*** Climatic conditions have shifted considerably in Bangladesh with the indirect effects of such changes on human health being experienced more by the urban population.<sup>17</sup> For example, in 2019, the incidence of vector-borne diseases was higher in Dhaka and Chattogram cities (34 percent) compared to the national average (25 percent) and rural areas (22 percent) in monsoon when vector-borne diseases are more prevalent. Air and sound pollution pose great health risks to the urban residents due to persistent traffic, major construction, brick kilns, and industrial sites. Another area of concern in urban areas is medical waste posing health hazards for the general population which can also release harmful greenhouse gases in the air and spread diseases/infections if not managed properly. In 2015, only half of infectious waste generated by health facilities in Dhaka was managed according to acceptable standards, while non-infectious wastes are collected by the city corporations from the health facilities and mixed with general waste.

<sup>13</sup> 2017-18 Bangladesh Demographic and Health Survey; World Bank. 2018. Hypertension and Type-2 Diabetes in Bangladesh: Continuum of Care Assessment and Opportunities for Action.

<sup>14</sup> 2017-18 Bangladesh Demographic and Health Survey.

<sup>15</sup> Health Emergency Operations Center and Control Room of the Directorate General of Health Services

<sup>16</sup> Hasan, K., Hossain, M.M., Sarwar, M.S., Wilder-Smith, A., Gozal, D., 2019, Unprecedented rise in dengue outbreaks in Bangladesh, The Lancet, Vol 394 December 14, 2019

<sup>17</sup> Mahmud, Iffat, Wameq A. Raza, and Md Rafi Hossain. 2021. Climate Afflictions. International Development in Focus. Washington, DC: World Bank. doi:10.1596/978-1-4648-1764-9.



11. **Government primary health care (PHC) services are underdeveloped in urban areas, leading to significant use of private sector providers and high household spending on health.** The government health system in rural areas is well developed; a comparable system is not in place in urban areas, where government health services are largely confined to hospitals and a limited number of primary-level facilities. There are only 35 primary-level clinics called government outdoor dispensaries covering all urban cities of Bangladesh that are owned by the Ministry of Health and Family Welfare (MoHFW). Out of these 35 government outdoor dispensaries, 17 are in Dhaka North and Dhaka South city corporation areas (catering to approximately 10.2 million people<sup>18</sup>) and nine in Chattogram city corporation area (for more than 3.9 million people<sup>19</sup>). These government outdoor dispensaries along with the outdoor department of tertiary-level facilities constitute the public HNP service delivery model and the nongovernmental organizations (NGOs) and the private sector fill the major gap. The government outdoor dispensaries and outpatient services at the tertiary hospitals are available only in the morning hours and the tertiary hospitals are often over-crowded with people seeking primary care from specialist doctors. The Ministry of Local Government, Rural Development and Cooperatives (MoLGRD&C) is providing selected PHC services through NGOs in specific areas of 12 city corporations and 13 municipalities financed by the Asian Development Bank (ADB). The urban population, particularly the poor, thus must rely on for- and non-profit private sector for health services. In 2021, for example, 53.5 percent of the urban poor residing in slums sought ANC from the private sector, 30.8 percent from an NGO and 23.1 percent from the public sector.<sup>20</sup> Similarly, the largest source of modern contraception for urban poor in slums was the private sector in 2021 – 78.2 percent from the private sector (particularly the pharmacies) compared to 14.6 percent from a government health facility.<sup>21</sup> The private sector services are more expensive than the government or NGO services.<sup>22</sup> Quality of care delivered by the NGO/private sector is variable while the NGOs provide only a limited set of services related to PHC. Despite the high costs and due to unavailability of a more affordable health care service, the urban poor are compelled to use the private sector that substantially increases household expenditure on health and often pushes families into poverty. Nine percent of urban households and 16 percent of rural households incurred catastrophic health expenditures (equivalent to 10 percent or more of total household expenditures) in 2010, estimated to push 3.5 percent of the population below the poverty line.<sup>23</sup>

12. **While national HNP strategies are well developed, division of responsibility has hampered investment in urban HNP services.** Under the government's Rules of Business (1996), the MoHFW is responsible for health services nationally, while 2009 legislation assigns LGIs (municipalities and city corporations) various responsibilities for health services.<sup>24</sup> These responsibilities are not defined as exclusive to the LGIs, and indeed, the MoHFW manages urban hospital services, along with 35 urban primary-level facilities (called government outdoor dispensaries) as mentioned above. With some exceptions, LGIs do not have the necessary technical capacities and systems to deliver substantial HNP services. Areas where capacities have been developed include delivery of immunization services (in collaboration with the MoHFW and NGOs), and implementation of a series of projects supporting HNP services provided by NGOs, managed by the Local Government Division (LGD) of the MoLGRD&C. The MoLGRD&C has responsibility for supporting

<sup>18</sup> <https://en.prothomalo.com/bangladesh/city/fzkq4hv4k7>

<sup>19</sup> <https://populationstat.com/bangladesh/chattogram>

<sup>20</sup> National Institute of Population Research and Training (NIPORT). Urban Health Survey 2021. Dhaka: NIPORT.

<sup>21</sup> Ibid

<sup>22</sup> Ibid

<sup>23</sup> 2013 Bangladesh Urban Health Survey; 2012 Bangladesh National Health Accounts; Khan, Jahangir A.M., Sayem Ahmed and Timothy G. Evans. 2017. Catastrophic healthcare expenditure and poverty related to out-of-pocket payments for healthcare in Bangladesh—an estimation of financial risk protection of universal health coverage." Health Policy and Planning. 32: 1102–1110.

<sup>24</sup> Local Government (City Corporation) Act (2009) and Local Government (Municipality) Act (2009).



LGIs in fulfilling their functions. In addition, LGIs hold unambiguous responsibilities related to public health functions like infectious disease vector (mosquito) control, water supply, sanitation, waste management, food safety regulation, etc. but do not have sufficient technical and financial resources to implement these.

13. ***In the HNP sector, the government and development partners, including the World Bank, have supported the government's health sector through a sector-wide approach (SWAp) since 1998, adopting a series of multiyear strategies, programs, and budgets.*** The MoHFW's ongoing Fourth Health, Population and Nutrition Sector Program (Fourth HPNSP) is a national program that covers the period January 2017 to June 2024 and is estimated to cost US\$17.7 billion. The program's objectives, results framework, activities, and budgets are described in a Program Implementation Plan (PIP), which has a financing gap of US\$460 million (closing in June 2024). The MoHFW's Fifth HPNSP (July 2024 to 2029, currently the PIP is under preparation) aims "to expand quality HNP services and strengthen required systems along with governance for improved efficiency and equity" with an estimated budget in the range of US\$24–27 billion.

14. ***Several development partners have been engaged in supporting urban health.*** Since 1998, ADB has been financing the MoLGRD&C's Urban Primary Healthcare Project in 12 city corporations and 13 municipalities to deliver primary health services, which will end in December 2024. ADB is likely to continue financing of urban PHC services beyond 2024 in support of the MoHFW's Fifth HPNSP as well as the MoLGRD&C through a coordinated approach. In addition, the Asian Infrastructure Investment Bank is keen on financing infrastructure for the delivery of urban health services. There is a need to ensure a coordinated approach to the partners' support in urban healthcare delivery.

### C. Relevance to Higher Level Objectives

15. ***The World Bank's strategy for Bangladesh emphasizes enhancing the poverty reduction impact of urbanization by improving urban public services, particularly for the poor, and achieving progress towards universal health coverage.*** One of the main objectives of the World Bank's Country Partnership Framework (CPF) FY23–27 discussed by the Board of Executive Directors on April 27, 2023 (Report No. 181003-BD) is to ensure inclusive and resilient human capital development for stronger socioeconomic resilience. The CPF focusses on investing in early years, gender focused HNP services, and financing for resilient human capital program.

16. ***The project will directly contribute to the priorities identified in the government's Eighth Five-Year Plan, which emphasizes the need to expand urban PHC services and "reprioritization of public health interventions" to improve environmental health.*** Moreover, the project is aligned with the priorities of the National Urban Health Strategy 2020. These policy documents reflect a consensus that has emerged among stakeholders on the major strategic elements of the government's approach to improving urban HNP services including environmental health and preventive services.

17. ***The project is consistent with the priorities of the national climate change policy and strategy,*** particularly the Bangladesh National Adaptation Plan (2023–2050) through its goal 3 (develop climate-smart cities for improved urban environment and well-being by improving human health in urban areas). Health is a cross cutting issue in the National Adaptation Plan. The project is also consistent with the Bangladesh Climate Change Strategy and Action Plan 2008's goal of improving health system adaptation to climate change impacts by addressing climate-sensitive health issues. The project is fully aligned with Bangladesh Country Climate and Development Report's Priority Areas 2 (decarbonization) and 3 (creating an enabling environment



and institutional realignment).

## II. PROJECT DESCRIPTION

### A. Project Development Objective

#### PDO Statement

18. The Project Development Objective (PDO) is to improve delivery of comprehensive primary healthcare services for selected urban areas.

19. For the purposes of the project, comprehensive PHC will include essential services for disease prevention, treatment, health promotion, as well as key public health services.

#### PDO Level Indicators

- (a) Children receiving nutrition services (ages 0-5 years, disaggregated by gender) (number).
- (b) Women receiving four or more antenatal care checkup (number).
- (c) People registered for hypertension screening and follow-up, disaggregated by gender (number).
- (d) Mosquito control unit of the LGD strengthened (yes/no).

### B. Project Components

20. ***The project will target selected urban areas of Bangladesh*** each of which present differing contexts, requiring flexibility in strategies and implementation mechanisms. Within each city corporation, areas targeted for project support will be determined by a mix of factors, including poverty levels, access to existing HNP services, presence of potential platforms for service improvements, and coordinated targeting with other urban development projects. Project components are as follows.

#### **Component 1. Improve urban primary HNP services led by the MoHFW [US\$100 million]**

21. ***Component 1 will support delivery of essential health services*** in selected urban areas through: (a) establishment of and/or improvement of primary health service delivery networks and arrangement for each catchment area, including by providing training, medicines, equipment, human resources, and other requisite inputs as well as equipping with climate resilient technologies, adequate water and sanitation facilities, and enhanced information and communications technologies at primary HNP centers, mobile and satellite clinics, and referral cells at secondary/tertiary-level hospitals, as relevant; and (b) support for day-to-day administration, management, monitoring, and coordination, including financial management (FM), procurement, monitoring and evaluation (M&E), citizen engagement, and environmental and social (E&S) management.

22. ***The project will support development of primary health service delivery networks arranged in a “hub-spoke” model for each catchment area, whereby several primary HNP centers will be linked to a secondary/tertiary-level facility.*** A selected set of existing government health facilities at the primary level



will be renovated, including government outdoor dispensaries, family planning clinics, and rooms allocated within other health facilities of the MoHFW. For each catchment area, which will be determined based on population numbers and locations of health facilities, there will be a network of primary HNP centers (with at least one female service provider) that will deliver essential health services and be linked to a secondary/tertiary-level facility for referral services. The essential health services will include reproductive, maternal, neonatal, child and adolescent health and nutrition services (including family planning and routine immunization for children), infectious disease services, and services for diagnosis, referral and management of selected NCDs. This will help in decongesting out-patient departments in the existing secondary/tertiary level facilities. Evening shifts will be organized at the primary HNP centers. A system will be established to manage patient referrals to the hospital from the primary level services in the catchment area. The healthcare providers will be trained on screening GBV survivors, providing emergency treatment, and referring for further care. The primary HNP centers will use energy efficient technology, e.g., solar panels, energy efficient bulbs, as feasible. The project will enhance promising information and communications technology (ICT) initiatives to support service delivery, management, and data reporting to the Directorate General of Health Services (DGHS)'s district health information system version 2 (DHIS2) and the adoption of the shared health record systems. Data protection and confidentiality will be ensured in line with the national rules and policies including the National ICT Policy 2018 and Digital Security Rules 2020.<sup>25</sup> For community engagement and outreach, a cadre of community health workers/volunteers, recruited from the target community, preferably female, will be trained and deployed with proper monitoring and supervision. Satellite clinics will be arranged to cover low-income groups particularly around the slum areas while mobile clinics will target street dwellers and homeless people. The use of ICT and investments in energy efficient technology and water supply and sanitation facilities will improve working conditions, security, and the quality of services, particularly for women and girls. A user/beneficiary satisfaction survey will be conducted to monitor quality of services and seek citizen feedback.

## **Component 2. Improve public health services led by the LGD, MoLGRD&C [US\$100 million]**

23. ***Component 2 will support delivery of environmental health and preventive services in selected urban areas*** through: (a) development and implementation of a comprehensive strategy for integrated vector surveillance and management, including capacity building and institutional strengthening; (b) support for behavior change communication and outreach interventions, including for air and noise pollution; (c) tree planting; (d) revision and/or development and implementation of strategy, arrangements, practices guidelines, policies, and standards for outhouse medical waste management (MWM); and support for day-to-day administration, management, monitoring, and coordination of the project, including financial management, procurement, M&E, citizen engagement, and E&S management.

24. ***The project will adopt a phased approach.*** For component 1, in the first phase (i.e., the Fourth HPNSP currently closing in June 2024), services will be delivered through ten government outdoor dispensaries and two other health facilities. Technical work to expand HNP services further will also be undertaken in phase 1. In the second phase (i.e., under the Fifth HPNSP July 2024 to June 2029), HNP services will be expanded either through setting-up of new primary health centers, or strategic purchase of services from NGOs/private sector, or a combination, in selected areas. In addition, innovative approaches to service delivery can be initiated, for example, a general practitioner model for service delivery, adopting public-private-partnership (PPP) through financing of services and/or contracting-out arrangements. For component 2, the first phase will cover Dhaka

<sup>25</sup> ICT Division of the Ministry of Posts, Telecommunications and Information Technology, National ICT Policy 2018, dated December 15, 2018; and Digital Security Rules 2020, dated March 8, 2020.



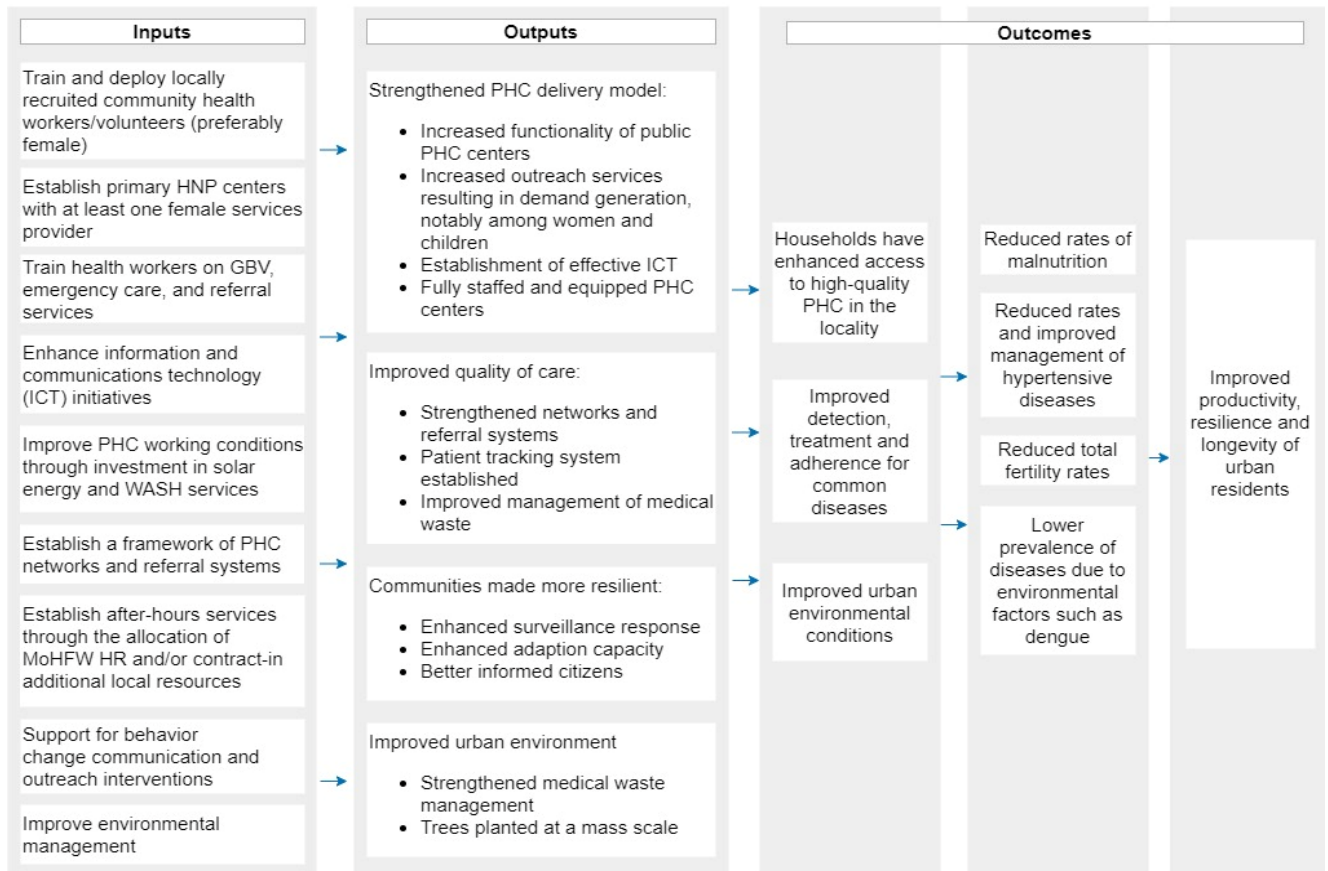
North, Dhaka South and Chattogram cities as well as *Savar* and *Tarabo* municipalities with selected services; while in the second phase, the range of services will be expanded in these areas and interventions will be rolled-out to other cities/municipalities, as feasible.

### C. Project Beneficiaries

25. **The project will benefit the entire population residing in the targeted areas.** Anyone who can access the primary HNP centers will benefit from the services. In addition, environmental health services will benefit all people living in the targeted areas and indirectly benefits will accrue to the entire country.

### D. Results Chain

**Problem statement:** Absence of comprehensive primary health care services in urban areas of Bangladesh.



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

26. **The World Bank has been engaged in the Bangladesh HNP sector since 1975 supporting a series of projects.** Building on this experience and the global knowledge of supporting delivery of PHC in other countries, the World Bank can assist the government in developing a sustainable public service delivery platform for urban PHC, in a pragmatic and flexible way, and pursuing innovative strategies to reduce inequity in coverage and address quality issues. More specifically, the project builds on technical assessment and analytical work completed by the World Bank and partners. It will promote collaboration between the MoHFW and MoLGRD&C, which is inadequate now and is much needed to ensure provision of urban PHC services. In



doing so, the project will provide a solid platform for leveraging resources from other development partners like ADB who are interested to finance urban PHC services and align their support to the MoHFW's Fifth HPNSP and the MoLGRD&C, as well as for bilateral partners to mobilize complimentary technical assistance. Moreover, the project will ensure synergies with other World Bank-financed projects – the Dhaka City Neighborhood Upgrading Project (P165477) under implementation, as well as the Bangladesh Environmental Sustainability and Transformation Project (P172817) and the First Green and Climate Resilient Development Credit (P179079) that are supporting initiatives for better air quality monitoring. In addition, the World Bank is preparing a Program for Results (P180283) operation in support of the Fifth HPNSP to increase access and utilization of quality health services to address priority health conditions with a focus on selected rural areas, thereby ensuring complementarity with the proposed investment operation for urban health.

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

27. **Several lessons have been learnt** from other urban PHC projects that have been incorporated into the current project design including:

- a. Focus upon PHC: Urban health projects that are planned and implemented close to the community level can help to build trust, encourage participation, and ensure that the needs of the community are met.
- b. Addressing environmental determinants of health: Health outcomes in urban areas are often influenced by environmental determinants of health. Urban health projects that address these factors can have a greater impact on health outcomes than those that focus solely on medical interventions.
- c. Collaborative partnerships: Successful urban health projects often involve collaboration between government agencies, community organizations, healthcare providers, and other stakeholders. By working together, these groups can leverage their respective strengths to achieve common goals.
- d. Tailoring interventions to local contexts: Urban areas are diverse, and health interventions that work in one neighborhood may not be effective in another.
- e. Monitoring and Evaluation: Regular M&E can help to identify successes, challenges, and areas for improvement in urban health projects. This feedback can be used to adjust and improve outcomes.

## III. IMPLEMENTATION ARRANGEMENTS

### A. Institutional and Implementation Arrangements

28. **The MoHFW and the LGD will be the implementing agencies for this project.** The MoHFW includes the Health Services Division (HSD) and the Medical Education and Family Welfare Division. Each of the government entities (MoHFW and LGD) will be fully responsible for implementing relevant project-financed activities (while ensuring coordination with each other). Implementation mechanisms will differ according to the existing structures and capacities of each implementing agency. Under component 1, the project will mobilize resources to the ongoing Fourth HPNSP and relevant Line Directorates (LDs) will be responsible for project implementation. After the closure of the Fourth HPNSP, currently scheduled to close in June 2024, the PIP and the relevant operational plan(s) under the Fifth HPNSP (currently under preparation and expected to start implementation from July 2024) will reflect the budget for the project activities under component 1. For component 2 to be implemented by the LGD of the MoLGRD&C, a development project proposal (DPP) will be prepared which will identify the budget and activities for the project. For component 2, a project



management unit (PMU) set-up at the LGD, within three months of project effectiveness, will be responsible for coordinating activities of the city corporations and municipalities. The PMU will also maintain the project account to receive and utilize World Bank funds, prepare financial reports, and undertake procurement of goods, works and services. The PMU will include at least: a full-time project director, a procurement specialist, an FM specialist, an E&S specialist, and an M&E specialist. Each of the targeted city corporations and municipalities will assign focal persons for the project. The PMU can include technical experts with relevant technical qualification and experience (e.g., entomologist, zoologist, researcher, etc.).

29. **Overall technical oversight and coordination will be ensured** by the existing Urban Health Coordination Committee that will meet at least twice a year. For technical oversight the existing Urban Health Working Group will continue to function, which will meet once every quarter. The LGD will establish a national level committee and additional committees chaired by the respective Mayors for regular monitoring of component 2, to meet as frequently as needed. Annex 1 provides details.

## B. Results Monitoring and Evaluation Arrangements

30. **The MoHFW and the LGD will be responsible for their respective components for: (a) collecting and compiling required data for the measurement of project indicators; (b) evaluating results; and (c) regular reporting.** M&E of the project will use indicators already regularly reported by the national health system and existing reporting systems. The MoHFW and the LGD will produce at least annual reports including the status of project indicators and agreed targets, and progress in implementation of critical project activities.

## C. Sustainability

31. **The sustainability of the proposed project is ensured** as the project will support strategies and implementation mechanisms that will be funded, managed, and expanded by the government. This will help catalyze a larger government program to sustainably improve urban primary HNP and public health services in a coordinated manner. The project will mobilize resources to the MoHFW's health sector program (in place since 1998) and develop partnership arrangements for close collaboration between the MoHFW and the MoLGRD&C that is critical for the provision of comprehensive PHC. By ensuring budgetary allocations are reflected in the annual development plans of the MoHFW and LGD, a line item would be created in the national budget, which will ensure continuity of the interventions after project closure.

## IV. PROJECT APPRAISAL SUMMARY

### A. Technical, Economic and Financial Analysis

32. **Investment in the health of urban populations is necessary for improvement in human capital nationally.** Urbanization both accompanies and contributes to economic growth through agglomeration. Economic benefits of agglomeration come about through improved and concentrated access to labor, suppliers, markets and services, easier knowledge exchange, and economies of scale. Simultaneously, the drawbacks of congestion negate the advantages of agglomeration, as the growth and compactness of cities lead to increased expenses and adversely affect the quality of life. Congestion costs can be reduced through planned investment and expansion of services and physical infrastructure by the government, thereby



harnessing the economic and social benefits of agglomeration.<sup>26</sup>

33. ***Supporting the development of a sustainable platform for service delivery will contribute to a healthier, and more productive population, and assist in the achievement of universal health coverage.***

There is a strong rationale for public sector financing and provision of urban PHC with the most compelling reason being the arguments of health as a basic human right and equity in access to health care. In addition, from an economic perspective, public provision of health care is justified on several grounds:

- a. ***Poverty alleviation and increased welfare through better health outcomes and greater equity.*** The Bangladeshi population bear a significant portion around 74 percent of health expenditure in 2020 out of their own pocket.<sup>27</sup> Provision of healthcare through the government outdoor dispensaries and health facilities will ensure the delivery of high-quality services free-of-cost while reducing out-of-pocket expenditures and ensuring protection against further impoverishment.
- b. ***Investments in primary HNP services will improve wellbeing and productivity of individuals.*** The project will reduce outbreak of vector borne diseases (like dengue) that can lower people's productivity and improve sanitation services (like handwashing stations and mobile toilets) that will improve their overall wellbeing. This will help build human capital necessary to achieve inclusive and sustainable development.
- c. ***The 'public good' nature of healthcare and the positive externalities resulting from the provision of HNP services.*** Public goods are primarily defined by their ability to be utilized by one individual without diminishing the availability or benefits to others. Moreover, positive externalities, such as the spill-over effects of benefits from one person to another, contribute to the accumulation of wealth through improved health, disease prevention, among other factors.
- d. ***Failures in markets for health insurance provide a fourth rationale for public sector intervention to improve efficiency and equity.*** Adverse selection and moral hazard, resulting from uncertainty and asymmetries in information in healthcare, pose significant challenges. Within the context of healthcare in Bangladesh, people are seeking care from the unregulated private sector providers due to an absence of a sustainable and reliable public health service delivery platform that can ensure an equitable provision of services. As a result, public financing for health care is required and is the norm in middle- and high-income countries.

34. ***Investment in developing a strong public service delivery system for primary HNP is considered extremely cost-effective.***

Investments in reproductive, maternal and child health in lower-middle-income countries such as Bangladesh yield high rates of return, producing economic and social benefits up to eleven times its cost.<sup>28</sup> Similarly, nutrition and vaccination interventions have a high rate of return on investment – estimated between US\$4 and US\$35 for every dollar invested.<sup>29</sup> Watson et al<sup>30</sup> conducted a systematic review of the cost-effectiveness across 37 low- and middle-income country contexts, and conclude that aspects such as task-shifting from highly trained medical workers in “hub” hospitals to primary health facilities with less-trained professionals, strong referral systems and outreach clinics are among the key drivers of the cost-

<sup>26</sup> World Bank. 2016. Leveraging Urbanization in South Asia: Managing Spatial Transformation for Prosperity and Livability.

<sup>27</sup> <https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=BD>

<sup>28</sup> World Health Organization (2013) The Partnership for Maternal, Newborn & Child Health and the University of Washington: A Global Investment Framework. Geneva for Women's and Children's Health: Advocacy Brochure. Geneva, Switzerland, 2013.

<sup>29</sup> Shekar, M, Kakietek, J, Dayton Eberwein, J, Walters, D. An investment framework for nutrition: reaching the global targets for stunting, anemia, breastfeeding, and wasting: The World Bank; 2017.

<sup>30</sup> Watson, S; Sahota, H; Taylor, CA; Chen, YF; Lilford, R (2018) Cost-effectiveness of health care service delivery interventions in low- and middle-income countries: A systematic review. Global Health Research and Policy 3(17). DOI: <https://doi.org/10.1186/s41256-018-0073-z>



effectiveness of such interventions.

35. ***A cost-benefit analysis for the proposed project yields positive net present values (NPVs) across a range of scenarios considered.*** The economic analysis carried out, compares the cost of the project with the measurable benefits derived from the implementation of project activities over a specified time horizon. The benefits assumed, grounded in the existing literature and conservative in approach, include lower infant and maternal morbidity and mortality rates, reduced out-of-pocket expenditure due to a lower disease burden, and more efficient healthcare seeking outcomes due to improvements in quality of care (less drug stock outs, lower time spent at the facilities, access to qualified health personnel). To account for inflation and changes in the time value of money, the cost-benefit analysis used a range of discount rates (3 and 5 percent) to account for temporal variation over a 10-, 15- and 20-year period. The calculation yields NPVs ranging from US\$115.2 million (most conservative approach assuming a discount rate of 5 percent over a 10-year period) to US\$607.9 million (least conservative approach assuming a discount rate of 3 percent over a 20-year period, see table 1). The benefits presented are likely the lower bound estimates of the actual economic impact of the project as it does not account for longer term direct and indirect benefits such as improved cognitive abilities of children, leading to long-term higher levels of productivity and economic returns, psychosocial benefits of having a cleaner environment, among others.

**Table 1: Net present value of the project (in US\$ million)**

	Discount rate: 3%	Discount rate: 5%
10 years	\$139.8	\$115.2
15 years	\$371.1	\$294.9
20 years	\$607.9	\$463.9

36. ***The project is aligned with the goals of the Paris Agreement on both mitigation and adaptation.*** Overall, the mitigation risk is low, and the adaptation risk is acceptable. The project will support activities that are universally aligned with the Paris Agreement mitigation goals and not at a material risk of having a negative impact on the country’s pathway on low emissions of greenhouse gases. As part of the renovation of the primary HNP centers, the project will support mitigation by reducing emissions of greenhouse gases. The project has been screened for climate change impacts and disasters. Bangladesh's urban population face significant climate vulnerabilities due to its location, high population density, and rapid urbanization. Climate change can exacerbate the prevalence of climate-sensitive diseases and cause heat stress due to the projected rise in temperature. The project will address climate change related vulnerabilities and enhance resilience by focusing on: (a) integrating climate change considerations into the design of the new primary HNP centers on adaptation measures to climate hazards; (b) supporting emergency preparedness and management capacities considering the health consequences of climate change; (c) strengthening the health systems to manage and treat climate-related diseases that are expected to increase due to climate change, such as vector-borne diseases and NCDs related to heat and increased temperatures; and (d) mitigating the direct causes of climate change and related health risks through measures such as vector management. The project will promote preventive measures and adaptation to the effects of air and sound pollution (that are exacerbated by climate change).



## B. Fiduciary

### (i) Financial Management

37. **Planning and budgeting:** Budget preparation and execution will use the Government of Bangladesh's integrated budgeting and accounting system (iBAS++). Under component 1, resources will be allocated to the relevant operational plans, responsible for implementing project activities. The LDs will incur expenditures for identified activities under the project using their current operational structure. The Financial Management and Audit Unit (FMAU) of HSD of MoHFW will submit financial reports to the World Bank. Under component 2, LGD will establish a PMU which will allocate annual budget for the city corporations and/or municipalities targeted by the project based on annual work plans. Allocation from the International Development Association (IDA) is included as reimbursable project aid (in a separate column) in the government's budget document.

38. **Staffing:** The existing FM structure under the MoHFW will be used to carry out the FM activities. A FM specialist and an Accounts Officer will be recruited under LGD for overall FM coordination.

39. **Financial authorization processes:** The country system for financial delegation, segregation of duties, and approval and authorization processes will be followed for the implementation of the project.

40. **Eligibility of financing:** IDA financing will not apply to specified categories of recurrent expenditures and the government shall ensure that the following expenditures are financed exclusively out of its own resource<sup>31</sup>: (a) all costs associated with land and land use rights required for the purposes of the project; (b) procurement of vehicles, recurrent expenditures for the purpose of attending meetings, conferences, seminars, workshops and study visits (sitting allowances / cash per diems / honoraria, notwithstanding eligible expenditures under incremental operating costs and training as defined in the Financing Agreement), and recurrent expenditures for fuel, and salaries and salary top-ups of the government's civil servants; and (c) taxes exceeding 15 percent of the total amount of IDA financing.

41. **Financial reporting:** Both the MoHFW and LGD will submit quarterly Interim Unaudited Financial Reports (IUFRs) to the World Bank within 45 days after the end of each quarter. The FMAU of the HSD of the MoHFW will compile financial data, relevant to project activities, of the relevant LDs and submit quarterly IUFRs in agreed formats. The PMU, under the LGD, will compile financial data related to the city corporations and municipalities targeted by the project paid from the Designated Account (DA) and submit the quarterly IUFRs in agreed formats.

42. **Fund flow:** The reimbursement method of disbursement will be used for activities implemented by the MoHFW. Funds will be disbursed to the government Treasury for expenditures incurred by the relevant operational plans. The PMU, under LGD, will open a DA with a national commercial bank in the form of a Convertible Taka Special Account (CONTASA) to receive funds from IDA for implementation of component 2. IDA funds will flow to the DA based on withdrawal applications submitted by the PMU to the World Bank. An alternative signatory arrangement, for authorized signatories of the PMU, will be made for submission of withdrawal applications to ensure unhindered flow of funds. For the MoHFW, IUFR-based disbursement will be used, while disbursement will be Statement of Expenditure-based for the LGD. Retroactive financing up to

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<sup>31</sup> For component 2, counterpart funding of around US\$20 million will cover such expenditure. For component 1, the MoHFW's allocation for the sector program will cover such expenditure.



SDR 3.73 million or US\$5 million equivalent for component 1 will be allowed for eligible expenditures incurred by the MoHFW during the period between July 1, 2023, and the date of the signed Financing Agreement. This will finance goods and services procured and operating costs incurred that are eligible under the project.

43. **External audit:** The Foreign Aided Project Audit Directorate will conduct separate audits of the annual financial statements of the LGD and the MoHFW. The auditors will express their opinion on each of the project financial statements in accordance with international standards of auditing and submit the reports to the World Bank within six months of the end of each fiscal year. In addition, the auditors are required to provide a detailed management letter containing their observations on internal controls and compliance with the financial covenants as laid out in the Financing Agreement for each of the agencies. There is no pending audit report for any of the projects funded by IDA under the two ministries.

44. **Internal audit:** The PMU of the LGD will prepare the terms of reference to hire an internal auditor and share it with the World Bank for review and endorsement. Two internal audits by external firms will be conducted for the LGD during the life of the project. For the MoHFW, the internal audit unit of the FMAU will conduct at least two rounds of internal audit during the project period.

45. **Audit Committee:** Two audit committees will be formed under the two ministries to review the audit reports, audit clarifications for resolution of observations, and to follow up implementation of audit recommendations. The MoHFW and the LGD will prepare terms of reference for their respective audit committees and share them with the World Bank for endorsement.

46. **FM risks and mitigation:** The FM risks for the project related to both the MoHFW and the LGD are described in Section VI (Key Risks) in detail and pertain to limited capacity to ensure compliance with financial rules and regulations, inadequate internal control measures and lack of qualified FM personnel. As part of the Fiduciary Action Plan of the World Bank financed Health Sector Support Project (HSSP, P160846) which is ongoing, the MoHFW's internal control is being strengthened through restructuring of the FMAU and now they have their own internal audit unit that is carrying this function out regularly. In addition, FM training is conducted regularly for all the MoHFW LDs. Mitigation measures under the project will include: (a) advanced procurement of FM personnel to ensure this recruitment is finalized by project effectiveness; (b) periodic internal audits to assess the operational efficiency and suggest recommendations to strengthen the internal control environment through implementation of an agreed action plan; (c) strengthening the inventory maintenance procedure; (d) introduction of an effective asset management system to ensure optimum usage and safeguarding of assets; (e) periodic bipartite/tripartite meetings involving the project, the relevant ministry, and external auditors; (f) training of staff on FM; and (g) establishment of an audit committee to follow up on implementation of audit recommendations. With these proposed mitigation measures, the FM risks are assessed as substantial.

## **(ii) Procurement**

47. **Applicable procurement procedures.** Procurement under the project will be carried out in accordance with the World Bank Procurement Regulations for IPF Borrowers, Fourth Edition, November 2020 ("Procurement Regulations") and the provisions stipulated in the Project Procurement Strategy for Development (PPSD) and the procurement plan that may be updated from time to time with the World Bank's approval. The government's Public Procurement Act 2006 and the Public Procurement Rules 2008 will be followed as applicable. The World Bank Procurement Regulations shall govern all procurement under the



project and shall take precedence if any conflict arises with the government's procurement rules and decision-making processes. The World Bank will provide any clarifications requested by the government to confirm the correct application of the World Bank's procurement procedures. The project will be subject to the World Bank's Anticorruption Guidelines, dated October 15, 2006, revised in January 2011, and as of July 1, 2016. The World Anticorruption Guidelines shall take precedence if any conflict arises with the national rules and processes. The Systematic Tracking of Exchanges in Procurement (STEP) will be used to record and track procurement transactions.

48. **Procurement methods and approaches.** The appropriate procurement methods and approaches for each procurement activity will be specified in the procurement plan. Procurement for goods and works will mostly include open bidding international and national market approach (subject to the provisions required for ensuring consistency with the World Bank's Procurement Regulations). Small-value simple procurement may follow the Request for Quotations method. Consulting services from firms will mostly be selected through the Quality and Cost Based Selection method, and individual consultants through competitive selection. The MoHFW will be responsible for all procurement under component 1 of the project. Procurement of goods will be done by the Central Medical Stores Depot (CMSD); civil works by the Public Works Department of the Ministry of Housing and Public Works; consultant and non-consultant services by the relevant operation plan(s). For the first year of project implementation, the relevant operational plan(s) may procure small-value goods using competitive procurement methods. Selected essential medicines required for immediate needs during the first year of project implementation may be procured by the relevant operational plan through Direct Selection method, from the Essential Drugs Company Ltd. (EDCL), while ensuring that the price and quality of the medicines are in line with the prevailing private sector market. For procurement of essential medicines to be done by HSD for the remaining project period up to the closing date of December 31, 2028, CMSD will procure using open competitive bidding international or national market approach as appropriate. Additional procuring entities from the Medical Education and Family Welfare Division of the MoHFW would be included under component 1 based on procurement capacity assessment to be undertaken by the World Bank. As an exception, selected essential medicines that are annually required in small quantities (less than US\$50,000 equivalent annually per medicine) or are not manufactured by the private sector in Bangladesh, and to be agreed with the World Bank, open competitive bidding may not be feasible and such selected medicines may be procured directly from EDCL. For component 2, the PMU to be set-up at the LGD will be responsible for all procurement related activities, including the procurement needs of the city corporations and municipalities targeted by the project.

49. **PPSD and Procurement Plan.** The PPSD will be prepared by the MoHFW and LGD to cover the respective procurement with detailed procurement arrangements and contract management plan, including associated risks and mitigation measures. The procurement plan will specify the applicable procurement method, market approach, and the World Bank's review requirement for each contract. The procurement plan will be maintained in STEP and updated at least annually or as necessary. A General Procurement Notice will be published on the World Bank's website and UNDB Online.

50. **Risk mitigation measures.** Procurement related risks are described in Section VI (Key Risks) in detail and pertain to a range of issues including inadequate technical preparation; delays in bid evaluation and contract award; slow approval processes within the government; inadequate controls mechanisms that are susceptible to manipulation; collusion and irregularities in the HNP sector primarily due to weak internal control functions and limited accountability and weak oversight over decision-making processes. With the following mitigation measures to be implemented by the MoHFW and LGD, the residual risk related to



procurement is substantial:

- a. Each procuring entity will submit to the World Bank a technical preparation plan for the key procurement packages listed in the procurement plan setting out the target dates and responsibility for completion of the technical prerequisite actions.
- b. Each procuring entity will complete procurement processes in a timely manner according to the activity schedule specified in the approved procurement plan and submit quarterly procurement progress monitoring reports to the Head of the Procuring Entity (HOPE), with a copy to the World Bank.
- c. Each procuring entity will use the government’s electronic government procurement system (eGP) where acceptable to the World Bank.
- d. Full-time government procurement staff (who received training in government procurement) will be assigned to the PMU of LGD and the relevant operational plan(s) of MoHFW. In addition, procurement consultants may be hired for a fixed period in the first two years of the project.
- e. The World Bank will provide training to the procuring entities on the World Bank’s Procurement Regulations and STEP system.
- f. Each procuring entity and the World Bank will regularly monitor implementation of the PPSD.
- g. The World Bank’s procurement implementation support will include prior reviews and post reviews, and provision of training and guidance as needed to the procuring entities.

**C. Legal Operational Policies**

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

**D. Environmental and Social**

51. **Environmental and social risk management:** The project’s E&S risks are rated 'substantial' mainly due to the risks and impacts associated with the generation and management of medical, solid and liquid wastes from delivery of services. The project will finance both outhouse and in-house management of medical waste. The LGD and relevant city corporations/municipalities under component 2 will implement outhouse MWM through innovative approaches including contracting-out PPP arrangements. To ensure proper management of medical waste by the PPP/contracted vendor, appropriate clauses for segregation, recycling, disinfection, proper disposal etc. will be included in the contract with provision for regular monitoring and supervision. In-house MWM will include mainly autoclave/microwave technology with built-in shredder treatment plant with required civil structures. In addition to the risks associated with waste generation, other anticipated environmental and social risks and impacts of the project may be of the following nature: (a) poor labor and working environment; (b) occupational health and safety of project workers; (c) noise, vibration, and dust pollution; (d) water pollution by the chemical used for vectors (mosquito) control; and (e) not all potential beneficiaries and stakeholders who come from diverse background and social strata are included. However, all these impacts are likely to be site specific, minor to moderate in nature, and can be mitigated with a proper management plan. An Environmental and Social Management Framework (ESMF) along with an integrated



Stakeholder Engagement Plan and Human and Occupational Resource Management Procedures were prepared and disclosed on June 12, 2023, on the MoHFW's website ([www.hsd.gov.bd](http://www.hsd.gov.bd)) and on June 22, 2023, on the LGD's website ([www.lgd.gov.bd](http://www.lgd.gov.bd)).

52. **Sexual exploitation and abuse (SEA)/sexual health (SH).** SEA/SH related risks are assessed as low and the following mitigation measures will be implemented by the MoHFW and LGD: prepare an Accountability and Response Framework that procedures how to respond to allegations of SEA/SH; ensure the grievance redressal system is able to manage potential cases of SEA/SH along with referral system in case survivors require such support; and raise awareness and disseminate information on SEA/SH among the project beneficiaries and stakeholders. The ESMF provides details on SEA/SH related risk management. Besides, the primary HNP centers will screen GBV survivors and refer them for further care as necessary.

53. **Gender.** To reduce pregnancy related complications and deaths, ANC is critical, and four or more visits are recommended as per MoHFW and international standards. However, the proportion of pregnant women accessing ANC is low and there are inequities in access to primary healthcare services by gender and place of residence. Women accessing maternal and reproductive health services vary between rural and urban, and slum and non-slum dwellers. The barriers to accessing ANC will be addressed by strengthening both the supply and demand. On the supply-side, the project will focus on upgrading and expanding health facilities, as well as providing equipment, medicines, and human resources. Under the project, several activities will focus on increasing access to HNP services by slum areas and vulnerable communities. The project will set up satellite and mobile clinics to ensure that women in slum areas and those experiencing homelessness are able to access these services. On the demand side, targeted communication and community engagement activities, particularly among the vulnerable populations, will help to generate demand for services. Given the cultural context, the presence of female service providers at the targeted facilities will help encourage uptake of services by women and reduce gender-related disparities. In Bangladesh, the high rate of GBV is a serious challenge with impacts on women's physical and mental health. Survivors often face difficulties accessing essential services. Therefore, the project will provide training for primary HNP center staff to screen GBV cases, provide emergency treatment, and refer for further care.

54. **Citizen engagement is an integral part of the project.** The project has been prepared based on extensive consultations with relevant stakeholders including government agencies, medical practitioners, public health specialists, private sector involved in healthcare, civil society, development partners, beneficiaries, and service providers. Consultations and stakeholder engagement will continue throughout project implementation. Both the MoHFW and LGD will ensure an effective grievance redressal system is in place to receive feedback, take appropriate measures, and report back to the citizens to close the feedback loop. In addition, the applicable Citizen Charters will be displayed at every health facility supported by the project. Furthermore, a user/beneficiary satisfaction surveys will be carried out to solicit feedback, monitor quality of services, and mitigate issues as needed.

55. **The MoHFW maintains a comprehensive grievance redressal mechanism (GRM)** that enable a broad range of stakeholders to channel concerns, questions, and complaints and resolution of these issues. The existing GRM will be used for this project and the DGHS will ensure access to and information relating to these GRMs are widely publicized. The DGHS GRM in its current form is a state-of-the-art online platform, together with partially offline processes at the citizens' end which is being promoted through public health facilities across the country. In each of these health facilities, display boards describe the process of submitting grievances over the phone and/or through text message to a dedicated number 16263. A consolidated view



of all registered grievances and suggestions is available at DGHS's web-platform at: <http://app.dghs.gov.bd/complaintbox/>. The DGHS has deployed dedicated staff and implemented standard operating procedures for providing responses to the complainants and initiating appropriate corrective action.

56. ***The LGD is currently using the government's central GRM*** accessible online and by phone: <https://www.grs.gov.bd/> which includes a detailed user manual as well as GRM guidelines and process map on the website. This central GRS will be further strengthened by setting-up site-specific grievance redress committees at the city corporations and municipalities under the project with detailed operational procedures for these committees/GRM.

## V. GRIEVANCE REDRESS SERVICES

57. ***Communities and individuals who believe that they are adversely affected by a project supported by the World Bank may submit complaints to existing project-level grievance mechanisms or the World Bank's Grievance Redress Service (GRS)***. The GRS ensures that complaints received are promptly reviewed in order to address project related concerns. Project affected communities and individuals may submit their complaint to the Bank's independent Accountability Mechanism (AM). The AM houses the Inspection Panel, which determines whether harm occurred, or could occur, as a result of World Bank non-compliance with its policies and procedures, and the Dispute Resolution Service, which provides communities and borrowers with the opportunity to address complaints through dispute resolution. Complaints may be submitted to the AM at any time after concerns have been brought directly to the attention of World Bank Management and after Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's GRS, please visit <http://www.worldbank.org/GRS>. For information on how to submit complaints to the World Bank's AM, please visit <https://accountability.worldbank.org>.

## VI. KEY RISKS

58. ***The overall risk rating of the project is substantial*** due to substantial risks related to: (a) technical design of the project; (b) institutional capacity for implementation and sustainability; (c) fiduciary; and (d) environmental and social aspects.

59. ***Risks associated with technical design are rated substantial*** due to the lack of a well-established public system for delivery of urban primary HNP services, and the involvement of two implementing agencies and LGIs that require close collaboration. These risks will be mitigated in several ways. The project will support initiatives that clearly have the potential for adoption and scale-up by the government using domestic resources. Bangladesh's experience with a SWAp in the HNP sector nationally will facilitate coordinated support by development partners to the government's strategies. On one hand, having two ministries will create complexities for project management; on the other hand, risks associated with a single implementing agency – fund flow delays and coordination problems – will be mitigated with having separate budgets and activities identified for the two ministries. Coordination between the MoHFW, LGD and the LGIs will be strengthened through regular missions fielded by the World Bank and meeting of the existing coordination platforms. Moreover, the phased approach provides sufficient flexibility to adapt to experiences gained and required course correction to implementation that will mitigate additional risks related to technical design.



60. **Risks associated with institutional capacity for implementation and sustainability are substantial.**

There is a complex political economy and currently very limited coordination between the MoHFW, LGD and the LGIs in delivering urban PHC services. By developing a public health delivery platform and strengthening of government facilities, the project will ensure sustainability of the interventions beyond the project period and mitigate associated risks. The project provides an important platform for collaboration of the two implementing agencies and LGIs that is critical for comprehensive primary care. Use of existing coordination mechanisms such as the Inter-Ministerial Urban Health Coordination Committee and the Urban Health Working Group will ensure the key stakeholders are regularly engaged.

61. **Fiduciary risks are substantial.** The FM risks related to both the MoHFW and the LGD include: (a) poor internal control environment resulting in non-compliance with financial rules and regulations; (b) inordinate delay in resolving external audit observations; (c) lack of efficient inventory and asset management; (d) delay in engaging an internal auditor with a suitable TOR; and (e) difficulty in retaining qualified FM personnel. Mitigation measures for the FM risks include training and capacity building measures; strengthening internal control measures through periodic audits and follow-up on recommendations; inventory management, etc. The procurement risks include: (a) delays in completing procurement processes; (b) slow government approval processes; (c) lack of a systematic mechanism for monitoring procurement performance and outcomes; (d) multiple agencies involved in procurement for component 1; (e) inadequate control mechanisms that are susceptible to manipulation; (f) collusion and irregularities in the HNP sector primarily due to weak internal control functions and limited accountability and oversight over decision-making processes; (g) lack of dedicated procurement professionals in the MoHFW; (h) limited competition due to low participation of international bidders; and (i) inadequate capacity for contract management. These risks will be mitigated by strengthening procurement functions through systematic planning, monitoring technical preparation and procurement progress against specified time standards, as well as capacity building.

62. **Environment and social risks are rated substantial** primarily due to generation of medical waste. The MoHFW has substantial capacity in managing in-house medical waste and the government has standard policies and practices in place that will be further strengthened by the project, including outhouse waste management as part of activities under component 2.



**VII. RESULTS FRAMEWORK AND MONITORING**

**Results Framework**

**COUNTRY: Bangladesh**

**Urban Health, Nutrition and Population Project**

**Project Development Objectives(s)**

To improve delivery of comprehensive primary healthcare services for selected urban areas.

**Project Development Objective Indicators**

<b>Indicator Name</b>	<b>PBC</b>	<b>Baseline</b>	<b>End Target</b>
<b>Improve delivery of comprehensive primary healthcare services for selected urban areas</b>			
Children receiving nutrition services (ages 0-5 years, disaggregated by gender) (Number)		0.00	2,457,168.00
Children receiving nutrition services (ages 0-5 years): male (Number)		0.00	17,775.00
Children receiving nutrition services (ages 0-5 years): female (Number)		0.00	17,775.00
Women receiving four or more antenatal care checkup (Number)		0.00	255,960.00
People registered for hypertension screening and follow-up, disaggregated by gender (Number)		0.00	1,279,800.00
People registered for hypertension screening and follow-up: male (Number)		0.00	639,900.00
People registered for hypertension screening and follow-up: female (Number)		0.00	639,900.00
Mosquito control unit of the LGD strengthened (Yes/No)		No	Yes



**Intermediate Results Indicators by Components**

Indicator Name	PBC	Baseline	End Target
<b>Component 1: Improve urban primary HNP services led by the MoHFW</b>			
Children who are fully immunized ages 0-12 months, disaggregated by gender (Number)		0.00	35,550.00
Children who are fully immunized ages 0-12 months: male (Number)		0.00	17,750.00
Children who are fully immunized ages 0-12 months: female (Number)		0.00	17,750.00
Pregnant women who received nutrition services (Number)		0.00	136,512.00
Primary HNP Center with solar panels where feasible (Percentage)		0.00	100.00
Primary HNP Center with no stock-out of essential medicines in the last one month (Percentage)		50.00	100.00
Primary HNP Center with at least one female service provider (Percentage)		0.00	100.00
People reached through communications and outreach activities, disaggregated by gender (Number)		0.00	1,850.00
People reached through communications and outreach activities: male (Number)		0.00	925.00
People reached through communications and outreach activities: female (Number)		0.00	925.00
A user/beneficiary feedback survey conducted (Number)		0.00	3.00
<b>Component 2: Improve public health services led by the LGD, MoLGRD&amp;C</b>			
Outhouse management of medical waste sites put in place according to standards (Number)		0.00	3.00
Early warning system for climate-sensitive diseases established for tracking at least one disease (Yes/No)		No	Yes



Indicator Name	PBC	Baseline	End Target
Trees planted to mitigate the effects of climate change (Number)		0.00	450,000.00

**Monitoring & Evaluation Plan: PDO Indicators**

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Children receiving nutrition services (ages 0-5 years, disaggregated by gender)	Children aged zero to five years who receive nutrition services, disaggregated by gender	Monthly	Primary HNP centers	Registers/DHIS2	DGHS, MoHFW
Children receiving nutrition services (ages 0-5 years): male	Male children aged zero to five years who receive nutrition services	Monthly	Primary HNP centers	Registers/DHIS2	DGHS, MoHFW
Children receiving nutrition services (ages 0-5 years): female	Female children aged zero to five years who receive nutrition services	Monthly	Primary HNP centers	Registers/DHIS2	DGHS, MoHFW
Women receiving four or more antenatal care checkup	Pregnant women who avail antenatal care services at least four times or more	Monthly	Primary HNP centers	Registers/DHIS2	DGHS, MoHFW
People registered for hypertension screening and follow-up, disaggregated by gender	People registered at the primary HNP centers supported by the project for hypertension screening and follow-up	Monthly	Primary HNP centers	Registers/DHIS2	DGHS, MoHFW
People registered for hypertension screening and follow-up: male	Males registered at the primary HNP centers	Monthly	Primary HNP centers	Registers/DHIS2	DGHS, MoHFW



	supported by the project for hypertension screening and follow-up				
People registered for hypertension screening and follow-up: female	Females registered at the primary HNP centers supported by the project for hypertension screening and follow-up	Monthly	Primary HNP centers	Registers/DHIS2	DGHS, MoHFW
Mosquito control unit of the LGD strengthened	The existing mosquito control unit of the LGD is strengthened with adequate technical support, equipment, human resources and training	Yearly	LGD	Qualitative and documentary evidence	LGD

**Monitoring & Evaluation Plan: Intermediate Results Indicators**

Indicator Name	Definition/Description	Frequency	Datasource	Methodology for Data Collection	Responsibility for Data Collection
Children who are fully immunized ages 0-12 months, disaggregated by gender	Children ages zero to twelve months who are fully immunized, disaggregated by gender	Monthly	Primary HNP centers	Registers/DHIS2	DGHS, MoHFW
Children who are fully immunized ages 0-12 months: male	Male children ages zero to twelve months who are fully immunized	Monthly	Primary HNP centers	Registers/DHIS2	DGHS, MoHFW
Children who are fully immunized ages 0-12 months: female	Female children ages zero to twelve months who are fully immunized	Monthly	Primary HNP centers	Registers/DHIS2	DGHS, MoHFW
Pregnant women who received nutrition services	Pregnant women who receive nutrition services	Monthly	Primary HNP centers	Registers/DHIS2	DGHS, MoHFW



Primary HNP Center with solar panels where feasible	Out of the total number of primary HNP centers supported by the project, the proportion of centers that have fitted a solar panel	Six-monthly	Primary HNP centers	Physical verification	DGHS, MoHFW
Primary HNP Center with no stock-out of essential medicines in the last one month	Out of the total number of primary HNP centers supported by the project, the proportion of centers reporting no stock-out of essential medicines in the past month. Essential medicines will include amlodipine, iron folic acid, amoxicillin, and metronidazole for the purposes of tracking this indicator	Six-monthly	Primary HNP centers	Registers	DGHS, MoHFW
Primary HNP Center with at least one female service provider	Out of the total number of primary HNP centers supported by the project, the proportion of centers where at least one female service provider is available at each shift (morning and evening)	Monthly	Primary HNP centers	Registers	DGHS, MoHFW
People reached through communications and outreach activities, disaggregated by gender	People reached through communications and outreach activities, disaggregated by gender	Monthly	Primary HNP centers/mobile teams/satellite clinics	Registers	DGHS, MoHFW



People reached through communications and outreach activities: male	Males reached through communications and outreach activities	Monthly	Primary HNP centers/mobile teams/satellite clinics	Registers	DGHS, MoHFW
People reached through communications and outreach activities: female	Females reached through communications and outreach activities	Monthly	Primary HNP centers/mobile teams/satellite clinics	Registers	DGHS, MoHFW
A user/beneficiary feedback survey conducted	A user/beneficiary feedback survey conducted at baseline, mid-term and endline	At baseline, mid-term and endline	Survey	Survey based quantitative and qualitative data	DGHS, MoHFW/The World Bank
Outhouse management of medical waste sites put in place according to standards	Outhouse management of medical waste sites put in place according to standards (cumulative)	Six-monthly	City corporations, municipalities	Documents, physical verification	LGD
Early warning system for climate-sensitive diseases established for tracking at least one disease	Early warning system for climate-sensitive diseases established for tracking at least one disease like dengue using a combination of data on weather conditions, vector surveillance and disease incidence	Yearly	LGD	Documents	LGD



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Trees planted to mitigate the effects of climate change	Trees planted to mitigate the effects of climate change (cumulative number)	Monthly	City corporations and municipalities	Documents/physical verification	LGD
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## ANNEX 1: Implementation arrangements and support plan

- 1. *Monitoring and coordination arrangements.*** The existing Urban Health Coordination Committee will ensure coordination of project activities, that is currently headed by the Secretary, Health Services Division (HSD), Ministry of Health and Family Welfare (MoHFW), and co-chaired by the Additional Secretary, Local Government Division (LGD), with participation of MoHFW officials and the focal persons of the targeted city corporations and municipalities. The Urban Health Coordination Committee will meet at least twice a year, or more frequently if required. For technical oversight the existing Urban Health Working Group will continue to function, which is currently co-chaired by the Additional Secretary (Planning), HSD, MoHFW and the Additional Secretary (Urban Development), LGD, and will meet once every quarter or more frequently as needed. The LGD will establish a National Level Committee headed by the Secretary of the LGD with representatives of the relevant LGIs, MoHFW, Ministry of Agriculture, Ministry of Environment, Climate Change and Forest, the Economic Relations Division and the Finance Division of the Ministry of Finance, the Socio Economic Infrastructure Division of the Planning Commission, the Implementation Monitoring and Evaluation Division of the Ministry of Planning, the Ministry of Housing and Public Works, and other relevant government agencies. In addition, the LGD may set-up committees to be chaired by the respective Mayors for regular monitoring of component 2 of the project, to meet as frequently as needed. The city corporations can use the Standing Committee on Education, Health, Family Planning and Health Safety system for monitoring project activities. The respective Civil Surgeon and Deputy Director – Family Planning can be co-opted in this committee. The Committee will include at least one female. In addition, Ward Health Committees may be set-up to include elected Ward Commissioners, and representatives of civil society, poor communities, and professional associations, with measures to ensure equitable participation by women. These Ward Health Committees (chaired by the relevant Ward Commissioner) can be responsible to ensure oversight and improved accountability of services at the community level. These monitoring mechanisms will complement the Urban Health Coordination Committee and the Urban Health Working Group. The composition and mandate of these monitoring committees and/or working group including chair/co-chair can be revised during project implementation in consultation with the World Bank.
- 2. *Strategy and approach for implementation support.*** The implementation support strategy is based on the combination of several mechanisms that will enable enhanced implementation support to the government and timely and effective monitoring of the project. These mechanisms include: (a) intensive supervision and handholding in the first year of implementation, particularly given the need for coordination and collaboration between the MoHFW, LGD of the MoLGRD&C and the local government institutions (LGIs); (b) regular technical meetings and field visits by the World Bank; (c) the MoHFW and the LGD reporting based on internal monitoring and follow-up; and (d) independent third-party monitoring to assess and monitor project progress throughout its implementation.
- 3.** The World Bank FM, procurement, social, and environmental specialists who are based in the country office will play a vital role in successful project implementation support, given that the project includes capacity building in these areas for the implementing agencies. These World Bank specialists, in collaboration with the task team leaders, will provide timely, effective, and intensive support to the client.
- 4. *Implementation support missions.*** The project will have semiannual implementation support missions, including field visits. The semiannual missions will focus on review of the project performance against the Results Framework, the activities and priorities identified in the operational plans and DPP, compliance to E&S and fiduciary requirements, and agreement on planned actions. To ensure high quality and



comprehensiveness of support considering the project design, the World Bank team will include specialists in FM, procurement, and safeguards, with the specific team composition for each mission determined based on the requirements at that time.

5. ***To develop sustainable mechanisms for service delivery and ensure smooth implementation, the project will adopt a phased approach.***

- a. ***In phase 1 (under the Fourth Health, Population and Nutrition Sector Program (HPNSP) currently ongoing and closing in June 2024),*** services will be delivered through existing government outdoor dispensaries of the MoHFW. Technical work to expand health, nutrition, and population (HNP) services further including defining catchment areas and identifying needs for setting-up additional primary HNP centers will also be undertaken in phase 1.
- b. ***In phase 2 (under the Fifth HPNSP from July 2024 to June 2029),*** expand HNP services either through setting-up of new primary HNP centers, or strategic purchase of services from the non-governmental organizations (NGOs)/private sector, or a combination. It would be difficult to find empty land for constructing new primary HNP centers. Hence, for new primary HNP centers to be set-up, existing government structures can be used, for example, health clinics of the institutions (LGIs) or space within community centers owned by the LGIs, and other government buildings as available. For expansion of services, a catchment area will be defined based on the population of that area and the number of primary HNP centers will be determined based on a fixed ratio (like the community clinics in the rural areas, each of which target 6,000 people).

6. ***Under component 1, HNP service delivery arrangements will cover four main tiers of service delivery*** to include: (a) primary HNP centers, (b) Mobile/Satellite Clinics, (c) Community Engagement, and (d) Referral Cell (in a tertiary hospital) as summarized in Table 1.

- a. ***Primary HNP centers*** will provide outpatient services. The center will operate in two shifts: morning and evening. Additional human resources (HR) will be deployed at the primary HNP center to cover the evening shift and will include physicians (preferably female), laboratory technologists/assistants, nurses, pharmacists, statisticians who will also deal with patient registration and maintaining database, cleaners, security guards, etc. The cleaners will be trained to deal with in-house medical waste management to ensure proper segregation, storage, and disposal. Depending on caseload, the number and type of HR required may change. The additional HR will be contracted-out under the project.
- b. Mobile teams will conduct both ***satellite clinics and mobile clinics***. Each team will be adequately staffed. Satellite clinics will cover low-income groups particularly around the slum areas. Mobile clinics will target street dwellers and homeless population. Digitalization may be piloted to replace conventional mobile teams. Experiences of Portable Health Clinics<sup>32</sup>, Digital Health Program<sup>33</sup> and others may be explored.
- c. For ***community engagement and outreach***, a cadre of community health workers/volunteers, recruited from the target community preferably female will need to be trained and deployed with proper monitoring and supervision. They will undertake door-to-door outreach to: (a) register target population from their defined catchment area; (b) undertake initial screening for selected non-communicable diseases (NCDs) like diabetes and hypertension; (c) identify and register children for the Expanded

<sup>32</sup> <https://grameen.technology/post/32/portable-health-clinic>

<sup>33</sup> <https://www.tbsnews.net/companies/digital-healthcare-hands-usaid-provide-health-services-marginalised-community-202252>



Program on Immunization (EPI); (d) identify and register eligible couples for family planning services; (e) encourage people to avail services of the primary HNP centers; (f) advocate for promotive and preventive HNP services; and (g) support in organizing satellite clinics. The number of community workers and their supervisors will depend on the catchment area and population, and they will report to the physicians at the primary HNP centers.

- d. A tertiary-level hospital in each catchment area will be selected to serve as the **referred hospital**, where patients will be sent from the primary HNP centers for further care. In each referral hospital, dedicated referral cell will need to be setup with one person dedicated (to be increased in case of load) to coordinate the referral mechanism. This person will receive the referred patient and navigate through the system of the hospital to ensure required services are provided.

Table 1.1: Urban Essential Health Service Package

<b>Satellite and Mobile Clinics</b>	<b>Primary HNP Center</b>	<b>Hospital</b>
	All Satellite and Mobile Clinic services	All primary HNP center services
Pre-conception, ANC, postnatal and newborn care after delivery	Normal delivery and neonatal care; identification, management and referral of obstetric and postnatal complications	Management of obstetric and neonatal emergencies
Integrated management of childhood illnesses	Adolescent health: diagnosis and treatment of sexually transmitted infections	Breast and cervical cancers: diagnosis and treatment
EPI	Family planning: all clinical methods; post-abortion, post-partum and menstrual regulation	Arsenicosis: case management
Adolescent health: counseling	Maternal, child and adolescent nutrition: management of severe acute malnutrition	Chronic obstructive pulmonary disease (COPD): case management
Family planning: counseling and non-clinical methods	Communicable, neglected tropical diseases and sexually transmitted diseases: diagnosis and treatment	Mental health: case management
Child, maternal and adolescent nutrition: counseling, assessment, prevention and primary management of malnutrition	NCDs (hypertension, diabetes, cardio-vascular disease): diagnosis and management	
Communicable diseases: awareness/behavior change communication	Breast and cervical cancers: teaching breast self-examination, diagnosis and referral	
NCDs: awareness/behavior change communication	Arsenicosis: identification of signs and referral	
Cervical and breast cancer: awareness	COPD: awareness and diagnosis	
Mental health: awareness	Mental health: counseling, identification of signs and referral	
Eye, ear, dental and skin care: awareness	Sexual and gender-based violence: identification, counseling and referral	
Emergency care: awareness of road traffic-related injuries and trauma care	Emergency care: road traffic-related injuries and trauma care: management of drowning, minor injuries, snake bites, poisoning	



7. ***Under component 2, the project will support development and implementation of a comprehensive strategy for management of infectious disease*** outbreaks in urban areas, among other things, notably requiring mechanisms for close collaboration between the LGIs, the MoHFW and the LGD. Possible areas of interventions will be vector (mosquito) management to deal with disease outbreaks, vector surveillance systems including a climate-based dengue early warning system, and outbreak response capacities. For effective vector control measures through innovative approaches, a multi-sectoral, targeted, data-driven response is needed. Interventions to be supported by the project will include physical control (such as draining breeding sites, clearing culverts, etc.) and strengthen capacity for integrated vector management in line with the LGD's national guidelines for prevention of mosquito-borne diseases. Overreliance on reactive fogging, space spraying targeting adult mosquitoes and untargeted larval control are not an efficient use of resources. Evidence suggests that mosquito control is most effective during the high temperature seasons as mosquito lifecycle is influenced by climatic conditions. Therefore, efforts for controlling mosquitoes should be strategically timed to maximize the effects of the interventions (spraying insecticides, clearing drainage, and other community-based interventions). Effective community engagement can also help generate and disseminate correct information regarding Aedes control and pave the way for innovative solutions. Project implementation guidelines will be prepared.