1. Country and Sector Background

Bangladesh has recorded substantial progress over the past two decades in economic growth and poverty reduction. A country with 160 million people and per capita income of United Stated Dollar (USD) 652 in fiscal year (FY) 2009, Gross Domestic Product (GDP) of Bangladesh grew on average 5.8 percent per annum over FY01-09 despite periods of political turmoil, fragile institutions, poor governance, and frequent challenges of large-scale destruction from natural disasters. Bangladesh has successfully weathered the global economic crisis and its GDP is expected to grow between 5.5 and 5.8 percent in FY11. There has also been rapid social transformation and human development particularly with the widespread entry of girls into the education system and women into the labor force to support rapid expansion of the garment industry.

2. There, however, remain significant development challenges. Bangladesh remains one of the poorest countries in South Asia with GDP per capita still half that of India and 40 percent of the population below the poverty line (in 2005). Prospects for change over the medium-term will depend on the continuation of macroeconomic stability, deepening of structural reforms and continued investment in human capital. Moreover, in one of the most densely-populated countries in the world, population growth and urbanization have given rise to problems of severe

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1 Information on poverty trends since 2005 is not yet available
infrastructure deficiencies, environmental degradation and urban congestion. At around 15 million inhabitants, the capital, Dhaka, is now the eighth largest city in the world, projected to become the third largest by 2020. Finally, the overall governance environment remains challenging, characterized by lack of checks and balances, weak accountability and corruption.

3. On the whole, Bangladesh has made laudable progress on many aspects of human development which has provided a foundation for improvements in growth, empowerment and social mobility. In education, Bangladesh has made significant progress in the last two decades in increasing access (Millennium Development Goal, MDG 2) and gender parity (MDG 3). In health, nutrition and population (HNP) related MDGs, infant and child mortality has had impressive declines, outstripping progress in the rest of the region. In recognition of the achievement of reduction in child mortality Bangladesh was awarded the United Nations MDG Award in 2010. Similarly, the maternal mortality ratio (MDG 5) was impressively reduced from 320 per 100,000 live births in 2001 to 194 deaths per 100,000 live births in 2010, which exceeded the expected decline by around 40 points. All these factors plus increased female job opportunities have contributed to declining fertility rates, which have been halved from the level of 1970 (one of the fastest declines in the world), although the fertility rate will need to come down further in order to avoid a doubling of the population in the next 40-50 years.

4. Nutrition indicators, however, have not progressed as envisioned and several structural challenges and weaknesses in the health system still remain. After a dramatic decline in child underweight rates (MDG 1c) from 66 percent in 1990 to 51 percent in 2000, progress nearly stagnated between 2000 and 2007. At this rate, Bangladesh is unlikely to meet the MDG target for nutrition. Bangladesh is also facing the alarming challenge of a double burden of non-communicable and communicable diseases. There are large disparities in HNP outcomes, access to care, and health care utilization between the rich and the poor. In addition, the HNP sector is faced with key health systems challenges and weaknesses such as an overly centralized health system, weak governance structure and regulatory framework, weak management and institutional capacity in the Ministry of Health and Family Welfare (MOHFW), fragmented public service delivery, inefficient allocation of public resources, lack of regulation of the private sector, shortage of human resources for health, high staff turnovers and absenteeism, lack of essential drugs and medical supplies and weak storage and distribution systems, and poor maintenance of health facilities and medical equipment.

5. The Government of Bangladesh (GOB) recognizes the importance of HNP for development and poverty reduction, and, over the past ten years, has implemented two HNP sector wide programs with several development partners (DPs): first the Health and Population Sector Program (HPSP 1998-2005) and the closing Health, Nutrition and Population Sector Program (HNPSP 2005 - 2011).

6. HNPSP has been a USD 4.3 billion six-year program which will be completed end of December 2011. It has been implemented through a sector-wide approach (SWAp) that has used government systems. HNPSP mobilized a total of USD 1.2 billion in DP assistance – which includes USD 684 million of pooled resources (USD 300 million IDA credit plus a Bank-administered multi-donor trust fund (MDTF) of USD 384 million from seven other DPs). HNPSP has three components: (i) accelerating achievement of HNP related MDGs; (ii) meeting new and emerging HNP challenges such as non-communicable diseases; and (iii) advancing
HNP sector modernization through reforms such as decentralization and contracting out with non-state providers. The joint mid-term review (MTR) of the HNPSP concluded that the program has made progress in strengthening service delivery and achieving its overall objective. Several HNPSP indicators have been already achieved, and most of the remaining indicators are progressing well and expected to be attained by program closure.

7. The MOHFW has prepared its new sector program, the Health, Population and Nutrition Sector Development Program (HPNSDP) and is revising its draft National Health Policy, based on the lessons learned from previous programs. The Program is also consistent with the priorities reflected in the Second National Strategy for Accelerated Poverty Reduction (NSAPR II)\(^2\). As per the Sixth Five-year Plan, the GOB’s priority is to stimulate demand and improve access to and utilization of HNP services in order to reduce morbidity and mortality, particularly among infants, children and women; reduce the population growth rate; and improve the nutritional status, especially of women and children.

8. The proposed Health Sector Development Project (HSDP) will support the implementation of the government’s sector program (HPNSDP). The Project is consistent with the GOB’s program and policies and will play an important role in operationalizing GOB’s commitments in the HNP sector as outlined in the Election Manifesto, Vision 2021, the National Health Policy and other national strategies, policies and programs.

2. Objectives

9. The objective for HSDP is to enable the GOB to strengthen health systems and improve health services, particularly for the poor.

3. Rationale for Bank Involvement

10. The proposed Project is a continuation of the Bank’s support to the GOB’s HNP sector. The Bank continues to be one of the key development partners in the Sector and has been assisting the GOB since 1975 to build its institutional capacity and strengthening its national health systems in order to improve health outcomes for the population. At present, MOHFW is implementing one of the largest and most complex programs in the region through a SWAp modality, which helps the GOB in coordinating development assistance to the Sector. The HSDP builds on implementation of the two health sector programs (HPSP and HNPSP).

11. An important feature of the HNP sector is the presence of highly committed bilateral and multilateral development agencies, which endorsed the two previous sector wide programs and now are fully committed to MOHFW’s HPNSDP. DP support to the Program has been prepared and coordinated through the HNP Consortium. A few of the DPs have expressed their interest in pooling their funds in a Multi-donor Trust Fund (MDTF) administered by IDA. Almost all the DPs, including the pool funders, will support Program implementation through different

activities, which will be governed by a Joint Financing Arrangement. The Bank’s financial support will supplement those from GOB and other DPs, while its technical expertise in nutrition, health care financing, governance, pro-poor health strategies, and monitoring and evaluation will complement that of other DPs.

12. The performance of Bank’s support so far has been successful. The early assessment of the outcomes of the Bank’s support to the HNP sector has been rated as satisfactory and the Bank is well placed to continue its engagement in the sector and build on its knowledge and on past achievements.

4. Description

13. The Project will support the implementation of the GOB’s sector program (HPNSDP 2011-2016) again through a sector-wide approach. The Project will finance a share of the overall program (together with co-financing from some development partners and parallel financing from others). This Program, and thus the Project, comprises two broad components: The components of the project are: (a) Improving health services, and (b) Strengthening health systems.

14. **Component 1: Improving Health**

- **Component 1.A: Improving Health Programs:** This sub-component will support the GOB’s interventions aiming at improving priority HNP services to accelerate the achievement of the HNP-related MDGs by scaling up the interventions undertaken by the closing sector program as well as introducing new interventions. It includes:

  i) the delivery of essential health services which seek to improve reproductive, adolescent, maternal, neonatal, infant and child health and family planning (FP) services through improving the quality and reliability of antenatal care, scaling up essential emergency obstetric and newborn care services and ensuring 24/7 services in selected district hospitals and upazila health centers, expanding facility- and community-based integrated management of childhood illnesses (IMCI) services, strengthening routine immunization services, increasing demand and use of FP services, and expanding the contraceptive method-mix;

  ii) interventions to improve the nutritional status, especially of pregnant women and children by integrating nutritional services in the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) services (mainstreaming the nutrition strategy), conducting behavior change communication (BCC) interventions (related to breastfeeding, complementary feeding, and hygiene practices), micronutrient interventions (periodic vitamin A supplements, therapeutic zinc supplements for management of diarrhea, multiple micronutrient powders, deworming drugs for children and adolescent girls and iron-folic acid supplements for pregnant women, lactating mothers, and adolescent girls), therapeutic feeding interventions (treatment of severe acute malnutrition), and strengthening sectoral and national capacity for improved planning, supervision, implementation and coordination of nutrition actions across sectors;
iii) the control and treatment of communicable diseases and non-communicable diseases (NCDs) by scaling up HIV/AIDS targeted preventive interventions for the most-at-risk groups, expanding quality directly observed treatment–short course (DOTS) services of TB, strengthening malaria control and treatment in the 13 highly endemic districts, strengthening the diagnosis and management of sexually transmitted diseases (STDs), strengthening the diagnosis and management of diabetes in primary and secondary care facilities, improving awareness about the cardio-vascular disease risks and their management, screening for early cancer detection, and strengthening of the disease surveillance system; and

iv) interventions to promote healthy behavior in support of the above programs and priorities with particular focus on interpersonal communication and community level interventions.

- **Component 1.B: Improving Service Provision:** This sub-component will support the GOB’s interventions for strengthening the service delivery system, including:

  i) primary health care with a focus on piloting the Upazila Health System (UHS) that would put in place a functional referral system at the upazila and district levels and improve the continuity of care across the different service delivery levels. This would include upgrading and equipping at least one upazila health complex (UHC) in each district, upgrading an appropriate number of health centers (to be determined based on the catchment area), and rehabilitating the community clinics and ensuring a functional entry point to the health system;

  ii) hospital management at the secondary and tertiary levels by improving the efficiency and quality of hospital services through clinical protocols, appropriate human resources (HR) and management structure; introducing hospital autonomy initially for the tertiary level specialized hospitals; introducing an accreditation tool; ensuring safe blood transfusion, and implementing an effective health care waste management plan; and

  iii) the provision of HNP services to the urban population by establishing a coordination mechanism between MOHFW and the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC) and expanding these services to urban areas which are currently not covered by MOLGRDC.

15. **Component 2: Strengthening Health Systems:** This component will support the GOB’s interventions for strengthening health systems, including:

- Governance and stewardship: conducting an institutional and regulatory analysis of the government and parastatal organizations in order to establish an effective regulatory framework, revising the Consumer Rights Protection Act and the Clients’ Charter of Rights, developing a regulatory framework for contracting out to non-governmental organizations (NGOs), updating the Public Private Partnership Strategy and developing an action plan, mainstreaming gender, equity and voice (GEV) elements in the OPs, and developing a local level accountability mechanism;
Health Sector planning and management: by ensuring consistency of the Program Implementation Plan (PIP) and OP budgets with the Medium Term Budgetary Framework (MTBF), facilitating the preparation of complementary development and revenue budgets, establishing monthly reviews of budget execution, introducing a resource allocation formula, decentralization of management of service delivery and delegation of commensurate financial power to the district level as feasible, piloting the functionality of an UHS, and updating the local level plans;

Human Resources for Health: developing a HR plan, establishing a functional HR Information System (HRIS), scaling up the production of the critical health workforce cadre, introducing incentive packages to deploy and retain critical health workforce in remote and rural areas, addressing the challenge of skilled-birth attendance by training community-based SBAs and/or nurse-midwives and family welfare visitors, and streamlining the recruitment and promotion of nurses;

Health care financing: developing a national health care financing framework to ensure equitable access of the poor to quality health services and decrease of out-of-pocket expenditure, and scaling up the Demand Side Financing program based on its evaluation;

Health Information System (HIS), monitoring and evaluation (M&E) and research: developing an M&E strategy and work plan in order to establish a sustainable M&E system with organizational mandate and institutional home, and conducting a comprehensive HIS assessment and developing a strategy with the aim of strengthening the Data Management and Information System that would integrate data from various systems and programs, and promote the use of data for decision making;

Quality of health care: developing a quality management strategy and policy for health care services, updating the existing standard operating procedures for the public hospitals, and conducting periodic user and provider satisfaction surveys;

Drug Administration and Regulation: strengthening the Government stewardship and policy formulation in the pharmaceutical sector; Strengthening pharmaceutical quality assurance and control; and strengthening public sector procurement and supply chain management of pharmaceuticals;

Procurement and supply chain management: strengthening the procurement capacity to ensure an efficient storage, inventory, supply and distribution chain, introducing an online procurement tracking system, and exploring options for electronic procurement; and

Physical Facilities and Maintenance: developing a master plan to guide the new construction and upgrading of health facilities, and preparing a comprehensive plan for repair and maintenance of health facilities, equipment, HR and drugs along with budget requirement.
5. Financing
Source: ($m.)
BORROWER/RECIPIENT
International Development Association (IDA) 350
Total 350

6. Implementation

16. A large group of DPs will support the new sector program (HPNSDP) through a Sector Wide Approach (SWAp), building on the implementation experience of HPSP and HNPSP. Under the closing program (HNPSP), a number of DPs have been co-financing the program by pooling their funds under an MDTF arrangement that is administered by the Bank. The Bank team has worked with the DPs in exploring alternative pooled funding arrangements. In the end, several DPs such as AusAID, DFID, KfW, JICA and USAID agreed that an MDTF administered by the Bank is the most appropriate arrangement for the new program at this stage but with the aim of strengthening the MOHFW fiduciary management and institutional capacity in order to move towards a GOB managed pooled arrangement at a later stage. In addition to pool funding arrangements, there will be non-pooling DPs who will channel their funds in parallel in support of the new sector program. In order to be successfully implemented, the partnership arrangement between the GOB and the DPs will be further strengthened through a JFA. The JFA will guide both the pooled and non-pooled funding contributions of the DPs as well as provide detailed arrangements for disbursing, managing and reporting on the use of funds. The process of consultations between MOHFW and all DPs will be further strengthened by replacing the HNP Forum with the Local Consultative Group (LCG-Health), which is part of GOB-DP overarching coordination mechanism.

17. The Project will be implemented by the MOHFW under a SWAp modality (as explained above) to ensure harmonization and effective implementation. The Project will be implemented by the MOHFW through existing institutional structures similar to the ending HNPSP but with significant improvements which build upon its experience. The various units under the LDs will implement the Project with policy and administrative guidance from the MOHFW and in consultation with the DPs. The five-year PIP and the three-year OPs will be reviewed by the DPs including the Bank. Another key change is the agreement of the MOHFW to jointly review the ADP with the DPs to ensure that priority interventions are adequately resourced. Also, the Annual Program Review (APR) jointly conducted by the MOHFW and the DPs to assess performance, identify gaps, and define the strategic priorities for the following year, will be synchronized with the preparation of the OPs and ADP in order to ensure that the APR recommended actions are included and can be implemented. In addition, there will be a coherent multi-year integrated and consolidated TA plan of the sector program, currently being developed, to support the MOHFW in program implementation and strengthening its institutional capacity at different levels, and increase focus on achieving results as well as carrying out the agreed upon reforms. This consolidated TA will be supported in parallel by DFID and other DPs. The MOHFW will carry out the Project in accordance with the Environment Management Plan (EMP), the Social Management Framework (SMF), and the Tribal Health Nutrition and Population Plan (THNPP).
7. Sustainability

18. GOB’s Sector Program (2011-2016) has a broad ownership base and the project will be implemented through existing government structures and systems. The Program reflects inputs from MOHFW implementing agencies at the central, district and upazila levels, other government ministries, DPs, NGOs and civil society organizations. These inputs were collected through extensive consultations with a wide range of stakeholders at multiple stages of the drafting process. As for implementation, building on the precedent set under HNPSP, no parallel structures will be created to manage the program and Bank-financing will continue to support strengthening of government systems to ensure sustainability of the institutional and management capacity.

19. Improved sustainability of public health spending will require major changes in how overall health care is financed over the medium to long term. Households directly finance the largest, and growing, share of health spending – 64 percent in 2007, up from 57 percent in 1997 – through out-of-pocket payments at the point of service. Although impoverishment due to catastrophic health expenditures does not appear at present to be a major issue in Bangladesh, this masks underutilization of care due to financial barriers, particularly of the poor. Though the GOB program aims to target the poor, disparities in utilization of HNP services and infrastructure-based budget allocation formula translate into public subsidies that disproportionately benefit the better off. The Project will support the development of a comprehensive health financing strategy that will outline measures to improve sustainability, equity and efficiency through resource mobilization and allocation mechanisms that promote achievement of desired results.

8. Lessons Learned from Past Operations in the Country/Sector

20. Health Reforms need to be fully owned by the GOB, supported by adequate technical assistance (TA) to establish the evidence, and based on a constructive policy dialogue from the DPs that recognizes the political economy of reforms. Planned reforms were not fully pursued under the now closing HNPSP such as the diversification of service delivery through contracting out with NGOs and modernization of the HNP sector through further decentralization and local level planning (LLP). The TA provided was not adequately and effectively mobilized in support of these reforms mainly due to constraints in GOB procedures for hiring international consultants and firms. Moreover, DPs persistently pursued reforms, envisaged at the program design stage, without sufficient adaptation to the changing political environment. During the preparation of the MOHFW’s new sector program, the DPs and GOB have jointly initiated a policy dialogue on several reform areas. The dialogue will expand beyond the MOHFW/Planning Wing and involve key decision makers as well as implementers. A coherent multi-year integrated and consolidated TA plan is being developed to support the MOHFW in implementing the agreed upon reforms. This consolidated TA will be supported separately by DFID and other DPs to ensure its effectiveness. The Project has several interventions to improve efficiency such as reducing the number of OPs implemented as part of the closing sector program, linking payments to performance, improving maintenance and operation of the health facilities, and
improving the utilization of available resources. The program aims at improving resource allocation, revitalizing the Community Clinics (CCs)\(^3\) and engaging with non-state providers in order to improve access and delivery of essential health services. The RF for the program also incorporates a number of pro-poor indicators (e.g., skilled birth delivery among the poorest 40 percent, expansion of CCs as a proxy for access to poor) to measure the performance of the sector program.

21. The PBF modality needs to be developed in close collaboration with implementers in the MOHFW and directly linked with the expected Project results. Under the closing program, PBF was implemented with mixed results. Performance was often measured through process level indicators that did not have a direct causal link with the desired program results, as measured in the RF. Further, it was not always clear which Line Directors (LDs) had responsibility for achievement of various PBF indicators and whether their OPs had appropriate provisions to ensure implementation of the activities required to achieve these results. Under the Project, a revised PBF modality using DAAR will be used as jointly agreed between MOHFW and DPs.

22. The pool funding arrangement needs to be more flexible and support capacity building and not just mitigating the fiduciary risks and complying with procedures. Under the program which is closing, the MDTF and fiduciary arrangements have been complex and cumbersome, resulting in implementation delays. The procurement workload has been unsustainably large primarily due to low prior review threshold levels. The quality of the procurement documents prepared by MOHFW has been poor, which requires several revisions that further exacerbate the delays. Also, the pool funders have different fund replenishment procedures, which require several administrative transactions. Under the new sector program, a Joint Financing Arrangement (JFA) will be employed to provide detailed and streamlined financing arrangements as well as the responsibilities of the signatories. The Bank is working with MOHFW to streamline some of the processes under the Project by exploring the possibility of increasing the prior review thresholds, using multi-year framework contracts, and putting in place mitigation mechanisms against risks and weaknesses identified during the procurement assessments. Also, there are capacity building measures such as introducing e-procurement and customizing the GOB automated integrated budgeting and accounting system (IBAS) for financial reporting. At the midterm of the Program, the GOB and DPs will assess the fund flow arrangements and assess future possibility of moving towards even strengthened alignment with the GOB’s Treasury system and possibility of sending direct financing to GOB’s Treasury account.

23. More concerted efforts are needed to improve the provision of primary health care services for the growing urban population. Under the closing program, there have been several gaps in primary health care coverage of urban areas, except in areas covered by the Urban Primary Health Care Project II, Smiling Sun Franchise Program and some other NGO providers. Under the new sector program, primary health care services for the poor will also be provided in the urban areas supported by other DPs and a strengthened coordination mechanism will be established between MOHFW and MOLGRDC.

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3 In 1996, community clinics were created to provide basic health care services at the village level and were in operation till 2001. In 2009, the Government has committed to operationalizing 18,000 community clinics, which will be done under the sector program.
9. Safeguard Policies (including public consultation)

24. The Project is categorized as Environmental Category B. The safeguard policy on Environmental Assessment (Operational Policy 4.01) is triggered and MOHFW has undertaken an Environmental Assessment and developed an acceptable EMP. The EMP 2011 has documented the achievements and improvements and lessons learnt from the implementation of Environmental Action Plan prepared in 2004 and also identifies existing gaps and mitigation measures required to be implemented under the Project. The environmental issues are triggered by and primarily associated with infection control and waste management. Other environmental issues related to construction include site location and planning, especially in sensitive ecological regions, and issues related to building design and construction. The revised and updated EMP also provides recommendations and new action points to address the identified gaps and a system for monitoring and evaluation, along with a new timeline and revised budget. Since the Project is multi-donor funded, it has been agreed with the GOB that IDA credit will not be used to finance the procurement of new incinerators.

25. The Project triggers Operational Policies 4.10 and 4.12 because of its proposed activities in the Chittagong Hill Tracts (CHT) and other areas populated by indigenous peoples, and a potential need for private land acquisition. With regards to the development of physical facilities, smaller facilities may be built on land available from private donation and/or direct purchase by MOHFW but the larger facilities might require private land acquisition.

26. Consequently, MOHFW has developed an SMF to deal with issues concerning indigenous peoples and involuntary resettlement. The SMF will apply to the Project and provide the basis to prepare and implement the Resettlement Plans and Indigenous People’s Plans, as and when required for the individual facilities. The Bank has reviewed the SMF and ensured compliance with the safeguard policies.

27. Operational Policy 4.10 necessitates the preparation of a THNPP to address the specific HNP needs of the indigenous people. MOHFW has prepared THNPP 2011 which has documents the improvements and lessons learnt from the implementation of THNPP prepared in 2004 and

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also identifies existing gaps and mitigation measures required to be implemented under the Project.

28. The social safeguards and environmental documents have been disclosed through the World Bank’s Infoshop as well as the MOHFW’s website. Hard copies will be available at the MOHFW.

10. List of Factual Technical Documents

- MOHFW Strategic Document for HPNSDP
- Bangladesh Health Sector Profile
- Upazila Health System Analysis: Improving health service delivery for the real poor
- Annual Program Review Reports of HNPSP
- Annual Program Implementation Report of HNPSP
- Procurement Assessment Report
- Public Expenditure and Financial Accountability Assessment Report
- Environment Management Plan of HPNSDP
- Social Management Framework for HPNSDP
- Tribal Health, Nutrition and Population Plan for HPNSDP
- Program Implementation Plan (2011 – 2016)

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