1. Key development issues

The Government’s Interim Poverty Reduction Strategy Paper (I-PRSP) adopted “a comprehensive approach premised on a rights-based framework, that highlights the need of progressive realization of rights in the shortest possible time”. The strategy envisions that, by the year 2015, Bangladesh would achieve the following MDG targets (in the health sector):

1. A reduction in infant and under five mortality rates by 65 per cent, and elimination of gender disparity in child mortality;
2. A reduction of the proportion of malnourished children under five by 50 per cent and elimination gender disparity in child malnutrition;
3. A reduction of maternal mortality rate by 75 per cent;
4. Ensured access to reproductive health services for all;
5. A substantial reduction, if not total elimination, of social violence against the poor and the disadvantaged groups, especially against women and children.

Notwithstanding its past achievements, Bangladesh is faced today with an unfinished agenda of systemic problems as originally identified in the Health and Population Sector Strategy (HPSS) of 1997.

The following are key issues faced by the sector today:

1. **Health Inequalities**. Despite the increase in average health indicators, the gap in health conditions between the rich and the poor remains high. Finding cost-effective ways of improving demand for/consumption of essential HNP services by the poor is critical.
2. **The Dynamics of Public and Non Public Health Service Provision**. In Bangladesh, total annual per capita spending on health averages US$11, of which only US$4 is from the public...
sector. Up to a third of the public budget on health is provided by DP from 1998-2003. Almost half of households use the non-public sector for treatment compared to only 10% who use the public sector. The very poor people are less likely to use either public or non-public services for any purpose (including treatment) compared to the less poor and the bulk of household expenditure (70%) on healthcare comes from out-of-pocket expenses-- the major share being spent on pharmaceuticals purchased largely from non-public providers. Therefore, GOB’s role as a provider and financier of health services should be reviewed. In particular, given the multiplicity of providers and the preferences of consumers for privately provided services, GOB should consider de-linking its purchasing and providing functions for specific HNP services where it lacks a comparative advantage.

3. Quality Health Care. As said, most services are provided by the non-public sector, largely in a poorly regulated environment. Developing feasible and acceptable strategies for regulating and enforcing regulation of quality, volume and price is critical for health services and pharmaceuticals.

3. The Changing Epidemiology. Bangladesh is faced today with a double disease burden that is, an increasing incidence of injuries, accidents (drowning being the leading cause of child mortality for the 1 to 5 year olds) and a growing burden of non-communicable diseases (NCD) in addition to its fair share of communicable diseases. Amongst non-communicable diseases (NCD), cancer and cardiovascular diseases are leading causes of morbidity and mortality. Projections show that as early as in 2010, NCDs will increase their share as cause of mortality from 40% in 1990 to 59%. Injuries are expected to increase their share from 9% to 11%. Hence, the MOHFW has to review its role on how best to handle these new challenges.

The recent HNP Strategic Investment Plan 2003-2010 confirms GOB commitment to pro-poor health service provision and addresses the need to reappraise the essential core functions of the public sector.

The SIP identifies seven long term challenges for the sector. (1) **Stimulating informed demand** for HNP services. Hereto effective information and communication strategies need be developed. (2) **Improving the quality and scope of HNP services** could be done through regulation, quality control measures, such as registration and accreditation of practitioners; (3) **Restructuring the way services are provided**. This includes ensuring greater efficiency and responsiveness to HNP challenges as they emerge; guaranteeing free provision of emergency services to those in need; and expanding HNP services in urban areas for provision of coordinated primary, secondary and tertiary care. (4) **Mobilizing more resources** for HNP services. The following sources for HNP financing, other than from general taxation, will be explored, based on work already carried out by MOHFW, and, where appropriate, scaled up: (a) Social (payroll) insurance, (b) Community financing schemes, (c) religious taxation (Zakaat), (d) charitable contributions through corporate social responsibility, (e) service fees, (f) private insurance. (5) **Improving equity**: ways are being explored for shifting resources towards areas with the greatest needs, through a revision of norms for per capita allocations to districts, weighted by a poverty-related index of health needs, for incentives for practitioners to attend to the needs of the poor, and for systems of demand-side financing. (6) **Improving service efficiencies** by enhancing workforce motivation and productivity and by the use of service providers according to their comparative advantage, and (7) **Improving sector governance and management**. Efforts will
focus on the following priorities: budget management, staff management, procurement of goods, and aid management.

Alignment with the Country Assistance Strategy (CAS). The World Bank’s Country Assistance Strategy for Bangladesh places special emphasis on poverty reduction and aims to consolidate gains in human development by strengthening priority health interventions. To effectively fight poverty it further supports the forging of partnerships between the public and the non-public sector and proposes (i) exploiting comparative advantages of agencies; (ii) improving regulation and supporting community-driven approaches; (iii) fostering private-sector-led solutions and forging partnerships for health service delivery; and (iv) improving health sector financing and adopting performance-based lending.

Role of Development Partners: The health sector is supported by a large group of DP, coordinated in a DP Consortium, which comprises bilateral and multilateral development partners who endorse the Governments HNPS SIP. Within the DP Consortium, a group (DFID, EC, IDA, Netherlands and SIDA) pool their resources with IDA, while other agencies continue parallel support within the HPSP sector framework.

Rationale for Bank Involvement. The Credit aims to enhance Bangladesh’s growth and poverty reduction prospects through investment in the Health, Nutrition and Population Sector. The operation builds on implementation of the first health sector SWAP (HPSP). An important feature of the HNP sector in Bangladesh is the presence of a well-coordinated group of highly committed DP (bilateral and multilateral agencies) who endorsed the HPSP and now are fully committed to the HNP Strategic Investment Plan and the I-PRSP -- under the financial management and institutional leadership of the WB. Some of these agencies prefer to pool finance (e.g. IDA, DFID, EU, Sida and RNE) whereas others prefer to continue parallel support the sector program (e.g. USAID and ADB, CIDA, German Embassy/ KFW/GTZ, JICA) while UN agencies focus their support to technical assistance (e.g. UNFPA, WHO, UNICEF) in specific areas. All these agencies will ensure that their activities fall within the sector framework for better delivery of urban and rural HNP services to the poor.

2. Proposed objective(s)

The project aims to assist GOB in the implementation of its Strategic Investment Plan 2003-2010 (SIP) for the HNPSP. It will do so in cooperation with a large group of DP through a SWAP of support.

To achieve these objectives, the program will focus on three major areas: (i) **Strengthening Public Health Sector Management and Stewardship Capacity**, including development of pro-poor targeting measures as well as strengthening sector-wide governance mechanisms; (ii) **Health Sector Diversification**, including the development of new delivery channels for publicly and non-publicly financed services; (iii) **Stimulating Demand** of essential services by poor households, including health advocacy and demand-side financing options. The project will measure success of its support by a sub-set of the indicators of the SIP.
HNPSP has a particular focus on services geared to the achievement of the four PRSP social development goals and targets that are within the mandate of the MOHFW and are likely to contribute most to its Millennium Development Goals and emerging HNP challenges.

3. Project description

The project will have three components, which are closely interlinked in their implementation. While the first component focuses on objectives for service delivery in the classical PHC domain and achieving the HNP MDGs, the second responds by developing policies and strategies to the changing disease burden due to urbanization and aging of the population. The third component addresses major policy reforms and strategies envisioned in order to achieve more overall equity and efficiency in the HNP sector.

Component 1: Accelerating achievement of health-related MDGs and PRSP strategies and of population policy objectives. The component supports the delivery of the essential service package (ESP). Such a package would focus on (a) reduction of maternal mortality, through public information campaigns to raise awareness about the importance of antenatal care and maternity services to reduce problems during pregnancy, labour and the postnatal/neonatal period and obstetric complications. Expansion of the skilled birth attendance program, a competency-based six-month training on basic midwifery for community health workers (FWAs and female HAs). Strengthening emergency obstetric services, as foreseen in the 2001 National Strategy for Maternal Health, by properly equipping and staffing EmOC services. Finally, a voucher programme to increase demand for maternal and neonatal health services and to insure against the costs normal delivery by a skilled provider and emergency obstetric care is being piloted and will be expanded under the program as part of a wider strategy to address demand-side financing (see Comp. 3). (b) All the interventions of this subcomponent will also be beneficial for the reduction of neonatal mortality. (c) Reduction in childhood morbidity and mortality would be supported by strengthening the routine EPI program, including polio eradication campaigns as needed, and scaling up IMCI to a national level after evaluation of the pilots. (d) the program will support the following strategies to support maternal and childhood nutrition: (i) public information campaigns to support the important role of nutrition at national and community level; (ii) education of families on nutritional needs and proper household-level feeding for children; (iii) initiate Infant and Young Child Feeding (IYCF) interventions, which promote exclusive breast feeding for 6 months and continue breastfeeding until 2 years with appropriate complementary feeding; (iv) strengthen the community IMCI package and linking it with regular health services; (v) further improve the coverage of vitamin-A supplementation every six month for all children 1-5 years of age; (vi) improve iron folate supplementation for adolescent girls and pregnant women, and (vii) IDD control through salt iodization. (e) Reducing fertility to replacement level (by 2015) through public information campaigns and service quality improvements, by increasing selective outreach services to urban slums and other hard-to-reach and low-performing areas, and by actively promoting cross-sectoral efforts to provide alternative roles to young women outside of early marriage and childbearing. (f) Reducing the burden of TB and malaria and preventing and controlling HIV/AIDS. For TB, MOHFW will focus be on increasing case detection while maintaining a high cure rate, improving the compliance of the private sector and academic institutions with the DOTS strategy, and ensure uninterrupted supplies of drugs and laboratory supplies. For Malaria, IDA will support the
implementation of the Revised Malaria Control Strategy, i.e. early diagnosis and prompt treatment (EDPT); selective vector control; promotion of Insecticide Treated Mosquito Nets (ITMN); surveillance, information management and outbreak preparedness and control; and community involvement and partnerships with NGOs and private sector under the Roll Back Malaria whose goal is to halve the burden of malaria by 2010. For HIV/AIDS, Bank’s present support through the HIV/AIDS Prevention Project (HAPP) will be folded into HNPSP after HAPP closes. The support will continue to focus on four major components and strategies: high-risk group interventions, communication and advocacy, blood safety and institutional strengthening.

Component 2: Meeting emerging HNP sector challenges. (a) Reducing injuries and implementing improvements in emergency services. The project will support the development of policies and strategies focusing on the following areas: public information campaigns to improve road, water and industrial safety and to raise community awareness of domestic injuries, including injuries due to violence, advocacy for violence prevention, medical, counselling and legal assistance to women victims of violence, establishment of emergency care facilities in high risk locations, and publicly financed insurance against catastrophic treatment costs, particularly for the poor. (b) The prevention and control of major non-communicable diseases (NCD). Five key strategies for improving the prevention and control of NCD will be supported under HNPSP: an assessment of the disease burden of major NCD and their common risk factors should be carried out; public information campaigns to increase awareness of the risks of smoking, unhealthy diet and benefits of physical inactivity; improved screening for the early detection of obesity, hypertension and diabetes; and improved diagnosis and management for the major NCD. Finally, policies need to be developed for publicly financed insurance against emergency treatment costs of NCD especially for poor families. (c) Urban health service development. Over the next five years, IDA will support MOHFW to move forward on the following fronts: improve liaison between DGHS and DFP and municipal authorities; provide clinical staff to the Ministry of Home Affairs for prison services; open discussions with MOLGRDC with a view to developing an integrated urban health development plan, and consider the case and carry out a feasibility study for a Centre of Excellence to be established at the National University of Dhaka by 2010. (d) Improve the HNP response to disasters. A broad, co-ordinated inter-sectoral response is required. However, within the HNP sector, a number of measures can be initiated quickly and sustained over the next five years: (i) improvements in inter-sectoral liaison and co-ordination, (ii) improvements in co-ordination within the HNP sector through strengthened communication and co-ordination mechanisms within DHS and between DHS and municipal authorities, the armed forces, NGOs and civil society, (iii) improvements in the management of emergency stocks, and (iv) maybe most importantly the development of a co-ordinated risk management plan, including training.

Component Three: Advancing HNP sector modernization. This component will deal with:

(a) public health sector management and stewardship capacity. Improving sector management will focusing on improving institutional and personal skills in the following functions: (i) planning and monitoring, in close liaison with the Financial Management and Audit Unit, to ensure that PIPs and Operational Plans are prepared in line with this Strategic Investment Plan and implemented according to agreed performance indicators; (ii) improved budget management
through an MTEF process; (iii) reform management, including developing reform proposals and
design, initiating them and assessing the results in terms of efficiency improvements; (iv)
improved aid management responsible for the co-ordination of aid proposals, the proper use of
pooled aid funds and the provision of activity and expenditure reports; and (v) the management
of contracts and commissions with private and NGO providers. (vi) information management,
most importantly the management and HNP information required to monitor the performance of
the sector and to identify priority interventions to improve its efficiency, equity and
effectiveness; improved surveillance systems form part of this area (routine surveillance,
priority communicable disease surveillance, emergency or outbreak related surveillance,
institutional surveillance, and sentinel surveillance).

Decentralisation and local level planning. Major targets have been established, agreed and
accepted for the 2003/04-05/06 period covering maternal and infant/child mortality, fertility
rates, malnutrition and communicable disease control. The next step is to ensure that each of the
various departments, directorates and administrative bodies that comprise the health sector in
Bangladesh understand clearly and agree on their contribution to achieving these stated goals, on
the basis of step-wise delegation of responsibility against agreed work plans and budgets
beginning with the management of the recurrent non-staff budget, followed by the small-item
capital budget, followed by the recurrent staff budget and with it delegated authority for staff
recruitment and management. Progress to each next step will be preceded by training and
accreditation and demonstrated competence at each level. Improvements in organisational and
individual performance will require capacity building at all levels, which will take time.

An umbrella bill for Hospital Autonomy is in the final stages of drafting. In terms of
decentralisation to districts, a pilot programme in six districts represents the first steps in this
process. Budgets are being prepared on the basis of Local-level Planning with stakeholder
participation. HNPSP will provide support for capacity strengthening.

(b) Health sector diversification. In order to diversify service provision, MOHFW and
municipalities need to develop capabilities to become active service purchasers in partnership
with NGOs and private providers. MOHFW will begin to tackle this important and complex
issue, in collaboration with the BMA, NGO networks and private sector providers. The pattern of
service provision will be adjusted over time by the increasing use of contracts and commissions
for NGOs to provide primary care in areas, where they have a comparative advantage, and for
private providers to offer secondary and tertiary services for poor people where they can do so
cost-effectively and at high quality.

(c) Stimulating demand for HNP services. This will be achieved through: (i) a greater attention
on effective communication, education and information strategies for key health problems;
public information campaigns, and active multisectoral health promotion to deal with
determinants of poor health. The comparative advantage of NGOs and the for-profit private
sector in providing communication services will be exploited to the full; (ii) expansion of
demand-side financing. This is already included in a number of local and community financing
schemes. In addition, an important trial has been started by the MOHFW with support from
Development Partners, including WHO, in the use of vouchers, which allow eligible poor
pregnant women to purchase maternal health services. These and other schemes will be expanded in geographical scope and extended to other priority services for poor people.

4. Safeguard policies that might apply
The MOHFW is carrying out an Environmental Assessment to comply with OD 4.01. The project is a Category B project and a health care waste management plan is being developed. A Social Assessment has been carried out and a Tribal Health Action Plan has been developed in compliance with OD 4.20. These will be discussed with GOB during the Appraisal mission and disclosed.

5. Tentative financing (2005-2009)
Source: ($m.)
BORROWER/RECIPIENT  2500
INTERNATIONAL DEVELOPMENT ASSOCIATION  200
EXPANDED COFINANCING  1750
Total  4500

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