Bangladesh Health Sector Support Program (HSSP)

Framework for Tribal Peoples Plan (FTPP)

March, 2017

MINISTRY OF HEALTH AND FAMILY WELFARE

Government of the People's Republic of Bangladesh

Table of contents

Abbreviations

CC	: Community Clinic
CHT	: Chittagong Hill Tracts
CHTRC or RC	: Chittagong Hill Tracts Regional Council
DGHS	: Directorate General of Health Services
DLIs	: disbursement-linked indicators
DP	: Development Partners
FTPP	: Framework for Tribal Peoples' Plan
GRC	: Grievance Redress Committee
HDC	: Hill District Council
HPNSP	: Health, Population and Nutrition Sector Program
HSSP	: Health Sector Support Program
IP	: Indigenous Peoples
MoCHTA	: Ministry of CHT Affairs
MOHFW	: Ministry of Health Family Welfare
PCJSS or JSS	: Parbatya Chattagram Jana Samhati Samity
SDGs	: Sustainable Development Goals
SWAp	: Sector Wide Approach
TP	: Tribal Peoples
TPP	: Tribal Peoples' Plan

1. Background

The Government of Bangladesh (GOB) has achieved noticeable progress in the areas of key health, nutrition, and population (HNP) outcomes, including several HNP-related Millennium Development Goal (MDG) targets in the recent years. In 2014, it crossed the per capita income threshold for World Bank classification as a lower-middle-income country. Between 2000 and 2014, under-five mortality declined from 94 to 46 per 1,000, while the maternal mortality ratio decreased from 399 to 188 per 100,000 births. Child undernutrition also declined but at a slower rate, as 51 percent of under-five children were stunted in 2000, compared to 36 percent in 2014. Inequalities persist though, as for example, 49 percent of under-five children were stunted among the lowest quintile of socioeconomic status.

Bangladesh has embraced the Sustainable Development Goals (SDGs) for 2030, including SDG 3, which focuses on ensuring health and promoting well-being. A specific objective is to achieve universal health coverage, which encompasses assuring access to HNP services without causing financial hardship.

Since 1998, Bangladesh and partners (DP) have pursued a sector-wide approach (SWAp), adopting a series of multi-year strategies, programs and budgets for management and development of the health nutrition and population sector, with support from both domestic and international financing. Currently, the government is in the latter stages of finalizing its Fourth Health, Population and Nutrition Sector Program (HPNSP), 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 has as its objectives "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." This objective is consistent with the Government of Bangladesh' commitment to SDGs and is a first, foundational, program towards the achievement of the Sustainable Development Goals by 2030. The support by the World Bank's to the programme is extended from its Health Sector Support Program (HSSP) and will use disbursement-linked indicators (DLIs) to track the programme's implementation progress.

2. Program Description

The 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. The Ministry of Health Family Welfare (MOHFW) is responsible for implementation of the 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, Directorate General of Health Economics Unit, and Directorate General of Nursing and Midwifery.

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 Upazila Health

Complexes, 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.

The programme comprises of 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.

The project's components are aligned with the Fourth Health, Population and Nutrition Sector Program and the specific results to be supported by World Bank's support through DLIs have been selectively chosen through an extensive consultation process to address key challenges that Bangladesh faces as it pursues the SDGs. These challenges are characterized in three ways: (a) foundational financing and system development priorities; (b) the unfinished MDG agenda; and (c) emerging challenges.

Component 1. Governance and Stewardship

As Bangladesh transitions to a middle-income economy, there are a number of governance and financing challenges that need to be addressed to set the foundation for progress towards the SDGs. A key priority is to improve governance and accountability systems, including for citizen engagement, and this area is a priority for the government's Fourth Health, Population and Nutrition Sector Program. To this end, the project will support further development of the MOHFW's system for patients and their families to communicate complaints, including a web-based mechanism. Further, in view of setting the foundation for increased government health spending in the medium term to achieve progress towards the SDGs, the project will support improvements in budget efficiency and allocation. This will include support to enhancing the planning and budgeting process, as well as funds flow and budget execution. In addition, the project will support an increase in budget allocation and execution towards repair and maintenance to support basic service delivery, which will also contribute to increasing delegation of budget authority to the service delivery level.
the project will also

Component 2. Health, Nutrition and Population Systems Strengthening

Crucial to effective utilization of public resources allocated to the sector are core systems for the management of the government service delivery system which will contribute to setting the necessary foundation for the government health system to contribute to the SDGs. A major area of focus for the project will therefore be reform and development of financial management, procurement, supply chain management, and asset management systems. The project will also support further development of the health management information system, a critical management tool that currently suffers from fragmentation and duplication.

Component 3. Provision of Quality Health, Nutrition and Population Services

Bangladesh has made substantial progress on the MDGs but important parts of that agenda present ongoing challenges. Although a number of service utilization indicators have shown substantial improvement (for example, the proportion of 1-year-old children covered with all recommended vaccinations rose from 73 percent in 2004 to 84 percent in 2014), expansion of coverage of other services, while significant, has been slower. For example, the proportion of married women (ages 15–49) who currently use modern contraceptive methods only slight increase, from 47 percent in

2004 to 54 percent in 2014. Similarly, the health and nutrition of adolescents have not been adequately addressed, with a variety of repercussions for young women in particular, as well as for their children and although the incidence of marriage at young ages is slowly decreasing, in 2014, the median age at first marriage was 16 years. Finally, there are also unfinished agenda in areas such as in the control of communicable diseases, including tuberculosis (TB) and other emerging diseases. Finally, regional inequalities in service access and utilization persist. For example, compared to the national average of 54 percent, current modern contraceptive use among married women was 47 percent in Chittagong division and 41 percent in Sylhet division and only 23 percent of deliveries were in a health facility in Sylhet division.

The Component 3 also includes activities to address several challenges that are emerging as their importance is expected to grow over time and that government responses are largely at the stage of policy and program development. This will include areas such as primary-level services for prevention, diagnosis, and management of non-communicable diseases are currently limited. In the context of this unfinished and emerging agenda, the project will provide support to maintain gains, achieve still higher levels of utilization, improve quality, and reduce inequalities.

3. Project Objectives

The proposed operation, HSSP, will use a set of 21 DLIs in responding to these key challenges. In supporting parts of the GOB's Fourth Sector Program – including the strengthening of national level systems – 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).

Given the parts of the of the GOB's Fourth Sector Program being supported, the Project Development Objective of HSSP is to strengthen the 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

4. Scopes and Objectives of the Framework for Tribal Peoples Plans (FTPP)

The HSSP will not finance any civil construction works and consequently World Bank's OP 4.12 on Involuntary Resettlement is not triggered. The World Bank's OP 4.10 on Indigenous Peoples which is triggered for the project, stipulates that development projects, including Fourth Health, Population and Nutrition Sector Program, planned and implemented in areas inhabited by TPs, should ensure that they are not adversely affected, and that they receive culturally compatible social and economic benefits. This FTPP is thus prepared for the purpose of clarification of the objectives that MOHFW will require to take in compliance of the OP 4.10:

- Screen all development and construction interventions to determine presence of TPs and, if so, ensure their direct participation in selection, design and implementation of the project's activities;
- Adopt socially and culturally appropriate measures to mitigate the unavoidable adverse impacts; and
- Wherever feasible, adopt special measures – in addition to those for impact mitigation – to reinforce and promote any available opportunities for socioeconomic development of the affected TP communities.
- Finally, no facility site should be selected, even at the preliminary stage, based only on official land records, which may not represent ground reality in terms of current uses and users.

5. Defining The 'Tribal Peoples' under the HSSP

The terminology 'tribal peoples' in the case of HSSP, will mean 'indigenous peoples' as made out in the World Bank's OP 4.10 on the Indigenous Peoples. However, tribal peoples are found to live in varied and changing contexts and hence, no single definition can capture their diversity. As such, MOHFW will use the World Bank's guidelines to identify TPs in particular geographic areas by examining the following characteristics:

- Self-identification as members of a distinct tribal cultural group and recognition of this identity by others;
- Collective attachment to geographically distinct habitats or ancestral territories in the project area and to the natural resources in these habitats and territories;
- Customary cultural, economic, social, or political institutions that are separate from those of the dominant society and culture; and
- A tribal language, often different from the official language of the country or region.

6. Tribal People in Bangladesh

Bangladesh is by and large religiously, ethnically and linguistically homogeneous. Its population of nearly 160 million is roughly 90 percent Muslim, with about 7% Hindus and others mainly following Buddhism and Christianity. Close to 99 percent speak Bangla and could be ethnically and culturally described as Bengali.

However, all across its territory, a large number of minority groups inhabit most of whom continue to keep their distinct ethnic traits, social institutions, linguistic and cultural traditions. In other words, many of them could be taken as 'indigenous peoples' as defined in various UN human rights instruments, including the World Bank's safeguards policy OP 4.10.

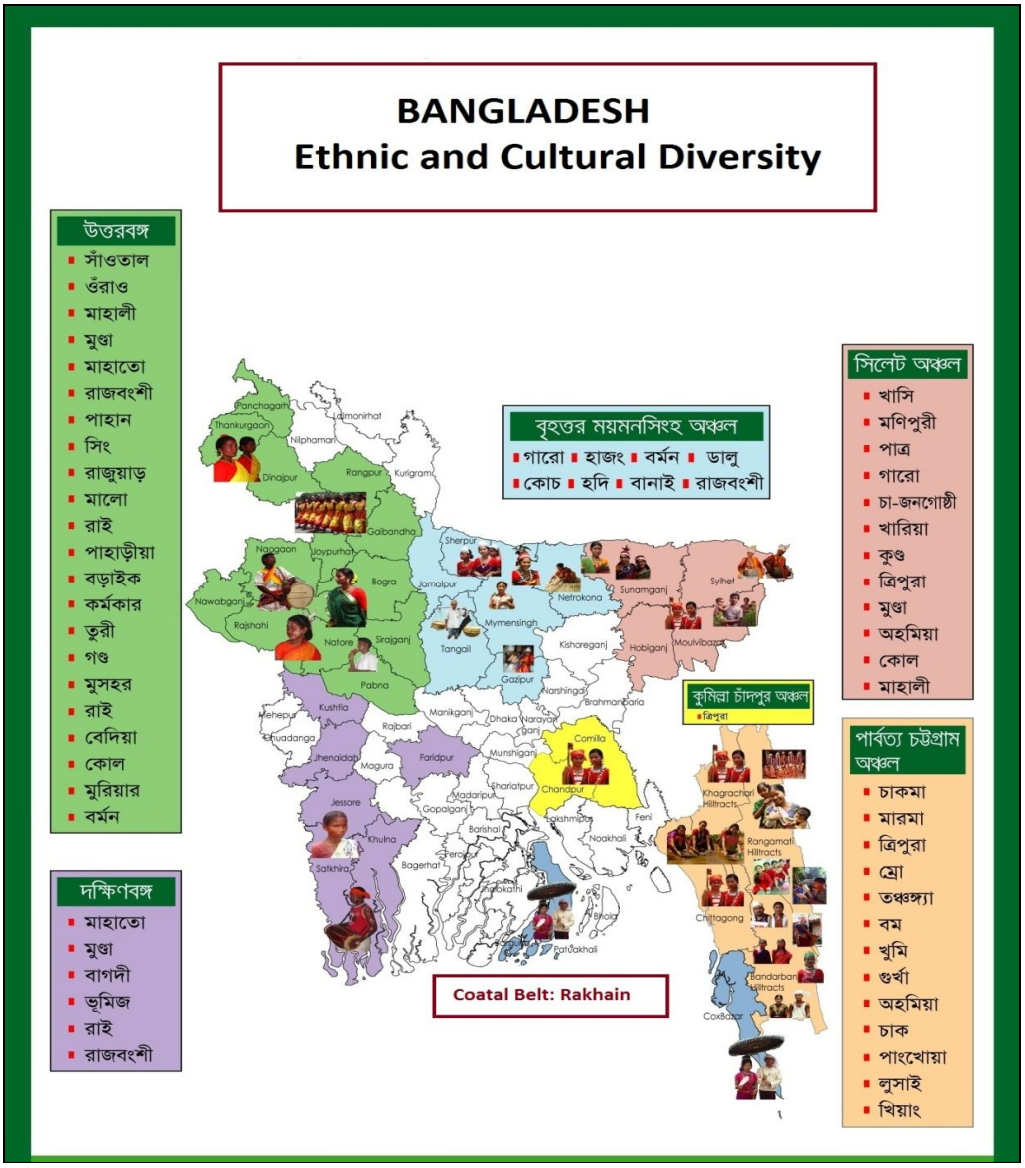
Tribal Peoples in Bangladesh are a small minority in Bangladesh. However, the precise number of their population is a subject of much debate. The government statistics are sketchy at best; the most recent census figures (2011) do not provide ethnically disaggregated data, so the only useful reference point is the previous census conducted in 1991, which put their total population at 1.2 million. Taking into account the average demographic growth rate of the country, their population at present should be around 1.5 million. However, the representatives of the tribal peoples and their organizations have expressed disagreement with this figure. The Bangladesh Adivasi Forum, an apex advocacy and networking organization of the ethnic minorities, has given a figure of 3 million as their total population. In any event, tribal peoples should constitute no more than between 1-2% of the total population of Bangladesh.

The total number of tribal groups is also a matter of much disagreement. The 1991 census mentions 29 groups. The recently adopted Small Ethnic Minority Cultural Institution Act (April 2010) mentions 27 different groups which is at present under revision and proposes 50 different groups. The Bangladesh Adivasi Forum mentions as many as 45 indigenous groups in one of their publications (Solidarity, 2003). A proposed draft law, called Bangladesh Indigenous Peoples' Rights Act, by Bangladesh Parliamentary Caucus on Tribal Peoples – a group of parliamentarians who advocate for the rights of the country's tribal peoples – enlists as many as 59 distinct ethnic minority groups. The reason stems partly from a vibrant movement of ethnic minority communities in recent years – particularly since the signing of the CHT Accord in December 1997 - with more marginalized groups increasingly becoming aware and assertive of their identity (The detailed list of the various ethnic minority groups as per the various laws and organizations is provided in Annex – 1).

Although the tribal peoples are scattered all over Bangladesh, they are overwhelmingly concentrated in several geographical pockets; namely North-West (Rajshahi & Dinajpur), North-East (Sylhet), Central region (Dhaka and Mymensingh), South (Barishal & Patuakhali), with the most significant concentration in the south-eastern corner – the Chittagong Hill Tracts. The location of the various ethnic minority groups by region is broadly as follows (The map in the next page shows the geographical regions in Bangladesh where most ethnic minorities are concentrated);

- North-west region (Rajshahi division - includes Rajshahi, Naogaon, Chapainawabganj, Natore, Sirajganj, Pabna, Joypurhat, Dinajpur, Thakurgaon, Rangpur, Bogra and Gaibandha district): major adivasi communities are: Santal, Uraon/Oraon, Munda, Mahato, Paharia, Malo, Pahan, Rajbongshi, Rajooar, Karmakar and Teli);
- North-east region (Sylhet division - includes Sylhet, Sunamganj, Habiganj and Moulvibazar district: major adivasi communities are; Khasi, Patro, Monipuri, Garo, Tripura and tea garden communities)
- Central region (Greater Mymensingh and Dhaka - includes Gazipur, Tangail, Sherpur, Jamalpur, Netrokona, Mymensingh): major adivasi communities are: Garo, Hajong, Koch, Banai, Rajbangshi, Dalu, Barman and Hodi

- Coastal region (Khulna, Chittagong and Barisal division - includes Patuakhali, Barguna, Chandpur, Chittagong, Cox's bazar, Khulna, Satkhira): major Adivasi communities are- Rakhhaine, Tripura, Munda and Ranbangshi.



- Chittagong Hill Tracts (Bandarban, Rangamati and Khagrachari): the indigenous communities are; Chakma, Marma, Tripura, Tanchangya, Mro, Lushai, Khyang, Khumi, Chak, Pangkhua, Bawm, Santal, Rakhaine, Asam/Asamese and Gorkha

By all accounts, tribal peoples in Bangladesh are some of the poorest and most marginalized in the country as illustrated in the box below;

BOX – 1 **Socio-economic facts on the Ethnic Minorities in Bangladesh**
• Poverty rate is higher than national average (approx. 30%): 65% in CHT and above 80% in the plains

- Average income is less than national average (84,000 taka): 26% less in CHT, 41% less in the plains
- Overwhelming dependence on agricultural sector: (80% in the plains, 72% in CHT)
- Salaried jobs/business; 3% in CHT, less than 1% in the plains.
- On average two-thirds of the tribal peoples in the plains are functionally landless. For certain groups, this is even higher (Santals, Mahato, Pahan, etc) - as high as 93%.
- As high as one-third of the tribal communities in the CHT remain dependent on Jum cultivation, variously known as shifting/slash and burn/swidden cultivation
- Overall, ethnic minorities living in the North (South and West) are more marginalized and poor.
- Access to credit/micro-finance: in CHT (54%), in the plains (62%) including from moneylenders (10%).

(Source: Baseline survey by UNDP/CHTDF (2007) and Oxfam (2009)

7. Legal and Institutional Framework for the FTPP

The Constitution of Bangladesh guarantees equal rights and equality before law of its citizens. Article 27 guarantees equality of citizens before the law and Article 28 prohibits discrimination on grounds of religion, sex, caste, race and place of birth. The same article also stipulates measures of 'affirmative actions' by the State in favor of the backward section of the citizens1.

Besides the Constitution, there is also a corpus of legal, institutional and policy dispositions for the safeguards of the tribal peoples' rights in Bangladesh. Much of it is focused for the CHT; however, there are also specific laws for the tribal peoples in the plains. Some of these laws were enacted during the colonial period (but still in force), but most have been adopted in recent years and, in the case of the CHT, after the signing of the CHT Accord in 1997.

7.1. Legal framework:

The Chittagong Hill Tracts Regulation 1900, popularly called 'CHT Manual 1900' is the oldest and one of the most frequently cited laws with regard to CHT. It was enacted by the British colonial administration in 1900 and defines land and revenue administration, the administrative system based on the Traditional Chieftainships (i.e. Circle Chiefs or Raja as popularly called in Bengali), customary land rights and tenure systems including on Jum cultivation as well as mitigation and arbitration of social disputes based on traditional customs of the peoples in the region. In subsequent decades, the Act was amended several times but, it still remains in force and serves as the key reference point for land administration and traditional customary governance of the region.

The government signed the CHT Accord with *Parbattya Chattagram Jana Samhati Samity* (PCJSS or JSS) in December 1997. Its signing was followed by a series of laws intended to strengthen the specific (unique in the context of Bangladesh, too) administrative set-up of the region. The Accord itself, deserves to be considered a quasi-legal document and remains the main reference for all subsequent legislation for CHT (elaborated under the section 7.2: Institutional Setup). In contrast to the CHT, there are fewer laws specific to the indigenous peoples in the plains. The State Acquisition and Tenancy Act, 1950 (East Bengal Act No. XXVIII of 1951) is the most relevant and important in this regard; it regulates land rights for the tribal groups (referred as 'aborigines' in the Act) in the plains through prohibiting the sale of land owned by the tribal peoples to non-tribal persons without the permission of the local Revenue Officer. The measure was explicitly taken to protect the indigenous

[1] The CHT Accord was signed in reference to these two Articles of the Constitution.

groups from being dispossessed of their lands by the more powerful and influential non-indigenous persons.

In addition to its domestic laws, Bangladesh is also signatory to most of the major international human rights instruments which are either directly or indirectly relevant to the rights of the tribal/indigenous peoples. Furthermore, Bangladesh is signatory to the ILO Convention 107 on Tribal Populations although it is yet to ratify the other important ILO convention on tribal peoples, Convention No. 169 of 1989. It is also one of the select few countries to abstain from voting on the UN Declaration on the Rights of the Indigenous Peoples (UNDRIP) in 2007. The table below provides a comprehensive picture (the 2 relevant ILO Conventions and the UNDRIP are added to the list);

SL	Name of the Treaties/Conventions	Year of Adoption by UN	Year of Ratification by Bangladesh
1.	International Convention on the Elimination of All Forms of Racial Discrimination	1965	1979
2.	International Covenant on Civil and Political Rights	1966	2000
3.	International Covenant on Economic, Social and Cultural Rights	1966	1998
4.	Convention on the Elimination of All Forms of Discrimination against Women	1979	1984
5.	Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	1984	1998
6.	Convention on the Rights of the Child	1989	1990
7.	Convention on Biological Diversity	1993	1994
8.	ILO Conventions No. 107 on Indigenous & Tribal Populations	1957	1972
9.	Convention on the Rights of Persons with Disabilities	2007	2008
10.	United Nations Declaration on the Rights of Indigenous Peoples	2007	Abstention
11	ILO Conventions No. 169 on Indigenous & Tribal Populations	1989	Yet to ratify

Relevant Health Plans and Policies

In the HNP 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, and the HNP sector programs. These 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, particularly the small ethnic and vulnerable communities (tribal people). 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 2011

National Health Policy 2011 considers access to HNP services 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. The 2011 Policy and the subsequent plans

of action are the relevant policy documents to address the needs of the small ethnic and vulnerable communities (tribal people).

Bangladesh Population Policy 2012
This policy addresses important gender issues including the small ethnic and vulnerable communities (tribal people). 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.

Bangladesh National Nutrition Policy (NNP) 2015
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.

7.2. Institutional Setup:
Following the signing of the CHT Accord, the Ministry of CHT Affairs (MoCHTA) was established in 1998 as the key government nodal agency in coordinating and supervising the development and administrative activities of the government, in most cases supplanting the role of the relevant line ministries in Dhaka. In this regard, it functions as the 'gateway of development services' for the region.

The CHT Accord also led to the creation of a number of institutions specific to CHT. The CHT Regional Council (CHTRC or RC) was established in 1998 by an act of Parliament in 1998. Its explicit mandate was to 'coordinate and supervise' development and administrative business of the government in the region. Following the Accord, the former Local District Councils of Bandarban, Rangamati and Khagrachari were transformed into the Hill District Councils (HDCs), each established by separate acts of parliament. Their role and mandate are identical except for some minor differences; besides various administrative roles, they are assumed to be the principal organs for implementation of development projects. Altogether, they have been given responsibility for supervising and implementing 33 broad areas of interventions, popularly known as 'transfer subjects'. As of now the government has formally transferred a number of agencies/departments as 'transfer subjects' which also include Department of Health and Department of Family Planning.

The Traditional Institutions comprising the village Karbari, mouza Headmen and Circle Chief still play a major role for ethnic minorities in the Chittagong Hill Tracts. Over the past decades, their role and authority have been somewhat curtailed by various laws, but they are still entrusted by law to play very important roles in land and revenue administration and traditional justice. Similar traditional social structures also do exist among the tribal communities in the plains although unlike their peers in the CHT, they do not have legal recognition.

In contrast with CHT, there is almost no comparable institutional set up for tribal peoples in the plains. The Special Affairs Division (SAD) was set up in 1989 with, among other issues, the CHT and tribal peoples' affairs under its responsibility. But following the establishment of the MoCHTA in 1998 it was dissolved. Nevertheless, an officer in the Prime Minister's Office (PMO) is assigned to look after the matters of the tribal communities in the plains and his role consists essentially of channeling government grant money to the designated districts and upazillas (as per the most recent available information, this includes 62 upazillas in 36 districts), where there are substantial numbers

of tribal population. The Upazilla Nirbahi Officer (UNO) supervises the distribution of the grants on behalf of the Deputy Commissioner (DC) at the field level, usually through a tribal people-led NGOs/CBOs. The entire process is managed by a Committee, chaired by the UNO with members from various relevant government agencies and including one or two ethnic minority representatives who are selected by the Deputy Commissioner.

8. Consultation and Participation

Participation of TPs in selection, design and implementation of the HSSP activities will largely determine the extent to which the FTPP objectives would be achieved. Where adverse impacts on TPs are likely, MOHFW will undertake free, prior and informed consultations with affected TP communities to ensure their broad community support for the HSSP interventions. Such consultations may also involve individuals or experts who work with and/or are knowledgeable of TP development issues and concerns. To facilitate effective participation, MOHFW will follow a time-table to consult the would-be affected TP communities at different stages of the program cycle. The primary objectives are to examine whether there is broad community support for the project activities and to seek the inputs/feedbacks of the TPs to avoid or minimize the adverse impacts; identify the impact mitigation measures; and assess and adopt economic opportunities which MOHFW could promote to complement the measures required to mitigate the adverse impacts. In case of absence of broad community support from the TPs, World Bank will not proceed further with financing of the related activities of the project.

To ensure broad community support through free, prior and informed consultations with the tribal communities, MOHFW will:

- Ensure widespread participation of TP communities with adequate gender and generational representation; customary/traditional TP organizations; community elders/leaders; civil society organizations like NGOs and CBOs; and groups knowledgeable of TP development issues and concerns.
- Provide them with all relevant information about the nature of the development activities, including that on potential adverse impacts, organize and conduct these consultations in manners to ensure full coverage of the TPs and free expression of their views and preferences.
- Document and share with the Bank the details of all community consultation meetings, with TP perceptions of the proposed activities and the associated impacts, especially the adverse ones; any inputs/feedbacks offered by TPs; and the minutes stating the conditions, if any, that have been agreed during the consultations, which may have provided the basis for their broad base community.

As part of preparation of this Framework for Tribal Peoples' Plan (FTPP), a consultation was held on 14 March 2017 in Dhaka, organized by the Ministry of Health and Family Welfare. The participants included representatives of tribal peoples and their representative institutions as well such as the CHT Regional Council and Hill District Council from Chittagong Hill Tracts and Jatiya Adivasi Parishad from the plains regions of Bangladesh. The suggestions and recommendations raised in the consultation are incorporated in this final draft of the FTPP. A summary of the discussions in the consultation and as well as the list of participants in the consultation is attached in Annex – 5 & 6.

9. Special Measures to strengthen activities relating to the Tribal People Communities

a) Recognizing social, economic, cultural and linguistic differences of the tribal people, improve coverage of services:
- Review coverage of service by CCs in tribal/ethnic minority areas. For households that are far from the closest health facilities or disconnected by stream/river/steep slope, satellite clinics or mobile clinics could be considered to extend the coverage.
- Support to infrastructure and service delivery in the public sector to fill in gaps and make the services more user friendly. If applicable, complement the public sector service delivery by engaging the private sector, more so at the community level.
- Manpower development by way of better recruitment, training and rewards systems.

b) Behavior change communication (BCC) plan: A BCC plan that specifically addresses the needs of the small ethnic and vulnerable communities (tribal people) will be developed. This will be guided by the existing BCC policies/guidelines of the MOHFW to address all the issues that are likely to improve the sensitivity of providing HNP services, particularly the prevalent socio-cultural beliefs and gender disparities; increasing the reach of the campaign through the use of all channels of communication (including, electronic media, press, hoardings, hand bills, posters, and inter-personal communication through health providers at all levels); and creating targeted campaigns in terms of content and messages for health workers, private practitioners, the community and local influential persons.

c) Capacity enhancements:
- Training and working with other systems of medicine and tribal/ethnic system of medicine practitioners.
- Development of strong and effective referral system.
- Integration with other departments to promote better resource utilization (e.g. forest department, education department etc.).
- Capacity to resolve conflicts and grievances in a culturally and linguistically sensitive manner and capacity to identify, prevent and resolve cross-cultural conflicts of complaints

d) Leverage the roles that the traditional leaders could play for involvement of small ethnic and vulnerable communities (tribal people). Traditional leaders are expected to play an important role in development and implementation of HNP services. They are highly respected and wield considerable influence in shaping the perception of their community. The traditional leaders involvement during various stages of implementation are important, especially for:
- Increasing awareness of the communities and soliciting their feedback.
- Ensuring involvement of and dissemination of information to the communities.
- Overall cooperation in implementation of HNP activities.
- Provide leadership roles in organizing the communities.
- Overcoming misconception and distractions keeping people away from utilizing quality services.
- Playing the role of advisor to providers and communities.

e) Systems for social management:
- Citizens' oversight system functioning in the Community Clinics needs to be enhanced in many of the Upazila health Offices, Upazila Health Complexes, Upazila Family Planning Offices and Family Welfare Centers to facilitate enhanced participation in health service governance by citizens, particularly the small ethnic and vulnerable communities (tribal people).

- Five of the DLIs under HSSP will support gender inclusiveness. DLI # 9 aims at deploying female midwives at upazila health complexes, which will contribute to the expected result of making the services more woman-friendly for institutional delivery. DLI # 13 will increase readiness of health facilities to provide family planning services to married couples right after a child's birth; DLI # 14 will increase capacity of health facilities to provide emergency obstetric care; DLI # 16 aims at developing a school-based adolescent girl health program; while DLI # 17 will improve nutrition services for mothers and pregnant women.
- Activities addressing the needs of the small ethnic and vulnerable community (tribal people) need to be incorporated in and implemented by the relevant operational plans.
- There is a need to identify health impacts of and related mitigation measures to deal with the effects of climate change including sea-level rise, increase in salinity, frequent storm surges, and rise in temperature, particularly in areas resided by the small ethnic and vulnerable communities (tribal people).

f) Systems for information disclosure and stakeholder consultation: DLI # 1, which focuses on strengthening the Grievance Redressal Mechanism of the MOHFW, will enable availability of information on grievances received and addressed and thereby improve transparency and disclosure. The MOHFW will use its existing citizen engagement mechanisms to seek feedback and continue with stakeholder consultations, particularly with the small ethnic and vulnerable communities (tribal people).

10. Implementation Arrangement

MOHFW will designate a specific official with relevant knowledge and skills, responsible for the implementation of the FTPP. The designated official (Indigenous Peoples/Social Safeguards Specialist) could be either a direct employee of the MOHFW or recruited from the market and his/her responsibility will include ensuring that the provisions of the FTPP are implemented as and when the individual healthcare facilities are found to give rise to social safeguard issues and for this will prepare Tribal Peoples' Plan as required. A template for TPP is attached in Annex-2.

During the implementation phase, MOHFW will prepare site-specific TPP (if required) where there are significant concentrations of the tribal people. The implementation of HSSP activities will also involve other government mandated institutions as relevant and applicable. In the case of the CHTs, this will include the MoCHTA, CHTRC and HDCs. In both CHT and the plains regions, MOHFW will also involve the representatives of the traditional institutions and community elders in the implementation of the TPPs. Special focus will be made to include the women and youth of the tribal peoples' communities.

The TPPs will also spell out the appropriate intervention mechanisms to reach out to the potential TP beneficiaries given that many TPs reside in remote and hard-to-reach areas.

A Job Description of the Indigenous Peoples/Social Safeguards Specialist is attached in the Annex – 3.

11. Grievance Redress Mechanism

The exact sources of grievances and complaints will remain unknown until they are formally lodged. The GOB believes in free flow of information and people's right to information and enacted 'The Right to Information Act, 2009 Bangladesh'. 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. The GOB has developed a dedicated web portal (http://www.grs.gov.bd/home/index_english) where the aggrieved ones could vent complaints and seek remedial measures. The MOHFW is committed to effective grievance redressal in its service delivery and has made arrangements of grievance and complaints using phones, short-messaging services, and web based platforms.

However, the system is yet to be fully developed and made functional. At service provision and decision making levels, limited information on grievances and complaints are available resulting extremely limited or no action to redress grievance. DLI 1 under HSSP will support the MOHFW in strengthening its GRS, thereby enhancing greater responsiveness and transparency to the public. Considering the need, MOHFW will establish a procedure to address complaints and grievances about any irregularities in application of the guidelines adopted in this FTPP for assessment and mitigation of social safeguard impacts. Based on consensus, the procedure will help to resolve issues/conflicts amicably and quickly and, in some cases saving the aggrieved persons resorting to expensive, time-consuming legal actions. The GRM will however not pre-empt a complainant's right to seek resolution in the courts of law.

Within this context, in areas where there are significant numbers of tribal people living, MOHFW will form a Grievance Redress Committee (GRC) at the district level with the following composition as suggested;

GRC Membership

Civil surgeon (or relevant HDC Member in the case of CHT)	Convener
Upazilla Parishad Chairman	Member
Union Parishad Chairman	Member
Concerned Local Level Health and Family Welfare Representative	Member
2 members of the TP community (1 male, 1 female)	Member
A CBO representative (preferably tribal in the plains) and in CHT a representative of Traditional Institution)	Member

The purpose of the GRCs is to ensure proper presentation of complaints and grievances, as well as impartial hearings and transparent decisions. Membership composition of the GRCs will take into account any traditional conflict resolution arrangements that TP communities may have in practice. If the aggrieved person is a female, MOHFW will ask a female UP Member or Municipal Ward Commissioner to participate in the hearings. Females will be encouraged to be part of the GRC.

If a resolution attempt at the local level fails, the GRC will refer the complaint with the minutes of the hearings to the Joint Secretary (Development and Medical Education) of MOHFW. The JS, who is expected to be fully aware of TP concerns as being addressed under the project will make a decision -- with guidance, if needed, of the MOHFW Secretary. A decision agreed with the aggrieved person(s) at any level of hearing or review will be binding on MOHFW.

All cases at the local level will be heard within four weeks of their receipt. At the ministry level, decisions on unresolved cases will be made and communicated to the GRC in no more than four weeks.

To ensure impartiality and transparency, hearings on complaints will remain open to the public. The GRCs will record the details of the complaints, the reasons that led to acceptance or rejection of the particular cases, and the decision agreed with the complainants. MOHFW will keep records of all

resolved and unresolved complaints and grievances and make them available for review as and when asked for by World Bank.

World Bank's Grievance Redress Service. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project-level grievance redress mechanism or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's Inspection Panel which 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. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit www.worldbank.org/grs. For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

12. Public disclosure of FTPP

The present FTPP will be disclosed by MOHFW to the TP communities, general public and relevant stakeholders following clearance from World Bank. It will be translated in to Bangla and together with the English version will be made available at its headquarters and district offices, concerned government offices in the project districts, and other places accessible to the TPs. Further, MOHFW will also post the entire FTPP and translated summary in its website, and inform the public through notification in two national newspapers (Bangla and English) about where they could be accessed for review and comments. MOHFW will also authorize the World Bank to disclose it at its Country Office Information Center and Infoshop. The disclosure will take into account the issue of language that is understandable to the concerned TP communities although it is generally understood that majority of them are able to read, write and communicate in Bangla.

13. Funding for implementation of the FTPP

The MOHFW will make specific budgetary provisions for the implementation of the present FTPP. Besides the salary and other entitlements of the personnel engaged in the implementation of FTPP, MOHFW will also make earmarked budgetary allocations from HSSP project budget for the TPs. The budgetary allocations will be clearly mentioned in the site-specific TPPs to be prepared (as and when needed).

14. Monitoring and reporting of the FTPP/TPP

Monitoring essential to ensure the proper adherence to the stipulations in this FTPP. The Indigenous Peoples/Social Safeguards Specialist will prepare the relevant monitoring tools and make regular monitoring visits in the field. S/he, in collaboration with the project's monitoring unit, will also prepare periodic safeguards reports for the HSSP. The monitoring data will include dis-aggregated data collected from field level project offices and maintained systematically in the project Head Office's central database.

It is also recommended that third party monitoring is carried out to oversee the implementation of FTPP to ensure greater accountability and transparency of the HSSP activities as regards the FTPP provisions.

Annex- 1: TP Communities as per various laws and census data

A. Bangladesh Adivasi Forum, 2005 (BAF), 2005

1. Asam, 2. Bawm, 3. Banai, 4. Bediya, 5. Bhumij, 6. Bagdi, 7. Chakma, 8. Chak, 9. Dalu, 10. Garo, 11. Gurkha, 12. Hajong, 13. Khasi, 14. Kharia, 15. Khyang, 16. Khumi, 17. Koch, 18. Kole, 19. Karmakar, 20. Khastriya Barman, 21. Khondo, 22. Lusai, 23. Marma, 24. Mro, 25. Monipuri, 26. Mahato, 27. Munda, 28. Malo, 29. Mahali, 30. Muriyar, 31. Musohor, 32. Oraon, 33. Pangkhu, 34. Paharia, 35. Pahan, 36. Patro, 37. Rakhaing, 38. Rajuar, 39. Rai, 40. Rajbongshi, 41. Santal, 42. Shing, 43. Turi, 44. Tangchangya, 45. Tripura

B. East Bengal State Acquisition and Tenancy Act (EBSATA), 1951

1. Banai, 2. Bhuiya, 3. Bhumij, 4. Dalu, 5. Garo, 6. Gond, 7. Hadi, 8. Hajang, 9. Ho, 10. Kharia, 11. Kharwar, 12. Koch (Dhaka Division), 13. Kora, 14. Mache, 15. Maghs (Bakerganj District), 16. Mal and SauriaPaharia, 17. Mundai, 18. Munda, 19. Oraon, 20. Sonthal, 21. Turi.

C. Small Ethnic Groups' Cultural Institution Act (SEGCIA), 2010

1. Barman, 2. Bawm, 3. Chak, 4. Chakma, 5. Dalu, 6. Garo, 7. Hajong, 8. Khasia/Khasi, 9. Khumi, 10. Koch, 11. Kol, 12. Kyang, 13. Lushai, 14. Malpahari, 15. Manipuri, 16. Marma, 17. Mong, 18. Mro, 19. Munda, 20. Orao, 21. Pahari, 22. Pankgua, 23. Rakhain, 24. Santal, 25. Tanchangya, 26. Tripura, 27. Ushai

The law is currently being revised by the government with advice from an 'expert' panel on indigenous peoples in Bangladesh. The proposed draft corrects the errors of the existing law and also includes for consideration additional communities who are excluded in the current version. The proposed communities are:

28. Mahato, 29. Kondo, 30. Gonju, 31. Gorat/Gorait, 32. Malo, 33. Teli, 34. Patro, 35. Banai, 36. Bagdi, 37. Bediya, 38. Baraik, 39. Bhumij, 40. Mushohor, 41. Mahali, 42. Rajoar, 43. Lohar, 44. Shabar, 45. Hadi, 46. Ho, 47. Kora, 48. Bheel, 49. Bhuimali, 50. Gurkha

D. Bangladesh Indigenous Peoples' Rights Act (BIPRA),

1. Asam, 2. Badia/Bedia, 3. Bagdi 4. Banai 5. Barman/Khatriya Barman 6. Bawm 7. Bhuimali 8. Bhuiyan 9. Bhumij 10. Bonaj/Buna 11. Boraik 12. Chai/Chaimal 13. Chak 14. Chakma 15. Dalu 16. Garo/Mandi 17. Gond 18. Gorat 19. Gorkha 20. Hadi 21. Hajong 22. Karmakar 23. Kharia 24. Kharwar 25. Khasi 26. Khiyang 27. Khumi 28. Koch/Rajbangshi 29. Kol 30. Konda 31. Kora 32. Lohar/Lahara 33. Lushai 34. Mahali 35. Mahato/Marmi/Murmi, 36. Malo 37. Manipuri 38. Marma 39. Mro/Murong 40. Munda/Mundari/Murari 41. Musohar 42. Oraon 43. Pahan 44. Paharia/Malpahari/Saoria/Pahari 45. Palla/Palia 46. Pankhua 47. Patra/Laleng 48. Pundra/Pod 49. Rai 50. Rajuar 51. Rakhain 52. RanaKarmakar 53. Raotia/Shing 54. Sabar 55. Santal 56. Tanchangya 57. Telia 58. Tripura 59. Turi

At the end of the proposed draft, it includes the following 5 different communities, under the category, "under consideration":

1. Bin/Bind 2. Karnidas 3. Nunia 4. Rabidas 5. Ruhidas

Annex- 2: Contents of Tribal Peoples Plan

A. Socio-economic Assessment of the TP Communities

- Include information and analysis cultural characteristics; social structure and economic activities; land tenure; customary and other rights to the use of natural resources; relationship with the local mainstream peoples; and other factors that have been suggested by TPs during consultations and are to be addressed in the TPP and project design.

B. Strategy for participation and consultation

- Indicate timing of consultation and the participants, such as affected TP communities, TP organizations, and individuals and entities who could provide useful feedback and inputs.
- Describe in detail how the methodology of 'free, prior and informed consultations' with the TP communities has been ensured.

C. Mitigation measures and activities

- Describe in detail the TP preferences and priorities, including those agreed between the TP communities/TP organizations and MOHFW during consultations.

D. Institutional arrangement

- Describe the specific role of the institution(s) responsible in the implementation of the FTTP
- Take into account the staff's experience, consulting services, and TP and civil society organizations involved in the implementing of the TPPS and make the suggestions/recommendations as necessary.

E. Grievance Redress Mechanism

- Based on the outlines provided in the FTTP, customize it for TPPs, taking into account any traditional conflict resolution arrangements that may have been in practice in the area

F. Budgetary provisions

- Budgetary allocations for the specific measures to be taken for the purpose of the TPPs. The allocation will address the recommendations/suggestions made in the consultations with the tribal peoples.

G. Implementation schedule

- Point out the deadlines for specific initiatives for the TP communities under the HSSP

H. Monitoring, Reporting and evaluation,

- A scheme along with monitoring indicators relevant to the TPP

Annex – 3: Terms of Reference (TOR) for the Indigenous Peoples/social Safeguards Specialist

Background

The Government of Bangladesh (GOB) has achieved noticeable progress in the areas of key health, nutrition, and population (HNP) outcomes, including several HNP-related Millennium Development Goal (MDG) targets in the recent years. In 2014, it crossed the per capita income threshold for World Bank classification as a lower-middle-income country. Between 2000 and 2014, under-five mortality declined from 94 to 46 per 1,000, while the maternal mortality ratio decreased from 399 to 188 per 100,000 births. Child undernutrition also declined but at a slower rate, as 51 percent of under-five children were stunted in 2000, compared to 36 percent in 2014. Inequalities persist though, as for example, 49 percent of under-five children were stunted among the lowest quintile of socioeconomic status.

Bangladesh has embraced the Sustainable Development Goals (SDGs) for 2030, including SDG 3, which focuses on ensuring health and promoting well-being. A specific objective is to achieve universal health coverage, which encompasses assuring access to HNP services without causing financial hardship.

Since 1998, Bangladesh and partners (DP) have pursued a sector-wide approach (SWAp), 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. Currently, the government is in the latter stages of finalizing its Fourth Health, Population and Nutrition Sector Program (HPNSP), 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 has as its objectives "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." This objective is consistent with the Government of Bangladesh' commitment to SDGs and is a first, foundational, program towards the achievement of the Sustainable Development Goals by 2030. The support by the World Bank's to the programme is extended from its Health Sector Support Program (HSSP) and will use disbursement-linked indicators (DLIs) to track the programme's implementation progress.

Programme Description

The 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. The Ministry of Health Family Welfare (MOHFW) is responsible for implementation of the 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, Directorate General of Health Economics Unit, and Directorate General of Nursing and Midwifery.

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 Upazila Health Complexes, 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.

The programme comprises of 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.

The project's components are aligned with the Fourth Health, Population and Nutrition Sector Program and the specific results to be supported by World Bank's support through DLIs have been selectively chosen through an extensive consultation process to address key challenges that Bangladesh faces as it pursues the SDGs. These challenges are characterized in three ways: (a) foundational financing and system development priorities; (b) the unfinished MDG agenda; and (c) emerging challenges.

Project Objectives

The proposed operation, HSSP, will use a set of 21 DLIs in responding to these key challenges. In supporting parts of the GOB's Fourth Sector Program – including the strengthening of national level systems – 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).

Given the parts of the of the GOB's Fourth Sector Program being supported, the Project Development Objective of HSSP is to strengthen the 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

Scopes and Objectives of the Framework for Tribal Peoples Plans

The HSSP will not finance any civil construction works and consequently World Bank's OP 4.12 on Involuntary Resettlement is not triggered. The World Bank's OP 4.10 on Indigenous Peoples which is triggered for the project, stipulates that development projects, including Fourth Health, Population and Nutrition Sector Program, planned and implemented in areas inhabited by TPs, should ensure that they are not adversely affected, and that they receive culturally compatible social and economic benefits. In compliance with these stipulations, MOHFW will require to work with the following objectives:

- Screen all development and construction interventions to determine presence of TPs and, if so, ensure their direct participation in selection, design and implementation of the project's activities;
- Adopt socially and culturally appropriate measures to mitigate the unavoidable adverse impacts; and
- Wherever feasible, adopt special measures – in addition to those for impact mitigation – to reinforce and promote any available opportunities for socioeconomic development of the affected TP communities.
- Finally, no facility site should be selected, even at the preliminary stage, based only on official land records, which may not represent ground reality in terms of current uses and users;

Major Responsibilities

Reporting to the Project Director, HSSP, the Social Safeguards Specialist will assume, among others, the following roles and responsibilities;

- Lead the tribal peoples/social safeguards related activities of the project.
- Develop, organize and deliver trainings and orientation of TP/social safeguards pertinent to the project with the stakeholders which will include, but not limited to; MOHFW/Project staff, Partner Organizations, and relevant stakeholders.
- Carry out social screening and assessment of relevant sub-projects to identify the presence of TP communities in the project areas
- Based on the data/information of the above screening/assessment, prepare site specific Tribal Peoples' Plan for the project.
- Carry out regular field visit to assess the quality and adequacy of screening, FTPP, and also supervision of social safeguards related activities
- Prepare and submit regular social safeguards monitoring and implementation progress reports
- Any other responsibility/activity asked by the project management

Qualifications

The Indigenous Peoples/Social Safeguards Specialist will possess the following qualifications;

- Minimum 8-10 years prior experience in the areas of tribal peoples/social safeguards with any reputed national/international organizations
- Previous experience of work with the TP communities will be considered an advantage
- Demonstrated capacity in delivering training/orientation and report writing both in English and Bengali
- Master degree in any subject of social science
- Previous experience on social safeguards with any ADB/World Bank funded is highly desirable.

Annex 4: Tribal People Screening for HSSP

[To be filled in for upazila by the designated government officials]

A. Identification

1. Name of Upazila: ………..……………

District/City Name: ………….........................….........

***2. Screening Date(s):** …………………………………………………………………………......*

B. Participation in Screening

3. Names of <u>official</u> who participated in screening:

4. *Is the subproject site located in an area inhabited by small ethnic community peoples?*

[ ] Yes [ ] No

If the answer is no, skip this section of the form.

5. *If the answer is Yes, is there any TPs Impacted by any interventions of the project?*

[ ] Yes [ ] No

6. *If the answer is Yes to question no. 5, is there any TPs also likely to be benefited from the subproject?*

[ ] Yes [ ] No

7. *If the answer is Yes to question no. 5, is there any TPs likely to be affected by the subproject?*

[ ] Yes [ ] No

If the answers to questions 5, 6 and/or 7 are no, skip the following sections of the form.

8. Have the TP community and the potential affected TPs been made aware of the potential positive and negative impacts and consulted for their feedback and inputs?

[ ] Yes [ ] No

13. Has there been a *<u>broad-based community consensus</u>* on the proposed interventions?

[ ] Yes [ ] No

9. Total number of would-be affected TP households: .....………………………………………….

10. The potential affected TP households have the following forms of rights to the required lands:

[ ] Legal: # of households: …………
[ ] Customary: # of households: …………
[ ] Lease agreements with any GoB agencies: # of households: …..…..…
[ ] Others (Mention): …………………………………..… # of households: ...……

11. Does the project affect any objects that are of religious and cultural significance to the TPs?

[ ] Yes [ ] No

12. If 'Yes', description of the objects:

…………………………………………………………………………………………………

……
13. The following are the three main economic activities of the potential affected TP households:
a. ……
b. ……
c. ……

14. Social concerns expressed by TP communities/organizations about the works proposed under the subproject: ……
……
……

15. The TP community and organizations perceive the social outcomes of the subproject:
[ ] Positive [ ] Negative [ ] Neither positive nor negative

16. Names of TP community members and organizations who participated in screening:
……

This Screening Form has been filled in by:

Name: …… Designation: ……..……..
Signature: …… Date: ……...

Annex – 5: Summary of the discussion of the consultation held on 14 March, in Dhaka

The consultation was organized by the Ministry of Health and Family Welfare (MOHFW) on 14 March, 2017 in the Conference Room of MOHFW, Secretariat complex, Dhaka. The participants included a broad range of stakeholders from various departments and ministries of the Government of Bangladesh, officials from the MOHFW, health care facilities from Sylhet and Chittagong division attended the meeting, tribal peoples' representatives from the CHTs and plains regions and various CHT institutions such as the CHT Regional Council and Hill District Councils. (List of the participant is given below in the Annex 6) (Figure A1). The meeting was chaired by Joint Chief, MOHFW.

Figure A1: Consultation workshop organized by MOHFW on 14 March, 2017

After general introduction, the draft FTPP was presented through PowerPoint. A lively discussion followed the presentation and many participants made important observations and recommendations on the draft FTPP and for its effective implementation in the subsequent phase. The key points raised in the consultation on the draft FTPP is provided below in summary:

- The FTPP, in its current form, does not mention any precise budget. In response, the MOHFW informed that it is only a framework, not a plan. When the Tribal Peoples' Plans (TPPs) are developed at upazila level, these will include specific budget
- Many health care workers from the field (CHT and Sylhet) told that they have been working on tribal health over the past years. The budgetary allocation is very important for effective delivery of the healthcare services to the TPs and the specific mention of budgetary allocation in the TPPs will be very important for their work.
- The representative of Ministry of CHT Affairs (MoCHTA) stressed on the importance of participation of the relevant stakeholders in the planning and implementation of the FTPP. He particularly pointed out the need of involving the Hill District Councils (HDCs) in the CHTs in the process. He also mentioned the importance of dis-aggregated data for which the MOHFW will require to take specific initiatives.
- The Civil Surgeon of Rangamati mentioned that the TPs usually live in hard to reach areas. The issue of effective outreach to them is very crucial. To illustrate his point, he told that CHT is 10% of Bangladesh in terms of geographical area and one particular Upazilla (Baghaichari) is larger than Feni district, where as there far fewer field level workers to serve the area. These issues should be addressed in the TPPs.

- A TP representative from CHT thanked MoHFW for the consultation. He, however, stressed on the importance of regular engagement between the MoHFW and the TPs and pointed out sharing regularly the relevant information with the stakeholders. He also raised the importance of involving the CHTRC and the HDCs (in CHT) in the planning and implementation of the TPPs. The HDCs are particularly important as health is one of the transfer subjects under them.
- Many participants stressed on the importance of the traditional institutions of the TPs and pointed out the important roles the headmen and karbaris play among the TP communities in the CHTs.
- There are many TP communities in the plain lands too. The participants asked MoHFW to draw attention to them too. The TPs in the plains are among the poorest in Bangladesh and virtually. Most of them do not have access to proper healthcare. Most actually are not even aware of the healthcare services given their low level of knowledge. Their villages still do not have electricity, roads, etc. As a result, while the average life expectancy in Bangladesh is increasing recently, this is not the case for the TPs. The family planning field workers are usually rarely seen in the TP villages.
- Participants from Khagrachari said that some TP communities have very small population and they might actually disappear soon. These TPs need especial programs from them. Working with volunteers from the same communities is raise the chances of access to healthcare for them
- The Civil surgeon from Sylhet told that they don't have sufficient information about tea gardens' residents' health situation. The tea garden workers usually tend to be apprehensive to the outsiders and don't want to express their problems. However, these communities are among the most vulnerable. There is an urgent requirement to study and assess their condition and based on this to undertake appropriate interventions for them.
- Many participants pointed out the remote and hard-to-reach areas where the TPs live. For example, in Thanchi upazila in Bandarban, there is a health complex. But many areas in the upazila need more than 2 days of trekking on foot and this is the only way to reach these communities. Maternal health among these communities remains a critical issue. Training of more midwives and birth attendant can effectively address their situation.
- MoHFW will require to collect updated data. Most recent available data are 7-9 years old. Fresh data in this regard is very important for effective monitoring and implementation as well.
- A specific DLI for CHT/TP will be good and will help to implement TP friendly interventions. CC, satellite and mobile medical team expansion should accommodate the ground reality (the criteria for CC establishment should not be like for 5000 people as it does not match the TP inhabited areas given their sparse population. Rather it should be one CC for each village in particular for the remote and hard to reach areas.
- A particular problem for effective delivery of the healthcare services in the TP inhabited areas is that doctors and healthcare professionals do not want to go to those areas. This is most acute in the CHTs. Working with the local NGOs could be an effective strategy in this regard.
- The delivery of the healthcare services should be more decentralized. In particular, there is scope in this regard in the CHT as health is a transfer subject already handed over to the HDCs.

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

SL No.	Name	Designation	Phone
1.	Dr. Nilo Kumar Tandangya	Councilor, CHTRC	01819675793
2.	M.M. Reza	CTA, PMMU	01819555525
3.	Dr. Mir Mustafizur Rahman	Health Officer Dhaka South City Corporation	01711547578
4.	Dr. Uday Shankar Chakma	Civil Surgeon, Bandarban	01746215350
5.	Begum Shaha Naz	Deputy Director of Family Planning	01711146922
6.	M. A. Jabbar	Councilor, KHDC	01553559274
7.	Biplob Barua	Deputy Director Family Planning, Khagrachari	01815592827
8.	Dr. Shahid Talukder	Civil Surgeon, Rangamaty	01554303477
9.	Sabir Kumar Chakma	Councilor, R. H. D. C	01720693062 01818930037
10	Thowai Hlamong Marma	Councilor, B. H. D. C	01553645252
11	Dr. Md. Mazed Chy Ovi	Representative, CS. Civil Surgeon office, Chittagong	01819173997
12	Dr. Abul Kalam Azad	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. Luthfun Naher Jasmin	DDFP Sylhet	01711174222
18	Dr. Md. Lutfor Rahman	VO, DNCC Dhaka	01711341086
19	Rabindranath Soren		01712278211
20	Dr. Abdus Salam Howlader	PM (Research) PMR, DGHS, Mohakhali	01712219534
21	Md. Abdur Rakib	Deputy Chief Ministry of cultural Affairs	01552474175

SL No.	Name	Designation	Phone
22	Md. Humayun Kabir	Assistant Chief PM, DGFP	01911361300
23	Md. Faruk Ahmed Bhuiyan	Line Director DGHS	01715165914
24	Dr. T.M. Mozibur Hoque	Director, ESD DGHS	01922455723
25	Subinay Bhattacharje	Deputy Secretary MOCHTA	01711156702
26	Hossain Shahid	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	Kamrun Nahar Sumi	Assistant Chief, MOHFW	01716597221
33	Dr. Md. Abdul Wadud	DPM (HSM), DGHS	01711300721
34	Nurun Nahar	SAC, MOHFW	01550153612
35	Mahfuza Akhter	Deputy Secretary ERD	01711003657
36	Md. Huzur Ali	SAC, MOHFW	01814-126168
37	Rejwanul Hoque	SAC, MOHFW	01715238975
38	Mohammad Abdul Azim	Assistant Director, DOF	01552361091
39	Md. Rafiqul Islam	SAC, MOHFW	01712659160
40	Shereen Akhter	SAC, MOHFW	01716323838
41	Dr. Md. Jaynal Hoque	PM (ARRH) MCH-S unit, DGFP	01534304749
42	Dr. Nurun Nahar Begum	DD & PM (OA) CCSDP, DGFP	01911344276
43	Prof. Ferdous Jahan	WB	01714133008
44	Sylvia Islam	Senior Development	01713013204

SL No.	Name	Designation	Phone
		Advisor Global Affairs Canada	
45	Dr. Iqbal Kabir	Coordinator CCHPU, MOHFW	01714165204
46	A. Waheed Khan	Planning & Coordinator PMMU, MOHFW	01713017615
47	Dr. Tanvir Ahmed	Assoc. Prof. BUET	
48	Zamina Israt	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	Shaila Sharmin Zaman	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	