HealthSector Support Project (HSSP)

SOCIAL MANAGEMENT FRAMEWORK

Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh

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ACRONYMS & ABBREVIATIONS

BPP	Bangladesh Population Policy
CC	Community Clinic
DGHS	Directorate General of Health Services
DHIS 2	District Health Information System 2
DLI	Disbursement Linked Indicator
DP	Development Partner
GEVA	Gender, Equity, Voice and Accountability
GOB	Government of Bangladesh
GRS	Grievance Redressal System
HEU	Health Economics Unit
HNP	Health, Nutrition and Population
HSSP	Health Sector Support Project
MCH	Medical College Hospital
MOHFW	Ministry of Health and Family Welfare
MOWCA	Ministry of Women and Children Affairs
NGO	Non-Governmental Organization
NHP	National Health Policy
NNP	National Nutrition Policy
OCC	One Stop Crisis Center
OP	Operational Policy
PDO	Project Development Objective
SMF	Social Management Framework
UHC	Upazila Health Complex
VAW	Violence Against Women
WHO	World Health Organization

A. Introduction

1. The Government of Bangladesh (GOB) and partners have pursued a sector-wide approach (SWAp) since 1998, adopting a series of multi-year strategies, programs and budgets for management and development of the health nutrition and population (HNP) sector, with support from both domestic and international financing. The government is in the latter stages of finalizing its Fourth Health, Population and Nutrition Sector Program, covering the 5.5 year period (between January 2017 and June 2022) with an estimated cost of US$14.8 billion. The Fourth Sector Program's overall objective is "to ensure that all citizens of Bangladesh enjoy health and well-being by expanding access to quality and equitable healthcare in a healthy and safe living environment." The World Bank's project, Health Sector Support Program (HSSP), will support implementation of the GOB's Fourth Sector Program and will be synchronized with its implementation timeline. HSSP is consistent with the GOB's program and policies and will play an important role in advancing key results areas with the use of disbursement-linked indicators (DLIs).

2. The Ministry of Health Family Welfare (MOHFW) considers the Fourth Sector Program as a first, foundational, program towards the achievement of the Sustainable Development Goals by 2030. The government's Fourth Sector Program builds on a successful history of the previous sector programs, with well-established planning and consultation processes as well as monitoring and coordination mechanisms. It encompasses three components: (i) Governance and Stewardship, (ii) HNP Systems Strengthening, and (iii) Provision of Quality HNP Services.Like previous sector programs, it is expected that a significant proportion of development partner (DP) support will be channeled through on-budget financing.

3. As Bangladesh builds on significant progress in the HNP sector and pursues progress towards the SDGs, it will face important challenges. These can be characterized in three ways: (i) foundational financing and system development priorities; (ii) the unfinished agenda relating to the Millennium Development Goals; and (iii) emerging challenges. The World Bank's project, HSSP, will use a set of 21 DLIs in responding to these key challenges. In supporting part of the GOB's Fourth Sector Program, which is national in scope, HSSP will benefit, directly and indirectly, the entire 160 million population of Bangladesh, including 50 million in Sylhet and Chittagong divisions, who are of particular focus for several indicators. Out of the 21 DLIs included in HSSP, 12 are focused on improving service delivery including maternal and child health and nutrition services in Chittagong and Sylhet (two out of the seven administrative divisions of Bangladesh).

4. The Project Development Objective (PDO) of HSSP is to strengthen the health, nutrition and population (HNP) sector's core management systems and improve delivery and utilization of essential HNP services, with a focus on selected geographical areas. The DLIs to be supported by HSSP are:

Component 1. Governance and Stewardship
1. Citizen feedback system is enhanced
2. Budget execution across programs is increased
3. Spending on repair and maintenance at the service delivery level is increased
Component 2. HNP Systems Strengthening
4. Financial management system is strengthened
5. Asset management system is implemented
6. Procurement process is improved using information technology
7. Institutional capacity is developed for procurement and supply chain management
8. Medicine stock tracking system is developed and implemented
9. Availability of midwives for maternal care is increased
10. Availability of specialist human resources for first-referral care is increased

11. Information systems are strengthened, including gender-disaggregated data
Component 3. Provision of Quality HNP Services
12. Utilization of maternal health care services is increased
13. Post-partum family planning services are improved
14. Emergency obstetric care services are improved
15. Immunization coverage and equity are enhanced
16. School-based adolescent health and nutrition services are developed
17. Maternal nutrition services are expanded
18. Infant and child nutrition services are expanded
19. Communicable disease control is improved
20. Non-communicable disease services are developed
21. Coordination on urban health services is improved

5. MOHFW is responsible for implementation of the GOB's Fourth Sector Program as a whole, including achievement of the results to be supported by the Project. The ministry encompasses a number of entities: Directorate General of Health Services (DGHS), Directorate General of Family Planning (DGFP), Directorate General of Health Economics Unit (HEU), and Directorate General of Nursing and Midwifery.

6. Government health facilities are situated at different administrative levels: national, division, district, Upazila, union, and ward. HSPP, through the use of its DLIs, will support system development at all levels and service delivery results at the Upazila level and below. Services are delivered by both DGHS and DGFP, operating through parallel systems. The lowest-level facility is the community clinic (CC), serving at the ward level as the first point of contact for primary health care services, including immunization, family planning, and health education. Each CC is intended to serve 6,000 people; currently, 13,094 CCs are functioning. At the union level, three kinds of facilities, each of which include physicians on staff, provide outpatient care: rural health centers, union sub-centers, and union health and family welfare centers. At the Upazila level, services are provided by UpazilaHealth Complexes (UHC), with inpatient capacity of 30–50 beds. Some of these facilities provide first-referral (secondary) care including comprehensive emergency obstetrical care. At the district level, district/general hospitals of different sizes (100–250 beds) provide secondary care, while some districts also have government medical colleges providing tertiary care. In addition, at the district level there are 10-20 bed maternal and child welfare centers providing family-planning as well as maternal care services. The government also runs a number of tertiary and specialized hospitals at the division and national levels.

B. HNP sector – Achievements and Challenges

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

8. With regard to maternal health care, the proportion of deliveries cared for in health facilities has risen from 12 percent in 2004 to 37 percent in 2014, but this level is an insufficient basis to assure continuity of care from delivery to emergency obstetric care in order to prevent maternal mortality. Indeed, along with increasing utilization of facility-based delivery care, referral and transport systems as

well as capacity for emergency obstetric care, including necessary staff, need to be put in place. Inequalities are also evident, as only 22.6 percent of deliveries in Sylhet division were in a health facility in 2014.

9. The health and nutrition of adolescents are not adequately addressed, with a variety of repercussions for young women in particular, as well as for their children. Although the incidence of marriage at young ages is slowly decreasing, in 2014, 59 percent of women aged 20 to 24 years were married before the age of 18. Compared to overall averages, young women have higher fertility, experience higher infant mortality, and are more likely to be under-nourished. Maternal and child nutrition also present continuing challenges. In 2004, 32 percent of women aged 15-49 were under-nourished and this declined significantly to 18 percent in 2014, although continuing progress is needed.

10. Shortage of adequate human resources is another major problem in the Health sector and Bangladesh ranks lowest in the Doctors/Nurses/Dentists per 10,000-population (6.02) amongst Pakistan, India and Sri Lanka (WHO Global Health Workforce Statistics, 2014 update[1]). According to a WHO estimate, Bangladesh has a shortage of more than 60,000 doctors, 280,000 nurses and 483,000 technologists. This shortage affects the access to health services among ethnic minorities and other vulnerable groups including women.

C. Project Activities and Social Issues

11. Ensuring gender friendly HNP services: There is a shortage of female medical personnel. Owing to religious bindings, social taboos etc., women and girls including adolescents prefer interacting with female doctors. A large number of female doctors do not stay in the remote areas citing family restrictions, poor schooling facilities for children, security at the workplace etc. to address this, DLI 9 aims at increasing the number of upazila health complexes with at least two midwives on staff.

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

13. Lack of effective Reporting System in the Healthcare System: The information systems are fragmented in the MOHFW and there is a need to avoid duplication of data. DLI 11 focuses on number of CCs reporting to District Health Information System 2 (DHIS 2) on an agreed format with gender disaggregated data. This will cover the CCs in Sylhet and Chittagong where small ethnic and vulnerable communities (tribal people) reside. Achievement of DLI 11 will assist in formulating gender specific and gender sensitive policies.

14. The small and ethnic vulnerable communities (tribal people) have their own practices and may not be able to access mainstream services. Specifically, small and ethnic vulnerable community groups in CHT live in small clusters in hard to reach areas that are often difficult to cover by the health facilities. The areas they inhabit, especially in CHT, are less likely to have improved infrastructure (like roads, schools, water supply and sanitation, health care facilities) due to the difficult geographic terrain. In two districts, Rangamati and Khagrachari, many of the small ethnic and vulnerable people live on hilltops that dot the vast expanse of waters. For them small country boats are the only means of transportation. HSSP will support the GOB in improving maternal and child HNP services in Sylhet and Chittagong, as

[1] http://www.who.int/hrh/statistics/hwfstats

well as strengthen health systems. Based on the available data, there is no evidence of any discrimination or barrier to access healthcare specifically for the small ethnic and vulnerable communities.

15. There is a need to ensure that vulnerable and marginalized groups, including small ethnic and vulnerable community (tribal people), are included in the planning process (especially needs prioritization), implementation and monitoring of activities. Specifically, in such participation and subsequent decision making, adopting the principles of "free, prior, and informed consultation that results in broad community support" of small ethnic communities should be institutionalized.

16. According to present healthcare system of the GOB, there is top down approach from the MOHFW up to the Upazila level where effective functionality of the service providers at different tiers are governed by the official oversight. Only at the community level, there is citizen oversight at the CCs. This means that GRS and peoples' participation is most effective at the CCs.

17. Access to healthcare is a concern for the small ethnic and vulnerable communities due to geographical and cultural practices. Since they reside in difficult terrain, the only way to commute is to walk in many of these areas, which impede easy movement of children, pregnant women and the elderly to the health facilities for seeking health services. The GOB is working to connect the Unions with the Upazila through the road network. A modality is needed where Health Assistants and FWAs may be asked to visit villages on regular interval thus covering inaccessible areas.

Gender, Equity, Voice and Accountability (GEVA) initiatives

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

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

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

- **Strategic Objective 1:** Introduce gender-sensitive policies, plans and evidence-based approaches to ensure policies, strategies, operational plans and other programs adhere to the principles of gender equity and effective practice. The main activities are to ensure: plans and programs are in line with the GOB's commitment to achieve gender equity; collection of adequate and relevant gender disaggregated information and use gender responsive indicators for monitoring and evaluation processes; regular gender auditing process in every health facilities; gender responsive health budget in every operational plan; and development of gender sensitive information and communication materials, etc.

- **Strategic Objective 2:** Ensure equitable access and utilization of services using a life-cycle approach -aiming to protect the health of young girls, adolescents and elderly women within a rights-based approach. The activities include strengthening maternal and child health services including adolescents, reproductive health, geriatric health and nutrition services; updating training modules, materials, guidelines (including counseling and communication) to provide services to socially excluded population (i.e. transgender, people with disabilities, small ethnic and vulnerable community, etc.); conducting training of trainers for health service providers; and enhance gender sensitive family planning and counseling services.

- **Strategic Objective 3.** Ensure gender mainstreaming in all programs with MOHFW and other ministries and organizations through equitable planning and budgeting. Advocacy with policymakers to change, develop and/or enforce laws and policies that promote gender equality and human rights. The activities involve incorporation of gender equity with concerned ministries and organizations so that mainstreaming of the gender perspective is in legislative drafting, budget preparation and other activities with major implications for gender equality.

- **Strategic Objective** 4. To ensure gender balanced human resources (service providers) in health sector with appropriate skills to deliver gender sensitive, non-discriminatory services. The activities include ensuring the development of gender sensitive human resources who are capable in providing quality services to all, irrespective of individual's sex, ensuring the development of gender balanced human resources who are capable in providing quality services to all, irrespective of individual's sex, and **e**nsuring that gender sensitive policies are practiced in HR dealings.

- **Strategic Objective** 5. To ensure involvement of key stakeholders- representatives of civil society and other stakeholders, particularly women, men, girls and other socially excluded communities, on planning, implementing and reviewing health and family welfare services and gender equity strategy. The activities include dialogue with civil society, stakeholders, NGOs on gender mainstreaming so that ownership and acceptance of an intervention or practice is increased.

- **Strategic Objective** 6. To ensure effective stewardship by the government ministry responsible for health. The activities include ensuring governance and stewardship in health sector program.

One-Stop Crisis Centers

20. To address issues relating to gender-based violence, one of the significant components of the Government is the one-stop crisis centers (OCC) in the Medical College Hospitals (MCHs). The idea behind OCC is to provide all required services for a victim of violence in an integrated manner at one place. The OCC provides the following services:

- Health Care
- Police Assistance
- Social Services
- Legal Assistance
- Psychological Counseling
- Shelter Service
- Medical legal examination with DNA Test

21. In addition, OCC plans to also offer:

- Integrated public service related to violence against women (VAW) will be improved and consolidated to increase quality, efficiency and sustainability.
- Awareness of VAW and related public services will be increased in relevant institutions and general public to promote the use of the concerned facilities.
- Institutional capacity of the Ministry of Women and Children Affairs (MOWCA) will be developed to improve and consolidate inter-ministerial coordination and action in relation to VAW.

22. Multi-Sectoral Program on VAW is the joint initiative of the Governments of Bangladesh and Denmark under the MOWCA. The project is being carried out in collaboration with the Ministry of Health and Family Welfare, Ministry of Home Affairs, Ministry of Information, Ministry of Social Welfare, Ministry of Law, Justice and Family Welfare, Ministry of Religious Affairs and Ministry of Education. The pilot and first phase of the project took place from May 2000 to December 2003 and from January 2004 to June 2008. The program is now in its 2nd phase, which was started from July 2008.Two OCCs have been established in Dhaka and Rajshahi MCHs during the pilot phase of the project. Four additional OCCs in Chittagong, Sylhet, Barisal and Khulna MCHs were established in the first phase of the project. In the second phase management and efficiency in six OCCs were improved.

D. The SMF Objectives, Scope and Methodology

23. The SMF recognizes the need for an early social assessment, during preplanning stage of activities at the field level to identify any adverse impact which helps to plan mitigation measures and help in mainstreaming this aspect throughout the implementation phase. SMF has been prepared fully by considering the WB safeguard policy and GOB regulatory/policy requirements. This framework includes social screening mechanisms; gender action plan; consultation dissemination framework; institutional arrangement and capacity building framework; and framework for monitoring and mitigation of adverse impacts. Following this SMF will ensure thatthe project design and implementation of the proposed activities are socially responsive and sound.

24. The SMF is intended to provide the necessary bases to determine applicability of the World Bank and other DPs' safeguard policies, identify the safeguards impacts, and prepare mitigation plans as and when required. The core principle behind the SMF is to avoid, minimize and mitigate issues relating to gender, social inclusion, and impacts on small ethnic and vulnerable communities (tribal people). As proposed here, this SMF seeks to address the inadequacy of the existing legal provisions to meet the social safeguard requirements of the DPs including the World Bank.The objective of the SMF is to help MOHFWto ensure that the project:

- Enhances social outcomes of the activities implemented;
- Identifies and mitigates adverse impacts that the selected development interventions might cause on people, including protection against loss of livelihood activities, with culturally, socially and economically appropriate measures; and
- Is prepared and implemented in compliance with the World Bank's and other DPs' social safeguards policies.

Scope of SMF

25. The scope of this SMF includes the followings:

1) Assess the baseline situation and potential social impacts of the project
2) To find out the project impacts and benefits
3) Review policies and acts of Bangladesh and the World Bank (OP4.10) in order to identify

applicable provisions in the proposed program/project and suggest ways to fill any gap between GOB and World Bank requirements.

4) Review of existing social management practices
5) Carry out a rapid review of social issues involved and make broad-based social assessment of the program/project (focusing on components and likely activities listed in the pre-feasibility study), highlighting potential positive and negative impacts of the program/project.
6) Assess the capacity of the institutions involved in the project, including the roles and responsibilities of implementing agencies, and offer guidelines for capacity development to address any gaps.
7) Assess gender and social inclusion considerations related to project activities. This includes: identification of key gender and inclusion related participation issues; identification of possible roles for women and disadvantage (or vulnerable groups) in project objectives and activities; examine the differences in knowledge, attitudes, practices, roles, status, wellbeing, constraints, needs and priorities related to gender and other differences; assess the potential for differentiated impact of project based on gender and exclusion and identify options to maximize benefits and minimize adverse effects;
8) Develop a communication and consultation strategy, in line with the overall communication and consultation strategy developed for the project to ensure that the project affected people as well as the vulnerable groups, including women, benefit from the effective and timely delivery of hydro-meteorological events and climate variability envisaged in the project;

Approach and Methodology

26. This SMF has been prepared based on preliminary social assessment carried out through literature review and stakeholder consultation. Literature review includes desk review of existing project documents, government policies, World Bank policies and all available secondary documents. It also comprised collection of secondary information, field level observation and stakeholders consultation.

E. Consultation

27. As part of preparation of the Government's program, the Ministry of Health and Family Welfare held several consultations in each geographic divisions of the country including Chittagong and Sylhet, to elicit feedback from people on the scope and priorities of the Government's program. Moreover, between September 5 to 9 and 25-29 of 2016, Dhaka level thematic workshops were held covering socials issues and aspects of the project (urban, nutrition, maternal and child health, gender, stakeholders' participation etc) with government, DP and CSOs. In a final consultation meeting held at Dhaka on March 14, 2017, the draft SMF was presented. Representatives from different districts (both government, CSOs and TPs) participated in the meeting.

28. During these workshops, social issues were discussed. Stakeholders felt that GEVA has substantially improved the inclusion and gender mainstreaming in health sector and the 2014-2024 Gender Equity and Action Plan needs to be implemented to ensure compliance with international best practices. Adequate monetary and human resources should be made available to this end. The consultation meetings revealed that Bangladesh government has made significant progress through the previous three sector programs in areas of social inclusion, grievance redress mechanisms and addressing the needs for poor and vulnerable groups. The community clinics that have been functional all over the country are the first point of health services for poor and vulnerable groups. Moreover, the union level health and family planning workers conduct door to door visits to households in all rural areas. These two components of the health sector reach out to the most vulnerable, poor and excluded citizens. In several consultation meetings, the participants suggested that in hard to reach areas, the present criteria for establishing a CC (one CC for 5000 people) should be changed and in each village, a CC should be

established to ensure easy access to service for vulnerable people living in remote areas. At all district level now there is a designated information officer (DIO) that any citizen can as for information about government services including health. The first DLI of the proposed program is about functional grievance redress system. It is expected that the activities to achieve this DLI will make the existing grievance redress mechanisms of the government more responsive, functional and effective. Finally, the activities of GEVA have resulted in better gender mainstreaming. The 2014-2024 action plan will further strengthen the gender and inclusion aspects in line with the World Bank policies.

29. There was a recognition that the GOB has made progress in the health sector with regards to access to services for vulnerable groups. However, the main problem that the sector faces is the acute shortage of human resources at every level of service delivery starting from specialist doctors to midwives and nurses. Second, due to lengthy process of public procurement system of the GOB, it becomes difficult to make arrangements for necessary medicines and supplies in a timely fashion. Thirdly, the ministry lacks adequate human resources to maintain GRS.

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

31. The NGOs and academics need to be more involved in policy dialogues and more frequently than what is practiced now. Research and evidence based policy making should be integrated in healthcare provisions.

F. Policy and Legal Framework for Social Safeguards

32. The GOB's health related laws and policies are quite adequate to ensure social safeguards' compliances following relevant provisions of the World Bank Operational Policy (OP) 4.10 and 4.12. To improve the access of disadvantaged and marginalized groups to basic and quality health care services; policy makers, international partners, political actors and NGOs have expressed strong commitments to gender equality and social inclusion. Accordingly, the issues of gender including women, children, the adolescent, small ethnic and vulnerable community (tribal people) have been brought to the fore in development discourses, and also reflected in various acts, policies, strategies and programs, including in the health sector.

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

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

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

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

been completed and it needs to be assessed how far the program has been put to practice.

Gender Equality and Social Inclusion in Health Plans and Policies

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

National Health Policy (NHP) 2011

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

Bangladesh Population Policy 2012 (BPP)

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

Bangladesh National Nutrition Policy (NNP) 2015

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

G. Framework for Social Impact Assessment

39. The project would support a wide range of activities. Most of the activities which are based on the production of healthcare services are unlikely to have adverse social implications. Rather, there is likelihood of huge positive impacts. However, it is important to consider the social equity or distribution

of impacts across different populations for example the poor, the elderly, adolescents, the unemployed, and women; members of the minority and/or other groups that are racially, ethnically, or culturally distinctive; or occupational, cultural, political, or value-based groups within the communities that will access health services.A nationally representative Social Impact Assessment (SIA) at the beginning of the project is recommendedso that both the positive and negative social aspects of health service delivery under this project funding can be adequately captured. The results will help the government to enhance the good practices and mitigate the negative impacts on wider population under health service delivery. The SIA will also advise to address the issues of alternative plans and alternative impacts of similar interventions.

SIA Principles

40. The following principles underpin this guideline:

- SIA will assess impacts (both beneficial and detrimental) arising from the project and cumulatively with other developments in the region.
- Social impact mitigation will incorporate the principles of good social management practices following the GOB and World Bank policies
- SIA will cover the full lifecycle of the project to the extent possible
- SIA will be based on the best data available (both secondary and primary)
- SIA will identify relevant stakeholders that will affect the project's implementation
- SIA will identify strategies to capitalize on social opportunities and to avoid, manage, mitigate or offset the predicted impacts arising from the project
- Communities will be engaged in a meaningful way during the development of the SIA, recognizing local knowledge, experience, customs and values.
- SIA will guide the capacity development of the implementing agencies
- SIA will also identify whether further GAP, Consultation and communication plans are necessary to optimize the social benefits of the project

Role of relevant organizations in preparing the SIA:

41. This guideline informs relevant parties on their roles in the development and implementation of a SIA.

<u>Project proponents (MoHFW)</u>

- It is important to prepare a SIA that identifies the social impacts and mitigation measures with a focus on those that are high risk, for the project lifecycle and that includes commitments for the project's operational phases.
- Commit to continuous improvement in SIAs through recognized regional and international best practices.
- Engage with the local community and interested stakeholders mainly those who would use the health services
- Engage with other implementing agencies on impacts and mitigation strategies.
- Engage with local governments on impacts and mitigation strategies.
- Engage with the community on impacts and mitigation strategies.
- Implement, monitor, review and report on mitigation strategies.
- Prepare commitments that are outcome-focused and relevant to social impacts needing mitigation.

Implementing Agencies

- Provide information and data for the social baseline assessment.
- Review the SIA and assessment of impacts on meteorological services to the community during the public consultation period.
- Where the MoHFWand its designated unit for social management (the planning wing) deem it necessary that outcome focused conditions are required for social impact measures, provide draft outcomes-focused conditions relevant to their areas of expertise for consideration in the evaluation report on the project.
- Maintain the database in coordinating with other agencies

Local level health service providers (district level civil surgeon's office, Upazilahealth complex, union level health and family welfare workers)

- Review and provide consistent information, data and advice for the social baseline assessment.
- Review and provide advice on the SIA and assessment of impacts on local level services to the community during the public consultation period and make a submission to the Ministry as appropriate.
- Engage and provide advice to MoHFW on strategies to mitigate these impacts on local level services.
- Represent local community groups as appropriate.
- Advise how the communication between local communities and service providers can be improved.

MoHFW will collate and consolidate information received from local level social screening and prepare the final SIA report

Non-government organizations

- Provide information and data for the social baseline assessment.
- Review the SIA and assessment of impacts on non government services to the community during the public consultation period.
- Engage with proponents on strategies to mitigate these impacts on non-government services.

Stage in Project/Policy Development

42. Social impacts will be different for each stage. Scoping of issues prior to analysis may lead the assessor to focus only on one stage. The specific stage in life of the project or policy is an important factor in determining effects.

Planning/Policy Development

43. Planning/policy development refers to all activities that take place from the time a project or policy is conceived to the point of construction activity or policy implementation. Examples include project design, revision, public comment, and the decision to go ahead. Social impacts actually begin the day the action is proposed and can be measured from that point. Social assessors must recognize the importance of local or national social constructions of reality.

Implementation/Operational phase

44. As project does not need major construction works, it might not affect communities land or structures severely. But in this period people will be concerned about appropriate access to health

services. For this stage it is important to find out how the information will be disseminated to the community and other agencies. It should be easy accessible.

Identify Social Impact Assessment Variables

45. Social impact assessment variables point to measurable change in human population, communities, and social relationships resulting from regional weather and climate services project. A list of social variables under the general headings of:

- Population Characteristic
- Community and Institutional Structures of the healthcare system of the government
- Political and Social Resources
- Individual and Family Changes
- Community Resources

46. The following matrix can be used for determining the impacts of this project:

Social Impact Assessment Variable	Planning/Policy Development	Implementation/Operation
Population Characteristics		
Population Change		
Ethnic and racial distribution		
Relocated populations		
Seasonal residents		
Community and Institutional Structures		
Voluntary associations		
Interest group activity		
Size and structure of local level health services		
Historical experience with health issues		
Employment/income characteristics		
Employment equity of minority groups		
Local/regional/national linkages		
Industrial/commercial diversity		
Political and Social Resources		
Distribution of power and authority		
Identifications of stakeholders		
Interested and affected publics		
Leadership capability and characteristics		
Individual and Family Changes		
Perceptions of risk, health, and safety		
Trust in political and social institutions		
Residential stability		
Attitudes toward policy/project		
Family and friendship networks		
Concerns about social well-being		
Community Resources		
Change in relevant community level health infrastructure		

Steps in the Social Impact Assessment Process

47. The following steps can be followed for preparing SIA:

1. Public Involvement - Develop an effective public plan to involve all potentially affected (both positively and negatively) publics.
2. Baseline Conditions - Describe the relevant human environment/area of influence and baseline.
3. Scoping - Identify the full range of probable social impacts that will be addressed based on discussion or interviews with numbers of all potentially affected.
4. Projection of Estimated Effects - Investigate the probable impacts.
5. Mitigation - Develop a mitigation plan.
6. Monitoring – Develop a monitoring program.

Principles for Social Impact Assessment

48. The following principles can be followed for preparation of SIA.

*** Involve the diverse public** *Identify and involve all potentially affected groups and individuals*
*** Analyze impact equity** *Clearly identify who will win and who will lose and emphasize vulnerability of under-represented groups*
*** Focus the assessment** *Deal with issues and public concerns that really count, not those that are just easy to count*
*** Identify methods and assumptions and define significance** *Describe how the SIA is conducted, what assumptions are used and how significance is determined.*
*** Provide feedback on social impacts to project planners** *Identify problems that could be solved with changes to the proposed action or alternatives.*
*** Use SIA practitioners** *Trained social scientist employing social science methods will provide the best results.*
*** Establish monitoring and mitigation programs** *Manage uncertainty by monitoring and mitigating impacts.*
*** Identify data sources** *Use published scientific literature, secondary data and primary data from the affected area.*
*** Plan for gaps in data** *Evaluate the missing information, and develop a strategy for proceeding.*

Project impacts and Benefits

49. One of the most important criteria, while preparing SIA is to find out the project impacts and benefits. Negative Project impacts will be minimal; as discussed in the following table:

Table 04: Possible Project impacts and its significance

Type of Loss	Nature and scope of impacts	Level of impacts and suggestions
Land	No private land will be acquired.	Project impact over land is insignificant as no land acquisition will be allowed under this project.
Displacement of Titled households	Titled households not be displaced due to project interventions.	Impacts will be insignificant.
Displacement of	No squatters will be affected	Impacts will be insignificant.

squatters		
CPR (Common Property Resources)	CPR will not be affected	Project will avoid any kind of CPR for implementation of this project.
Trees	No trees will be affected.	Impact on trees is insignificant as well.
Income and Livelihood	No income and livelihood will be affected	No significant impact on income and livelihood.
Health	No construction work will be undertaken and thus dust and noise etc will not affect community people's health conditions.	Project impact on health is insignificant;
Gender	No major adverse impact on gender, but the project will significantly improve the healthcare services for women and girls.	Mainly the positive impact on the gender mainstreaming.
Vulnerable communities and tribal people	No major impacts but small ethnic communities might not be willingto access the health services	Significant positive impact will be observed. Small ethnic communities have to be involved with the project where necessary.

H. Framework for Communication Strategy and Action Plan (CSAP)

Purpose of the CSAP

50. The Communication Strategy and Action Plan (CSAP) is a living document that will link the healthcare services related information with a feedback process that can be monitored, evaluated, updated and adapted. As such it will ensure that the growing knowledge and experience gained during its implementation stages will (i) be duly shared with different publics and stakeholders, and (ii) provide guidance to resolve any communication conflicts across key stakeholders.

Targeted populations and scope of work for CSAP

51. The stakeholders and target population will include:

- People in the rural areas accessing health services in Sylhet and Chittagong divisions
- Local elites and other stakeholders (e.g, traditional healers, religious leaders) influencing the health seeking behavior of the area residents.
-

Scope of work

- Conduct stakeholder mapping and assessing their roles in the community in seeking healthcare services
- Identify appropriate channels of communication for information sharing and feedback

52. As part of the social assessment, the communication-relevant parameters will be analyzed; a strategy will be formulated and presented in the CSAP.

I. Implementation Arrangement and Monitoring and Evaluation

53. Planning wing of the MoHFW will be responsible for implementing the SMF. The wing is composed of one Joint Chief, two deputy chiefs and 16 desk officers will be responsible for implementing the SMF. Capacity building training needs assessment will have to be conducted and necessary training will have to be imparted during the first year of the project. The GNSPU is committed to provide required attention to GEVA issues, particularly adolescent friendly and sexual and reproductive health and rights services and gender-based violence. The GNSPU needs technical expertise and human resource to implement the activities included in the Gender Equity Strategy. Moreover, due to inadequate manpower, and minimum expertise of the Line Directorates, GNSPU is yet to start the basic work including gender reporting, gender auditing, etc.

Monitoring and Evaluation

54. Impacts of the proposed subcomponents on physical, socioeconomic and cultural environment will be monitored on the basis of a scheduled plan. The MoHFW will be responsible to adhere with monitoring parameters, locations, schedule and responsibilities. Impact monitoring will be carried out through internal monitoring system. Likewise, mid-term evaluation and final evaluation will be carried out:

J. Grievance Redress

55. Grievances are issues, concerns, problems, or claims (perceived or actual) that individuals or community groups want to address and be resolved by the Project. The grievance mechanism is a way to deal with and resolve complaints and grievances faster and thus enhance project performance standards in terms of social and resettlement management.

56. World Bank has specific clauses/guidelines requiring the borrower/client to set up and maintain a grievance redress mechanism at the Project level. This mechanism does not replace donors' accountability mechanism, but is intended to solve project specific grievances. If aggrieved, it is expected that affected people will first approach the grievance mechanism before taking the issue to other forums. The GRC system established in this project is expected to be effective in resolving grievances related to project benefits. All affected persons will have full and free access to GRCs.

57. GOB believes in free flow of information and people's right to information. In view of ante 'The Right To Information Act, 2009 Bangladesh' came into effect on 6 April, 2009. The right to information shall ensure that transparency and accountability in all public, autonomous and statutory organizations and in private organizations run on government or foreign funding shall increase, corruption shall decrease and good governance shall be established. GOB has developed a dedicated web portal (http://www.grs.gov.bd/home/index_english) where the aggrieved ones could ventilate complains and seek remedial measures. All the ministries including MOHFW have also developed GRS mechanism within the ministry to ensure better accountability and transparency. The project will not have a project-specific GRS in areas where there is no tribal people living. As a mainstream government healthcare services, it will use the existing government GRS system. In areas, where there is a significant number of tribal people living, separate GRS system will be developed and made functional (for details please refer to the FTPP). Moreover, owing to the very nature and social standing of the tribal people and other vulnerable groups, most of them prefer not to complain against any wrongdoing by the HRH fearing repercussion. At the same time, the DGHS and DGFP personnel do not have a functional system to address the complaints received. The DGHS and DGFP need to improve their internal mechanisms to avert wrongdoings by the HRH and establish a functional GRS. The Program needs to sensitize MOHFW on this aspect. The realization of DLI 1 will accelerate these activities.

58. Communities and individuals who believe that they are adversely affected by a World Bank supported project may submit complaints to existing project-level grievance redress mechanisms or the Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. To ensure impartiality and transparency, hearings on complaints at the GRC level will remain open to the public. The GRC will record the details of the complaints and their resolution in a register, including intake details, resolution process, and the closing procedures.

59. Project affected communities and individuals may submit their complaint to the World Bank's independent Inspection Panel that determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond[2].

K. Budget

60. To comply with the social safeguard policies, adequate financial resources will be required. The MoHFW will make specific budgetary provisions for the implementation of the SMF. The budget is subject to revision based on project requirements during the implementation stage. The executing agency will have to undergo capacity building trainings as well as trainings for the project beneficiaries to be able to have the understanding to be in the information loop. The budget should address it as an integrated component within cost of the project. A particular section of the budget will include other costs involved with project implementation including project disclosure, public consultations and focus group discussions, surveys, training, and monitoring and evaluation. This approximation may be revised based on changes on any additional impacts to be considered during implementation. Therefore, the budget will remain as a dynamic process for cost estimate during implementation.

L. SMFDisclosure

61. MOHFW will disclose Bangla translation of a summary of SMF to the public in Bangladesh, and authorize the World Bank to disclose it at its Country Office Information Center and in its Info shop. MOHFW will ensure that copies of the translated document are available at its headquarters and district offices,concerned government offices in the project districts, and other places accessible to the general public. As to disclosure, MOHFW will inform the public through notification in two national newspapers (Bangla and English) about the SMF and where it could be accessed for review and comments.

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

Annex-1: Social Safeguard Screening for HSSP

[To be filled in for upazilaby the designated government officials]

A. Identification

1. Name of Upazila: ……..……..……..…

District/City Name:
…….…….....…….....

2. Screening Date(s): *…….....*

B. Participation in Screening

3. Names of official who participated in screening:

4. Local Government representatives and community members & organizations participated in screening: List them in separate pages with names and addresses, in terms of community selection and any other information to identify them during preparation of impact mitigation plans.

5. Are there households and individuals living in the communities covered by the health services who are otherwise vulnerable?

a. Female headed HH	persons F	M
b. Other Female HH	persons F	M
c. Disabled HH	persons F	M
d. Tribal HH	persons F	M
e. Extreme poor HH		
f. Hijraindviduals		

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6. What are the measures that the community residents suggested to ensure effective healthcare services to these vulnerable groups?

List the main points

On behalf of the Upazila health complex, this Screening Form has been filled in by:

Name: …… Designation: ……..……..

Signature: …… Date: ……...

Annex-2: List of Stakeholders Met in Final Consultation Meeting at Dhaka

Participant of Stakeholder Consultation on EMP, FTPP & SMF for the 4th Health Population & Nutrition Sector Program (HPNSP) of Ministry of Health and Family Welfare (MOHFW) (March 14, 2017)

SL No.	Name	Designation	Phone
1.	Dr. Nilo Kumar Tandangya	Councilor, CHTRC	01819675793
2.	M.M. Reza	CTA, PMMU	01819555525
3.	Dr. Mir MustafizurRahman	Health Officer Dhaka South City Corporation	01711547578
4.	Dr. UdaySarkarChakma	Civil Surgeon, Bandarban	01746215350
5.	Begum ShahaNaz	Deputy Director of Family Planning	01711146922
6.	M. A. Jabbar	Councilor, KHDC	01553559274
7.	BiplobBarun	Deputy Director Family Planning, Khagrachari	01815592827
8.	Dr. ShahidTalukder	Civil Surgeon, Rangamaty	01554303477
9.	SabirkumarChakm	Councilor, R. H. D. C	01720693062 01818930037
10.	ThowaiHlamongmarma	Councilor, B. H. D. C	01553645252
11.	Dr. Md. MazedChyOvi	Representative, CS. Civil Surgeon office, Chittagong	01819173997
12.	Dr. AbulKalamAzad	Civil Surgeon office Sylhet	01711111429
13.	K M Hasanuzzaman	Executive Engineer, HED	01718780526
14.	Dr. U Khey Win	DDFP Chittagong	01817734833
15.	Dr. Md. Abdus Salam	Civil Surgeon Khagrachari	01819361412
16.	Dr. Aung THA Loo	DDFP Bandarban	01715546605
17.	Dr. LuthfunnaherJasmin	DDFP Sylhet	01711174222
18.	Dr. Md. LutforRahman	VO, DNCC Dhaka	01711341086
19.	Rabindranath Saren		01712278211
20.	Dr. Abdus Salam Howlader	PM (Research) PMR, DGHS, Mohakhali	01712219534

SL No.	Name	Designation	Phone
21.	Md. AbdurRakib	Deputy Chief Ministry of cultural Affairs	01552474175
22.	Md. HumayunKabir	Assistant Chief PM, DGFP	01911361300
23.	Md. Faruk Ahmed Bhuiya	Line Director DGHS	01715165914
24.	Dr. T.M. MoziburHoque	Director, ESD DGHS	01922455723
25.	SubinayBhattacharge	Deputy Secretary MOCHTA	01711156702
26.	HossainShohid	UNDP	01819241272
27.	S.Y. Khan Mojlish	CHTDF-UNDP	01610012347
28.	Most. Salma Khatun	Deputy Director, Admin Directorate General of Nursing and Midwifery	01716357755
29.	Most. Shahinoor Begum	Assistant Director, COD, Directorate General of Nursing and Midwifery (DGNM), Dhaka	01731-926976
30.	Dr. Saiful Islam	DPM CBHC, DGHS	01818031386
31.	S.M. Sadekul Islam	Executive Engineer PWD	9552912
32.	KamrunNaharSumi	Assistant Chief, MOHFW	01716597221
33.	Dr. Md. Abdul Wadud	DPM (HSM), DGHS	01711300721
34.	NurunNahar	SAC, MOHFW	01550153612
35.	MahfuzaAkhter	Deputy Secretary ERD	01711003657
36.	Md. Huzur Ali	SAC, MOHFW	01814-126168
37.	RejwanulHoque	SAC, MOHFW	01715238975
38.	Mohammad Abdul Azim	Assistant Director, DOF	01552361091
39.	Md. Rafiqul Islam	SAC, MOHFW	01712659160
40.	ShereenAkhter	SAC, MOHFW	01716323838
41.	Dr. Md. JaynalHoque	PM (ARRH) MCH-S unit, DGFP	01534304749
42.	Dr. NurunNahar Begum	DD & PM (OA) CCSDP, DGFP	01911344276

SL No.	Name	Designation	Phone
43.	Prof. FerdousJahan	WB	01714133008
44.	Sylvia Islam	Senior Development Advisor Global Affairs Canada	01713013204
45.	Dr. IqbalKabir	Coordinator CCHPU, MOHFW	01714165204
46.	A.Waheed Khan	Planning & Coordinator PMMU, MOHFW	01713017615
47.	Dr. Tanvir Ahmed	Assoc. Prof. BUET	
48.	ZaminaIsrat	Technical Support Nutrition to Add. Sec. PH&WH, MOHFW	01711243411
49.	Md. Abdul Mannan	P&C Specialist, PMMU, Ministry of Health and Family Welfare, Azimpur, Dhaka	01552443625
50.	ShailaSharminZaman	M&E Specialist, PMMU, Ministry of Health and Family Welfare, Azimpur, Dhaka.	01733505577
51.	Md. Zahidul Islam	PMO (FP), PMMU, Ministry of Health and Family Welfare, Azimpur, Dhaka.	01552344528
52.	Md. Ibrahim Khalil	SAC, MOHFW	01709600472
53.	Md. Akteruzzaman	PMMU	