

**Health Sector Support Project (HSSP)**

**Including**

**Additional Financing**

**Updated SOCIAL MANAGEMENT FRAMEWORK**

**Ministry of Health and Family Welfare**

**Government of the People’s Republic of Bangladesh**

**July 2018**

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# Acronyms & Abbreviations

BPP Bangladesh Population Policy

CC Community Clinic

DGHS Directorate General of Health Services

DHIS2 District Health Information System 2

DLI Disbursement Linked Indicator

DP Development Partner

FDMNs Forcibly Displaced Myanmar Nationals

GBV Gender Based Violence

GEVA Gender, Equity, Voice and Accountability

GOB Government of Bangladesh

GRS Grievance Redress 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

WFC Women Friendly Center

**Executive Summary**

Since late 1990s, the GOB and development partners (DP) have pursued a sector-wide approach (SWAp) in the HNP sector. The Ministry of Health and Family Welfare (MOHFW) has implemented three consecutive Sector Programs in between July 1998 and December 2016. The Ministry currently implementing its fourth Sector Program titled ‘4th Health, Population and Nutrition Sector Program (4th HPNSP)’ covering a 5.5-year period between January 2017 and June 2022 with an estimated cost of US$ 14.7 billion. The 4th HPNSP encompasses three components: (a) Governance and Stewardship, (b) HNP Systems Strengthening, and (c) Provision of Quality HNP Services. The Program’s 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.” Like the previous three sector programs, it is expected that a significant proportion of DPs support will be channeled through on-budget financing. Since October 2017, the World Bank is implementing its Health Sector Support Project (HSSP) having three components through which the Bank is providing support to the 4th HPNSP.

1. Since August 2017, about 700,000 forcefully displaced people have crossed into Bangladesh from Myanmar. The majority are settled in large congested camps across Cox’s Bazar District in Chittagong Division who joined over 200,000 people displaced in the previous years. This sudden influx of forcibly displaced Myanmar nationals (FDMNs) is placing an immense strain on an already resource-constrained social service delivery system including health services. The MOHFW will continue to deliver humanitarian aid directly and through United Nations (UN) agencies and local/international NGOs for supply of food, HNP services, sanitation, water and other essential services to these FDMNs. To enhance the capacity of the MOHFW to respond to the crisis and support it in extending HNP services to the FDMNs in Cox’s Bazar district, a fourth component has been added in the HSSP to channel the Bank’s additional financing. Direct beneficiaries of the 4th component of HSSP are the FDMNs, whereas, the same for the original three components are Bangladeshi nationals.
2. The Additional Financing (AF) under the 4th Component of HSSP intends to provide health services delivery to the FDMNs and Host Communities across in Cox’s Bazar District under Chittagong Division. The 4th component will also be implemented by the MOHFW. There are 3 sub-components under the proposed Component 4, in addition to the 3 components of the original HSSP.

Table 1: Components of HSSP and Additional financing

|  |
| --- |
| **Component 1. Governance and Stewardship** |
| 1. Enhancing the Recipient’s citizen feedback system for its health services, including making the performance of the system and the responses to the messages received more transparent to the public
 |
| 1. Improving budget efficiency and allocation in the HNP sector through the increase of budget allocation and execution towards repair and maintenance to support basic service delivery.
 |
| **Component 2. HNP Systems Strengthening** |
| 1. Improving the Recipient’s financial management, procurement, supply chain management and asset management systems in the HNP sector.
 |
| 1. Improving the quality of the health management information system through the completeness of the reporting and inclusion of gender, for gender-disaggregated report, from the community clinic level.
 |
| 1. Improving human resource in the HNP sector through the appointment and retention of qualified midwives at Upazila Health Complexes
 |
| **Component 3. Provision of Quality HNP Services** |
| 1. Improving coverage of essential services at the primary and first-referral levels for reproductive (including family planning), maternal, neonatal, child, and adolescent health and nutrition, including reducing geographic inequalities.
 |
| 1. Supporting the Recipient in addressing emerging areas through the strengthening of the coordination mechanisms with the Ministry of Local Government, Rural Development and Cooperatives and urban local governments and the development and implementation of a pilot to address non-communicable diseases (hypertension), starting from screening and referral services at the community clinic level.
 |
| **Component 4. Development of HNP Services for FDMNs in Cox’s Bazar District** |
| 1. Enhancing the Recipient’s planning, coordination, monitoring and management capacities for providing scaled up and new HNP services providing care to the FDMNs in Cox’s Bazar District, including for disease surveillance and outbreak response, service management referral systems, and medical waste management.
 |
| 1. (a) Enhancing delivery of the Essential Service Package to the FDMNs at community clinics and similar facilities in Cox’s Bazar District; (b) Enhancing delivery of the Essential Service Package to the FDMNs at union level and similar facilities in Cox’s Bazar District; and (c) Supporting integrated communication and outreach strategies focused on improving HNP-related household knowledge and behaviors in Cox’s Bazar District.
 |
| 1. Enhancing the delivery of the Essential Service Package to the FDMNs at Upazila Health Complexes and the District Hospital in Cox’s Bazar District.
 |

1. The 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. 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, and with the additional financing under Component 4, the FDMNs.
2. 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 the MOHFW to 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.
* Lays down specific mitigation measures to maximize the benefits especially for the women victims of gender-based violence, particularly in the area of mental health of the FDMNs.
1. The original HSSP is designed for improving health service delivery with special focus on Chittagong and Sylhet Divisions and the project has been under implementation since October 2017. The additional financing to HSSP intends to develop capacity of the MOHFW to provide HNP services to the FDMN’s across Cox’s Bazar District under Chittagong division. Direct beneficiaries of the 4th component are the FDMNs, whereas, the same for the original three components are Bangladeshi nationals.
2. 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. The Project will not trigger OP 4.12 as no land acquisition will take place in this project. Also, no intervention in this project will cause direct impact on livelihood or income. There are pockets in the Cox’s Bazar District where tribal people reside, although, there is no presence of tribal people within the camp. The MOHFW prepared a Framework for Tribal People’s Plan (FTPP) under the original project. The proposed additional financing will attempt to address impacts of the FDMNs on the host communities that will also include tribal people. Therefore, this same framework will be used for this additional financing.
3. 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. under the existing fourth program.
4. As regards the **Component 4 for the FDMNs** on the basis of current humanitarian interventions, programs to address psychosocial needs will continue to be supported. The component will support MOHFW in providingoversight and any necessary support to continued interventions to address psychosocial and mental health needs. The Women Friendly Centers that deliver psychosocial interventions, counseling services and referral to sexual and reproductive health and mental health services, will prove to be enormously helpful in this regard.
5. The Component 4 of this project may involve construction of small scale infrastructure civil works for which the required labor force and associated goods and services may not be fully supplied locally. In such a scenario, the Project may require Bangladeshi labors or a mix of FDMN and Bangladeshi labors. The migration to and temporary settlement of laborers in this project, referred to as labor influx, carries an array of potentially positive and negative impacts in terms of demands on public infrastructure, utilities, housing and sustainable resource management and the strain on social dynamics on top of the present situation. The project will take appropriate measures through Labor Influx Management Plan to manage the associated labor influx cases.
6. The overall project will likely have positive social impacts through its support to beneficiary feedback, promoting gender, voice and accountability (through achievement of DLI 1). It will strengthen the focus on improving equity by linking disbursement with improved results in the poorest performing areas of the country, some of which also should be thoroughly assessed. Negative Project impacts will be minimal.
7. As part of preparation of the Government’s program, the MOHFW held several consultations in each geographic divisions of the country including Chittagong and Sylhet, to obtain feedback from people. *As part of preparation of the AF under the additional component 4 of HSSP*, MOHFW held consultations with a group of stakeholders involving the Government, NGOs & civil society, and UN agencies active in Cox’s Bazar with the FDMNs on August 13-15, 2018 and subsequently on 2-6 September 2018. Further consultations with the FDMNs and other stakeholders will be carried out all through the project’s lifecycle.
8. A nationally representative Social Impact Assessment (SIA) at the beginning of the project is recommended so that both the positive and negative social aspects of health service delivery under this project funding can be adequately captured. As regard the Component 4 under additional financing, the SIA will particularly look into the issues of equity of benefits from the project’s support among the recipients. The SIA will also carefully analyze the issues of vulnerability among certain sections of the FDMNs such as, children, women and elderly, and put forward measures for their mitigation.
9. The project will prepare a Communication Strategy and Action Plan (CSAP) 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. The CSAP will be a living document.
10. The MOHFW will be responsible for the implementation of the SMF for the Component 4 under Additional Financing to HSSP. The Civil Surgeon of Cox’s Bazar district will be the key responsible official for its implementation at field level. The MOHFW will assign qualified staff or recruit from the market qualified consultants for ensuring the necessary technical assistance for the implementation of the SMF.
11. Impacts of the project 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.
12. The MOHFW will set up an appropriate Grievance Redress Mechanism (GRM) that will receive, keep records and resolve within a reasonable timeframe all cases of grievances from the beneficiaries and stakeholders. Particular measures will be taken in responding to GBV related grievance cases to ensure the sensitivity and privacy of the grievance related information of the beneficiary FDMNs.
13. The MOHFW will make specific budgetary provisions for the implementation of the SMF. The budget will be subject to revision based on project requirements during the implementation stage.
14. The MOHFW will disclose the SMF on its website and by making hardcopies of it available in its field offices. A Bangla translation of the document will also be disclosed on MOHFW website along with hardcopies in the field offices. Comments received from the stakeholders will be incorporated to the final version of the SMF.

# Introduction

The Government of Bangladesh (GOB) and development partners (DPs) have pursued a sector-wide approach (SWAP) on public health services since 1998, adopting a series of multiyear strategies, programs, and budgets (1998–2003, 2003–11, and 2011–16) for management and development of the health, population and nutrition (HNP) sector, with both domestic and international financing. The World Bank has been a partner to the GOB in support of the health sector since 1975 and has supported Bangladesh’s HNP sector programs since 1998 through three investment financing operations. The latest of the investment financing operations of the Bank is ‘Health Sector Support Project (HSSP)’ which has been in implementation since October 2017. Progress of the Project with respect to the development objective and implementation performance is satisfactory.

1. The Ministry of Health and Family Welfare (MOHFW) is implementing 4th HPNSP covering a 5.5-year period between January 2017 and June 2022 with an estimated cost of US$ 14.7 billion. The Program’s 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 4th HPNSP 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 Government’s program encompasses three components: (a) Governance and Stewardship, (b) HNP Systems Strengthening, and (c) Provision of Quality HNP Services.
2. Like the previous three sector programs, it is expected that a significant proportion of DPs support will be channeled through on-budget financing. The original HSSP has three components through which the Bank is providing support to the Government’s Fourth Sector Program- 4th Health, Population and Nutrition Sector Program (4th HPNSP) based on IPF-DLI mechanism. The Project Development Objective (PDO) of HSSP is to strengthen the HNP sector’s core management systems and delivery of essential HNP services, with a focus on selected geographical areas, (i.e., Chittagong and Sylhet Divisions).
3. Since August 2017, about 700,000 forcibly displaced people have crossed into Bangladesh from Myanmar. The majority are settled in large congested camps across Cox’s Bazar District in Chittagong Division, while some are living amongst host communities. The forcibly displaced Myanmar nationals (FDMNs) joined over 200,000 people displaced from Myanmar in previous years. The MOHFW has been providing HNP services to the FDMNs since the influx. However, this influx is placing an immense strain on an already resource-constrained social service delivery system. Given the uncertainty and expected delays in repatriation, the MOHFW will continue to deliver humanitarian aid directly and through United Nations (UN) agencies and local/international NGOs for supply of food, HNP services, sanitation, water and other essential services. A fourth component is added in the HSSP with the Bank’s additional financing to enhance the capacity of MOHFW to respond to the crisis and support it in extending HNP services to the FDMNs in Cox’s Bazar district. Direct beneficiaries of the 4th component of HSSP are the FDMNs, whereas, the same for the original three components are Bangladeshi nationals.

# Project Description

1. The Additional Financing (AF) AF will be implemented by the MOHFW. The responsible MOHFW field official in Cox’s Bazar District is currently the Civil Surgeon. The additional financing is to strengthen the capacity of the MOHFW to respond to the crisis and support it in extending HNP services to the FDMNs in Cox’s Bazar District. There are 3 sub-components under the proposed Component 4, in addition to the 3 components of the original project:

 Table 1: Components of HSSP and Additional financing

|  |
| --- |
| **Component 1. Governance and Stewardship** |
| 1. Enhancing the Recipient’s citizen feedback system for its health services, including making the performance of the system and the responses to the messages received more transparent to the public
 |
| 1. Improving budget efficiency and allocation in the HNP sector through the increase of budget allocation and execution towards repair and maintenance to support basic service delivery.
 |
| **Component 2. HNP Systems Strengthening** |
| 1. Improving the Recipient’s financial management, procurement, supply chain management and asset management systems in the HNP sector.
 |
| 1. Improving the quality of the health management information system through the completeness of the reporting and inclusion of gender, for gender-disaggregated report, from the community clinic level.
 |
| 1. Improving human resource in the HNP sector through the appointment and retention of qualified midwives at Upazila Health Complexes
 |
| **Component 3. Provision of Quality HNP Services** |
| 1. Improving coverage of essential services at the primary and first-referral levels for reproductive (including family planning), maternal, neonatal, child, and adolescent health and nutrition, including reducing geographic inequalities.
 |
| 1. Supporting the Recipient in addressing emerging areas through the strengthening of the coordination mechanisms with the Ministry of Local Government, Rural Development and Cooperatives and urban local governments and the development and implementation of a pilot to address non-communicable diseases (hypertension), starting from screening and referral services at the community clinic level.
 |
| **Component 4. Development of HNP Services for FDMNs in Cox’s Bazar District** |
| 1. Enhancing the Recipient’s planning, coordination, monitoring and management capacities for providing scaled up and new HNP services providing care to the FDMNs in Cox’s Bazar District, including for disease surveillance and outbreak response, service management referral systems, and medical waste management.
 |
| 1. (a) Enhancing delivery of the Essential Service Package to the FDMNs at community clinics and similar facilities in Cox’s Bazar District;

(b) Enhancing delivery of the Essential Service Package to the FDMNs at union level and similar facilities in Cox’s Bazar District; and(c) Supporting integrated communication and outreach strategies focused on improving HNP-related household knowledge and behaviors in Cox’s Bazar District. |
| 1. Enhancing the delivery of the Essential Service Package to the FDMNs at *Upazila* Health Complexes and the District Hospital in Cox’s Bazar District.
 |

# The SMF Objectives, Scope and Methodology

1. 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 that the project design and implementation of the proposed activities are socially responsive and sound.
2. 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, and with the additional financing under Component 4, the FDMNs. 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 MOHFW to 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; World Health Organization (WHO) will provide technical assistance for MWM to the health facilities that will be supported by the Additional Financing and
* Is prepared and implemented in compliance with the World Bank’s and other DPs’ social safeguards policies.
* Lays down specific mitigation measures to maximize the benefits especially for the women victims of gender-based violence, particularly in the area of mental health of the FDMNs.

**Scope of SMF**

1. The scope of this SMF includes the followings:
* Assess the baseline situation and potential social impacts of the project
* To find out the project impacts and benefits
* 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.
* Review of existing social management practices
* 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.
* 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.
* 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. Such measures under the Component 4 will specifically address the HNP issues of gender-based violence of the FDMN women;
* 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;
1. 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 stakeholder’s consultation.

# Project location and visible physical features of Component 4

1. The original HSSP was designed for improving health service delivery particularly in the Chittagong and Sylhet Divisions and the project has been under implementation since October 2017. The additional financing intends to develop capacity of the MOHFW to provide HNP services to the FDMN’s across Cox’s Bazar District under Chittagong division.
2. It is to be mentioned that the tents in the camps are temporary structures built with bamboo and plastic sheets which can be easily dismantled and re-built. In the rare case that such shifting may be required; the tents would be moved as per need and decision of the GOB. The fourth component of the HSSP on the FDMNs will complement, and not replace, life-saving HNP services that are supported by humanitarian programs. It will allow MOHFW to identify priorities for continued essential humanitarian assistance in the context of development of government capacities and services with the support of the additional financing and other medium-term support from partners. While the official closing date of the additional financing will align with that of the HSSP (December 31, 2022), however, implementation of the new component, and disbursement of the additional financing, is planned for a period of three years, that is, July 2018 to June 2021.

Table 2. HNP facilities providing services to the displaced population

|  |  |
| --- | --- |
|  | Number |
| **Primary and outpatient services** |  |
| Nutrition services of different types | 231 |
| Community Clinics, Health Posts and others of different types | 226 |
| Primary Health Centers (analogous to Union-level) | 32 |
| **Referral and inpatient services** |  |
| Field Hospitals | 8 |
| Upazila Health Complexes | 2 |
| District Hospital | 1 |

*Source: WHO and MOHFW facility mapping data.*

# Policy and Legal Framework for Social Safeguards

1. 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. 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. The Project will not trigger OP 4.12 as no land acquisition will take place in this project. No intervention in this project will cause direct impact on livelihood or income.
2. The original project includes 16 DLIs that will improve services in Chittagong and Sylhet. A large portion of the tribal people lives in Chittagong Hill Tracts areas. There are also pockets in the Cox’s Bazar District where tribal people reside; however, there is no presence of tribal people within the camp. The MOHFW has prepared a Framework for Tribal People’s Plan (FTPP) under the original project. The proposed additional financing will attempt to address impacts of the FDMNs on the host communities that will also include tribal peoples. So, this same framework will be used for this additional financing.

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

1. 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)**

1. 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**

1. 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; Seventh Five Year Plan (FY 2016-2020), Accelerating Growth, Empowering Citizens, Tribal/Ethnic Health Population and Nutrition Plan for the Health, Population and Nutrition Sector Development Program 2011 to 2016 and the 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**

1. 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)**

1. 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**

1. 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

**UN Convention Relating to the Status of Refugees, 1951**

1. The Convention is the main instrument that determines the rights of refugees seeking asylum from persecution in other countries. Bangladesh is not a signatory to the Convention including the 1967 Optional Protocol, hence it is not obliged to abide by its stipulations. However, welcoming the FDMNs in its territory and providing them shelter is a testament of upholding the spirit of the Convention.

# Project Activities and Social Issues

1. **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 7 aims at increasing the number of upazila health complexes with at least two midwives on staff.
2. **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.
3. **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 8 focuses on number of CCs reporting to District Health Information System 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 8 will assist in formulating gender specific and gender sensitive policies. 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. The original HSSP will support the GOB in improving maternal and child HNP services in Sylhet and Chittagong, as 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.
4. 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.
5. 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.
6. 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.
7. **Vulnerable FDMN Population in the Camps:** The FDMNs are highly vulnerable to disease outbreaks. Low coverage of routine immunization has exposed the displaced population to infectious diseases that have largely been controlled in Bangladesh. The FDMNs have experienced outbreaks of diphtheria and measles. Due to poor water and sanitation conditions, risk of cholera, endemic to the area, is high in the settlements. In such conditions, the population suffers from high incidence of diarrhea which undermines nutritional status and increases mortality risks, particularly among children. In addition to water‐borne diseases, there are seasonal risks of dengue and malaria, transmitted by mosquitos. Congestion, poor hygiene, inadequate housing, and indoor air pollution, also contribute to high incidence of skin diseases and respiratory infections.
8. **Government Health Delivery System and Host communities are under Severe Stress in Cox’s Bazar area:** The crisis has had a severe impact on the local population and the government HNP system in Cox’s Bazar District.The local population of the district has been affected by exposure to infectiousdiseases, by increased poverty undermining nutritional status and access to services, and by the strain ongovernment HNP services including diversion of management attention, personnel and resources. Forexample, due to high coverage of routine immunization in Bangladesh, diphtheria has been unknown inthe country for many years. The recent outbreak among the FDMNs, involving over6,800 cases and 42 deaths, caused 52 cases among the local population as well. The MOHFW’sadministrative capacity, both at the district and national levels, has been stretched by the influx. Thelimited human resources available to the district administration are almost entirely focused on the crisis,while a significant portion of the attention of national‐level policy‐makers and administrators has beendiverted to Cox’s Bazar District. MOHFW has temporarily assigned health care professionals to work in thedistrict, which has affected services elsewhere in the country.

# Gender, Equity, Voice and Accountability (GEVA) Initiatives

1. 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. under the existing fourth program. 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.
1. The Women Friendly Centers havecapacity to provide basic counseling; for more severe cases, the patients will be referred to higher levelservices for clinical diagnosis and treatment. To‐date, it is reported that 115,000 people have beenreached by these interventions, while 6,000 women and girls have received care. On the basis of currentprograms, following international best‐practice and technical standards, this sub‐component willsupport MOHFW in providing oversight and necessary support to continued interventions to psychosocial and mental health needs of the displaced population,including ensuring referral pathways from community‐level to clinical services.
2. 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 facility; 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**

1. 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
2. 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.
3. 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 MOHFW, Ministry of Home Affairs, Ministry of Information, Ministry of Social Welfare, Ministry of Law, Justice and Parliamentary Affairs, 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.
4. As regards the **Component 4 of HSSP for the FDMNs** on the basis of current humanitarian interventions, programs to address psychosocial needs will continue to be supported. Many displaced have been victims of sexual and gender‐based violence in Myanmar and remain at risk in the camps, including the risks of trafficking and rape. Moregenerally, the violence experienced by the displaced population while escaping to Bangladesh increase vulnerability topsychosocial and mental health disorders. The component will support MOHFW in providingoversight and any necessary support to continued interventions to address psychosocial and mental health needs. The Women Friendly Centers that deliver psychosocial interventions, counseling services and referral as needed to sexual and reproductive health and mental health services, as well as community‐level social and behavior change communication will prove to be enormously helpful in this regard. These Centers, being operated by partners in and near the displaced camps, have the capacity to provide basic counseling, although for more severe cases, the patients will be referred to higher level facilities for HNP services. The component will also provide necessarysupport in building the capacities of HNP services to provide immediate care forsurvivors of such violence, including training of service providers following international best practice and technical standards.
5. This component will strengthen the capacity of the MOHFW to deliver sexual and reproductive health services to the FDMNs as part of the Essential Service Package, as well as support the MOHFW in providing oversight and support to NGO provided services.
6. The original project did not undertake any civil works. No land acquisition, displacement of people (with or without title) from public or private lands, or any adverse impacts on livelihoods took place under the project. The component 4, may fund small scale construction of temporary structures to serve as community clinics or health service delivery points within the camps; some scale up of existing facilities outside the camps that serve both local people and refugees may also be required. These will most likely be done by UN agencies on behalf of the Ministry. All construction is expected to take place within public lands or lands which have been allocated by the Government for FDMNs’ camps. Therefore, no land acquisition or involuntary resettlement is expected. If any shifting of structures within the camps is required to optimize use of space for upgrade of existing facilities and/or building new ones, this will be done on a purely voluntary basis, after a documented consultation process is put in place. So project will not trigger OP 4.12 as-
* No private land acquisition will be permitted;
* Through screening, the project will make sure that no squatters are affected;
* In case any existing structures within the camps need to be shifted to make way for health service delivery points/clinics, all shifting will take place purely on a voluntary basis;
* The implementing agency will ensure that appropriate and adequate institutional arrangements are in place to monitor and supervise any land related issue that may ensue due to upgrade/construction/shifting of structures.
1. Screening forms are attached with Annex 1 and Annex 1.1 which MOHFW and contractors will fill before any construction works take place. If any private land is used temporarily on voluntary basis, project authority will make sure that consultation is taken place with the land owners. Project authority would require MOU with the private land owners if land is requiring voluntary basis.

# Labor Influx

1. A key objective of the World Bank’s environmental and social safeguard policies is to help avoid, minimize or mitigate adverse impacts of its projects on people and the environment. Component 4 of HSSP may involve construction of small scale infrastructure civil works for which the required labor force and associated goods and services cannot be fully supplied locally. The Project may require Bangladeshi labors or a mix of FDMN and Bangladeshi labors. The migration to and temporary settlement of laborers in this project, referred to as labor influx, carries an array of potentially positive and negative impacts in terms of demands on public infrastructure, utilities, housing and sustainable resource management and the strain on social dynamics on top of the present situation.
2. Labor influx may cause gender based violence which is an umbrella term for any harmful act that is perpetrated against a person’s will, and that is caused by differences in power between people of different genders, i.e., between males and females and people of other gender and sexual identities. Women and girls in the camps may be affected by gender-based violence due to the subordinate status of women in the camp. Gender-based violence takes many forms, including sexual, physical, and psychological abuse.
3. The Project will have Labor Influx Management Plan to address specific activities that will be undertaken to minimize the impact on the local community and FDMNs, including elements such as worker codes of conduct, training programs on HIV/AIDS, etc.

# Project Impacts and Benefits

1. One of the most important criteria, while preparing SIA is to find out the project impacts and benefits. The project fully supports gender inclusiveness, taking forward the Government’s Gender Equity Strategy and Action Plan (2014–2024) that has strategic objectives to strengthen the gender aspects of the HNP sector program, including the health sector response to victims of gender-based violence. The strategy aims to introduce gender-sensitive policies, plans, and evidence-based approaches; ensure equitable access to and utilization of services using a lifecycle approach aiming to protect the health of young girls, adolescents, and elderly women within a rights-based perspective; and mainstream gender in all MOHFW programs with a specific focus on gender-sensitive planning and ensuring gender-balanced human resources. These elements will be expanded to fit the AF components wherever appropriate.
2. The additional financing will support services, especially mental health services, to survivors of gender based violence in the camps. In addition to the provision of immediate care to survivors of violence, the additional financing will provide necessary support to deliver psychosocial counseling through Women Friendly Centers that are being operated by partners in and near the displaced camps. Capacities to address this issue will improve through training of service providers following international best practice and technical standards. The additional financing includes indicators to specifically track provision of services to women and female children and thus, contribute to reducing any disparity that may exist.
3. Currently, referral and inpatient services for the displaced population are being provided by the MOHFW Sadar District Hospital, the two MOHFW Upazila Health Complexes in Ukhia and Teknaf, and eight temporary field hospitals run by a variety of partners. Going forward, the component 4 of HSSP will support MOHFW in further developing the capacities of the District Hospital and the Ukhia and Teknaf Upazila Health Complexes, contributing to a single investment plan that will coordinate support to these facilities by different partners. Human resources, equipment, laboratory capacity, surgical capacity, water and sanitation, infection control and medical waste management (MWM), are evident areas requiring investment. The single plan will consider the need for continued humanitarian support to temporary field hospitals in and near the displaced camps to supplement the referral capacity of MOHFW facilities.
4. Along with the activities to be supported by the additional financing, the ongoing interventions under original HSSP will continue. The original HSSP supports increased coverage of facility‐based deliveries, family planning services and emergency obstetric care, reducing the risk of maternal mortality in Chittagong Division, including Cox’s Bazar District. Activities focused on maternal and adolescent health and nutrition include the development of a school‐based adolescent health program that will include both boys and girls, targeted communications and behavior change interventions to improve nutrition services for mothers and pregnant women, and the deployment of female midwives, which will contribute to making services more woman‐friendly. The recruitment process of approximately 3,000 midwives is underway and the first batch of 600 midwives is expected to be posted in HNP facilities nationwide by the end of 2018.
5. The overall project will likely have positive social impacts through its support to beneficiary feedback, promoting gender, voice and accountability (through achievement of DLI 1). It will strengthen the focus on improving equity by linking disbursement with improved results in the poorest performing areas of the country, some of which also should be thoroughly assessed. Negative Project impacts will be minimal.
6. As regard the Component 4, the additional financing may fund small scale construction of temporary structures to serve as community clinics or health service delivery points within the camps. In most cases existing structures would be used or enhanced, although some scale up of existing facilities outside the camps that serve both local people and refugees may also be required. These will most likely be undertaken by UN agencies on behalf of the Ministry. All construction is expected to take place within public lands which have been allocated for FDMN camps. Some portion of the camps may be on private land and owners of the private land might have allotted those lands temporarily for camp uses. Consultations will be carried out for intervention to take place on those private lands. MOU with the land owners must be conducted before any construction or intervention taking place. Any activities that are involuntary in nature will not be carried out in this project. Therefore, no land acquisition or involuntary resettlement is expected.
7. Within the camps, any agency working under the Bank financing to upgrade existing facilities or build small scale structures will do a site screening to identify unused space for the purpose. In case (and because the service delivery has to be strategically placed so as to provide even coverage) the upgrade or small scale civil works would require existing structures to be shifted to optimize space, such activities would have to be carried out on the basis of detailed consultation, ensuring that the shifting is done on a completely voluntary basis. The tents the camps would be moved a few feet away at most, based on the willingness of the affected party. The SIA will include guidance specific to this and provide a detailed consultation strategy. It is to be noted that there is already a process of consultation and coordination being followed by the UN agencies and NGOs working at the field level. The project’s consultation strategy will be informed by the latter and will build linkages to maintain the coordination aspects. It will be an ongoing process throughout the life of the project. The potential social impacts of the Component are outlined in the table below:

Table 3: 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 and permitted to acquire. In case of component 4, all the construction works will be conducted on government land and within tents. | Project impact over land is insignificant as no land acquisition will be allowed under this project. |
| Temporary shifting of the FDMNs during construction (if needed) | Displacement will be temporary if required. Project will provide full support if relocation is required. Project will bear all the relevant cost of shifting. | Impacts will be insignificant. |
| Common Property Resources | Common Property Resources 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 | The project will not affect the impact and livelihood of the beneficiaries.  | Rather, the interventions will make a positive impacts on the people’s income and livelihood by providing them quality health services |
| 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 |

# HNP sector – Achievements and Challenges

1. Bangladesh has made very good progress in expanding coverage of basic HNP services, but there are 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.
2. 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.
3. 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 face 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.
4. 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). 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.
5. The main challenge for component 4 of HSSP is with the FDMNs of around one million who have enormous needs for HNP services. The FDMNs includes large numbers of women, children and other vulnerable groups who require basic HNP services. Children under five years are 18.5 percent of the population, older children and adolescents constitute a further 36.2 percent of the population, and around 20 percent of the population is women of reproductive age. This population has large requirements for reproductive, maternal, neonatal, child and adolescent HNP services, particularly as they reportedly had poor access to such services in the past. Demand is hampered by a lack of knowledge about the benefits of basic services such as maternal care, and the population came to Bangladesh with very low essential immunization coverage.

# Consultation

1. As part of preparation of the Government’s program, the MOHFW 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 consultation meeting held at Dhaka on March 14, 2017, the SMF was presented. Representatives from different districts (both government, CSOs and TPs) participated in the meeting *(List of participants provided in Annex -2).*
2. 55. 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.
3. There was 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.
4. 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.
5. *As part of preparation of the AF under the new component 4*, MOHFW has held consultations with a group of stakeholders *(list of the participants provided in the Annex – 2.1)* involving the Government, NGOs & civil society, and UN agencies active in Cox’s Bazar with the FDMNs on August 13-15, 2018 and subsequently on 2-6 September 2018. The August consultations also involved focus group discussions (FGDs) with the FDMNs including one held with the orphan children. The consultations covered the following issues:
* Identifying HNP needs of the beneficiaries based on disease burden recorded thus far and disease surveillance data.
* Mapping of the various health posts inside the camp and health facilities outside the camp that are providing HNP services to the FDMN population. This also included capacity assessment of each of the health facility/post in terms of doctors, nurses, medicines, equipment, etc. available.
* Identifying specific needs of women and children as well as victims of gender-based violence (GBV). Capacity assessment of the Women Friendly Spaces that deal with GBV and sexual and reproductive health issues.
* Taking stock of the vaccination campaign held to understand the future needs for immunization of children.
* Identifying the needs for family planning interventions and commodities, as well as scoping of implementation modality.
* Assessment of the ongoing nutrition interventions to identify additional treatment needs to deal with moderate and severely malnourished children. The assessment also included identifying needs/activities for prevention of malnutrition among children and pregnant women.
1. Further consultations with the FDMNs and other stakeholders will be carried out all through the project’s lifecycle. Key stakeholders will include project beneficiaries, Government entities, DPs as well as community-based organizations active in the health sector in Cox’s Bazar area. A tentative plan of consultations required at different stages is given below:

Table 4: Consultation Plan for Component 4

|  |  |  |
| --- | --- | --- |
| Project Phase | Activities | Responsible Agency |
| Project Initiation Stage | * Project information dissemination on various components.
* Disclosure of preliminary plans of different activities
* Consultation with the voluntary private land owners
* Discussion about MOU procedure between private land owners and project authority
* Preliminary Information sharing about the tentative alignment/sites with the PAPs in case of temporary impact on livelihood.
* Separate consultation with FDMNs about the project activities and interventions, and the possible impacts
* Separate consultation with FDMNs women and children
* Procedure to Address the grievances
 | MOHFW  |
| Implementation Stage | * Stakeholder consultations with project beneficiaries and local community
* Consultation with labors
* Consultation with private landowners about the MOU with project authorities
 | MOHFW/ Implementing NGO |
| * Disclosure of final entitlements/social safeguard documents to different stakeholders
 | MOHFW/ Implementing NGO |
| * Discussion on labor issues during construction
 | MOHFW/ Implementing NGO |
| * Discussion on construction works and potential impacts
 | MOHFW/ Implementing NGO |

1. The component’s Communication Stakeholders Engagement Strategy will further detail the component’s consultation methods and approaches.

# Framework for Social Impact Assessment

1. 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 recommended so 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.
2. As regard the Component 4 under additional financing, the SIA will particularly look into the issues of equity of benefits from the project’s support among the recipients. This will ensure that all the potential beneficiaries among the FDMNs - women, children, men and young people – can share equally the benefits from the component’s support. The SIA will also carefully analyze the issues of vulnerability among certain sections of the FDMNs such as, children, women and elderly, and put forward measures for their mitigation, if not the possible remedies. In particular, it will focus on the issues of gender-based violence and the consequent needs for psycho-social rehabilitation, reproductive health needs of the young and adult women of reproductive age, potential impact of natural disasters on the precarious camps, social and behavior change communication and other interventions to reduce the vulnerability of the FDMNs, specific requirements for stakeholders’ engagement and consultations, the mechanisms for beneficiary feedback on the interventions, and finally, the impacts on the host communities along with the mitigation measures.

**SIA Principles**

1. 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**

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

**Project proponents (MOHFW)**

* 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 MOHFW and 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, Upazila health 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.
1. 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**

1. 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**

1. 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**

1. 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**

1. 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
1. The following matrix can be used for determining the impacts of this project:

Table 5: Social Impact Assessment Variable matrix

|  |  |  |
| --- | --- | --- |
| **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**

1. The following steps can be followed for preparing SIA:
2. **Public Involvement -** Develop an effective plan to involve all potentially affected including the FDMNs and the host community (both positively and negatively) publics.
3. **Baseline Conditions -** Describe the relevant human environment/area of influence and baseline.
4. **Scoping -** Identify the full range of probable social impacts that will be addressed based on discussion or interviews with numbers of all potentially affected people, FDMNs and host community
5. **Projection of Estimated Effects -** Investigate the probable impacts.
6. **Mitigation -** Develop a separate mitigation plan for component 4.
7. **Monitoring –** Develop a monitoring program.

**Principles for Social Impact Assessment**

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

|  |
| --- |
| **\* Involve the diverse public***Identify and involve all potentially affected groups and individuals including* FDMNs |
| **\* 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.* |

**Management of Labor Influx**

1. Social impacts are critical to address, as even a modest labor influx already may lead to negative impacts on the host community. During construction, project may require some Bangladeshi labors which may cause conflict among FDMNs, host community and outside labors. The list below indicates categories of social risk associated with labor influx and any of the following issues may rise conflict in the project area.
2. **Risk of social conflict:** Conflicts may arise among the local community, FDMNs and the construction workers, which may be related to religious, cultural or ethnic differences, or based on competition for local resources. The local community through consultation and FGD’s should be informed about the labors. Unskilled labors should be engaged from the local community. Host community engagement in this process will be helpful. Tensions may also arise between different groups within the labor force, and pre-existing conflicts in the local community may be exacerbated. Ethnic and regional conflicts may be aggravated if workers from one group are moving into the territory of the other.
3. **Increased risk of illicit behavior and crime**: The influx of workers and service providers into communities may increase the rate of crimes and/or a perception of insecurity by the local community. Such illicit behavior or crimes can include theft, physical assaults, substance abuse, prostitution and human trafficking. List of all workers in the project area should be recorded on a regular basis. So that monitoring will be easier for the project authority.
4. **Influx of additional population:** Host community is already supporting many of the FDMNs. As this project will be running for a longer period, people can migrate to the project area in addition to the labor force, thereby exacerbating the problems of labor influx. These might be people who expect to get a job with the project, family members of workers, as well as traders, suppliers and other service providers (including sex workers), particularly in areas where the local capacity to provide goods and services is limited.
5. **Impacts on community dynamics:** Depending on the number of incoming workers and their engagement with the host community, the composition of the local community, and with it the community dynamics, may change significantly. Pre-existing social conflict may intensify as a result of such changes.
6. **Increased burden on and competition for public service provision**: The presence of construction workers and service providers can generate additional demand for the provision of public services, such as water, electricity, medical services, transport, education and social services. This is particularly the case when the influx of workers is not accommodated by additional or separate supply systems.
7. **Increased risk of communicable diseases and burden on local health services**: The influx of people (both FDMNs and labor) may bring communicable diseases to the project area, including sexually transmitted diseases (STDs), or the incoming workers may be exposed to diseases to which they have low resistance. This can result in an additional burden on local health resources. Workers with health concerns relating to substance abuse, mental issues or STDs may not wish to visit the project’s medical facility and instead go anonymously to local medical providers, thereby placing further stress on local resources.
8. **Gender-based violence:** Construction workers are predominantly younger males. Those who are away from home on the construction job are typically separated from their family and act outside their normal sphere of social control. This can lead to inappropriate and criminal behavior, such as sexual harassment of women and girls, exploitative sexual relations, and illicit sexual relations with minors
9. During construction, it is required to conduct a screening attached with annex 4 and submitted to World Bank. MOHFW will try to engage local labors as much as possible. Before engaging the labors, it is required to conduct consultation with the community people and FDMNs. A code of conduct must be prepared for the non-FDMN labors. It is very important that MOHFW together with the contractor will conduct a general screening. If more detailed is required, then detailed screening can be conducted. Screening reports have to be submitted to World Bank.
10. If project requires non-FDMN labors, local host community should be preferred for skilled and non-skilled labors. If skilled labors are not found within the host community, project will inform community through consultation the following information:
11. Number of skilled labors are hired from outside the community;
12. The length of contract of the labors with the project;
13. Number of unskilled labors hired from the community;
14. Help identify the presence and significance of project-related impacts on local communities;
15. Ensure that adequate mitigation measures are established (and modified as needed) and implemented in a timely manner;
16. Ensure that the mitigation measures are achieving their objectives of addressing corresponding impacts.
17. Moreover, the Contractor will be encouraged, to employ staff and labor with required qualifications and experience on or near the project adjacent community. To ensure health and safety of the workers and project personnel, the Contractor shall ensure that local health providers, doctors, bed facilities, ambulance service etc. are available. Contractor shall take all necessary welfare and hygiene requirements and for the prevention of epidemics for his personnel and the surrounding community. The Contractor shall conduct awareness programme on Sexually Transmitted Diseases (STD) including HIV/AIDS, at regular interval via a qualified service provider for his workers and community. The Contractor shall take all necessary steps and precautions at all times to preserve peace and protection of persons and property on and near the Site, may be occurred by his labor. The work area and labor accommodation area shall be properly marked and fenced, so that surrounding community will not be disturbed.
18. The Contractor shall submit to the MOHFW at every month, complete and accurate records of the employment of labor at the Site. The records shall include the names, ages, genders, hours worked and wages paid to all workers. A general Labor Influx Screening Sheet is provided in Annex – 4 to this SMF.

#  Framework for Communication Strategy and Action Plan (CSAP)

1. **Purpose of the CSAP**
2. 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.
3. **Targeted populations and scope of work for CSAP**
4. 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.
* Community elders, women representatives, implementing agencies, representatives from host communities in the case of the Component 4.
1. **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
1. As part of the social assessment, the communication-relevant parameters will be analyzed; a strategy will be formulated and presented in the CSAP.

# Implementation Arrangement and Monitoring and Evaluation

1. The Planning Wing of the MOHFW 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 of MOHFW 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.
2. The MOHFW will be equally responsible for the implementation of the SMF for the Component 4 under Additional Financing. The Civil Surgeon of Cox’s Bazar district will be the key responsible official for its implementation at field level. The MOHFW will assign qualified staff or recruit from the market qualified consultants for ensuring the necessary technical assistance for implementation of the SMF. A full-time team of 3 (three) consultants is proposed:
3. Social Expert
4. Gender Expert
5. Communications and Outreach Expert
6. The Terms of Reference of the above 3 consultants are provided in Annex – 3.

# Monitoring and Evaluation

1. Impacts of the proposed component 4 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.
2. The Planning Wing of the Health Services Division and the Planning Branch of the Medical Education and Family Welfare Division are responsible for planning, monitoring, and reporting on the progress of the 4th HPNSP and serve as the primary points of contact for monitoring and communicating to the World Bank on the project, including the additional financing. Under component 4 of HSSP, results of the new activities to be supported by additional financing will be reflected by the following additional indicators. The HSSP results framework will continue to be monitored.

 Table 6. Additional PDO and intermediate level indicators for Component 4

|  |
| --- |
| **PDO indicators** |
| 1. Number of children immunized from among the displaced population in Cox's Bazar District (annual) |
| 2. Number of births among the displaced population delivered in an HNP facility (annual) |
| **Intermediate level indicators** |
| 3. Number of facilities (equivalent to Union-level facilities) providing an appropriate mix of family planning methods to the displaced population in Cox's Bazar District (cumulative) |
| 4. Number of facilities providing emergency obstetric care to the displaced population (cumulative) |

1. The MOHFW will assign qualified staff for monitoring of the component or will recruit from the market a competent Monitoring Expert on full-time basis during the project period. S/he will develop relevant monitoring tools and mechanisms based on the existing MOHFW monitoring system.
2. Monitoring of and reporting on the project must be complemented by an effective GRM proposed in SMF in order to address issues arising from project implementation. GRM will help to detect unanticipated or recurring problems, and to manage them. The project implementing agency sets up and supports the GRM, in a manner satisfactory to the World Bank, to receive, manage and facilitate resolution of stakeholders’ concerns and grievances in a timely manner. It is important that the GRM is designed to accommodate all project-related issues raised, including issues related to labor influx. The way to make complaints needs to be simple and well publicized. The GRM is usually scaled to the risks and potential adverse impacts of the project. The following factors will be considered in the project for the effective GRM:

(i) their publicity and accessibility, (ii) the transparency of their operation, (iii) the credibility of their decision-making process and structure, (iv) their confidentiality and hence protection from any potential retaliation, and (v) the effectiveness of the associated business processes to resolve grievances where appropriate.

1. The monitoring team/Expert will prepare monthly/quarterly/six-monthly/annual monitoring reports, with inputs from the other team member, on the progress of the additional financing component and will share with World Bank for comments and feedback. The Team/Expert will also take the lead in carrying out the mid-term and final evaluation of the component under the guidance of the project management.
2. An outline of Terms of Reference for the Monitoring & Evaluation Consultant/Expert is given in Annex – 3.

# Grievance Redress Mechanism (GRM) for the Additional Financing

1. 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.
2. The MOHFW centrally operates a platform for receiving grievances and feedback from the beneficiaries that uses the internet, text messages and the telephone to obtain cases of grievances. This grievance redress system is accessible by all including the FDMNs and keeps detailed information electronically of the following: (i) name of the person; (ii) date complaint was received; (iii) nature of complaint; (iv) location, and (v) how the complaint was resolved. The existing system will be used to fully address and respond to any project‐related grievances from the FDMNs and other stakeholders.
3. The GRM will be implemented under the following operating principles: i) all cases received should be recorded; ii) resolutions must be communicated to the complainant; and iii) all cases will be monitored through its completion or countermeasure implementation. The MOHFW’s field level staff will serve as facilitators to the FDMNs in submitting the cases of grievances. The MOHFW will also assign specific staff for the grievance redress at the camp level.
4. The Women Friendly Centers (WFC) at the camp level will receive and deal with the grievances related to GBV. Specific staff will be assigned by MOHFW at the WFCs for dealing with GBV related grievance cases who will ensure the sensitivity and privacy of the grievance related information of the beneficiary FDMNs.

# World Bank’s Grievance Redress System (GRS)

1. 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 World Bank’s Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB’s independent 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 [*http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service*](http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service). For information on how to submit complaints to the World Bank Inspection Panel, please visit [www.inspectionpanel.org](http://www.inspectionpanel.org/).

# Budget

1. 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.
2. For the additional financing under Component 4, a tentative budget is presented below:

*Table 7: Estimated budget for Implementation of SMF for Component 4*

| **Item** | **BDT lakh** | **US$** | **The mitigation measure issues addressed** |
| --- | --- | --- | --- |
| Staff Salary | 432 | 515,000 | Strengthen institutional capacity and compliance |
| Staff training/capacity development | 16 | 20,000 | Strengthen institutional capacity and compliance |
| Consultations | 30 | 36,000 | Strengthen policy and legal framework |
| Communications (including materials development and audio-visual materials) | 36 | 43,000 | Strengthening implementation and policy framework |
| Logistics & conveyance | 16 | 20,000 | Strengthening implementation |
| Contingency/miscellaneous | 10 | 12,000 | Strengthen institutional capacity and compliance |
| Total | 540 | 646,000  |  |

# SMF Disclosure

1. MOHFW will disclose the SMF, along with its Bangla translation, to the public in Bangladesh, and authorize the World Bank to disclose it at its website. 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 including in the refugee camps for the Component 4. 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.

# Annex - 1: Social Safeguard 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**

1. *Names of official who participated in screening*:
2. *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.*
3. Are there households and individuals living in the communities covered by the health services who are otherwise vulnerable?
	1. Female headed HH persons F M
	2. Other Female HH persons F M
	3. Disabled HH persons F M
	4. Tribal HH persons F M
	5. Extreme poor HH
	6. Hijra individuals

==========================================================

1. 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 - 1.1: Screening form for social Assessment

|  |  |  |  |
| --- | --- | --- | --- |
| **Probable Impacts** | **Yes** | **No** | **Remarks** |
| 1. Will project require any temporary private land usage for construction? |  |  |  |
| 2. If yes, Is it voluntary basis? |  |  |  |
| 3. If yes, does the land owner and project authority conducted any MOU? |  |  | Please submit the MOU to WB |
| 4. Is the site for land usage known? |  |  |  |
| 5. Is the ownership status and current usage of land to be used known? |  |  |  |
| 6. Does the project require to shift any existing structures within the camp? |  |  |  |
| 7. Does adequate space available in the close proximity within the community to shift the existing structures? |  |  |  |
| 8. Does the project require to shift any existing structures from the host community? |  |  |  |
| 9. Will there be loss of income sources and means of livelihoods due to project intervention? |  |  |  |
| 10. Will people lose access to natural resources, communal facilities and services? |  |  |  |
| 11. Will access to land and resources owned communally or by the state be restricted? |  |  |  |
| 12. Does the project authority conducted consultation with the local community, host community, labors? |  |  | Please inform the numbers of consultation carried out and with whom  |
| 13. Does the project authority inform FDMNs, Non- FDMNs and labors about GRM? |  |  |  |
| 14. Will the project require non- FDMNs labors? |  |  |  |
| 15. If yes, does the project considers to engage labors from host communities? |  |  |  |
| 16. Does the project conducted consultation with the local community about the labor influx? |  |  |  |

# 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 (4th 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 Mustafizur Rahman | Health Officer, Dhaka South City Corporation | 01711547578 |
| 4. | Dr. Uday Sarkar 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, Rangamati | 01554303477 |
| 9. | Sabir Kumar Chakma | Councilor, R. H. D. C | 0172069306201818930037 |
| 10 | Thowai Hla Mong Marma | Councilor, B. H. D. C | 01553645252 |
| 11 | Dr. Md. MazedChyOvi | 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. Luthfunnaher Jasmin | DDFP, Sylhet | 01711174222 |
| 18 | Dr. Md. Lutfor Rahman | VO, DNCC, Dhaka | 01711341086 |
| 19 | Rabindranath Saren |  | 01712278211 |
| 20 | Dr. Abdus Salam Howlader | PM (Research) PMR, DGHS, Mohakhali | 01712219534 |
| 21 | Md. Abdur Rakib | Deputy Chief, Ministry of Cultural Affairs | 01552474175 |
| 22 | Md. Humayun Kabir | Assistant Chief PM, DGFP | 01911361300 |
| 23 | Md. Faruk Ahmed Bhuiya | Line Director DGHS | 01715165914 |
| 24 | Dr. T.M. Mozibur Hoque | Director, ESD DGHS | 01922455723 |
| 25 | Subinay Bhattacharjee | Deputy Secretary MOCHTA | 01711156702 |
| 26 | Hossain Shohid | UNDP | 01819241272 |
| 27 | S.Y. Khan Mojlish | CHTDF-UNDP | 01610012347 |
| 28 | Most. Salma Khatun | Deputy Director, Admin, DGNM | 01716357755 |
| 29 | Most. Shahinoor Begum | Assistant Director, COD, DGNM, Dhaka | 01731-926976 |
| 30 | Dr. Saiful Islam | DPM CBHC, DGHS | 01818031386 |
| 31 | S.M. Sadekul Islam | Executive Engineer PWD | 9552912 |
| 32 | KamrunNahar 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 AdvisorGlobal Affairs Canada | 01713013204 |
| 45 | Dr. Iqbal Kabir | Coordinator CCHPU, MOHFW | 01714165204 |
| 46 | A.Waheed Khan | Planning & Coordinator Advisor, 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, MOHFW | 01552443625 |
| 50 | Shaila Sharmin Zaman | M&C Specialist, PMMU, MOHFW | 01733505577 |
| 51 | Md. Zahidul Islam | PMO (FP), PMMU, MOHFW | 01552344528 |
| 52 | Md. Ibrahim Khalil | SAC, MOHFW | 01709600472 |
| 53 | Md. Akteruzzaman | PMMU |  |

# Annex – 2.1 : List of Participants for the Micro Planning Workshop for sub-window fund for FDMN

**Hotel Sayeman, Cox’s Bazar**

**August 13-15 and September 3-6, 2018**

|  |  |  |
| --- | --- | --- |
| Sl. | Name, Designation & Organization | Contact Details |
| 1. | Dr. Md. Abdus SalamCivil SurgeonMinistry of Health & Family Welfare**,** Cox’s Bazar | Cell: 01819361412; email: coxsbazar@cs.dghs.gov.bd;PS: Mr. Osman Gani, Cell: 01554315660 |
| 2. | Dr. Pintu Kanti BhattacharyaDeputy Director (Family Planning)Ministry of Health & Family Welfare, Cox’s Bazar | PS – Mr. Amanullah;Cell 01858529074; email: amanmito@gmail.com; |
| 3. | Brig. Gen. (Retd.) Dr. Mohammad AliDGHS Coordination CenterMinistry of Health & Family Welfare, Cox’s Bazar | Cell: 01718948266email: m.alir19@hotmail.com  |
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# Annex – 3: Terms of Reference

## Social Expert

Duration of contract: 3 Years

Duty Station: Cox’s Bazar

1. **Role and Responsibilities**

The overall responsibility of the Social Specialist/Expert will be to assist the PIU in the implementation of the SMF for the Component 4 for the FDMNs. S/he support/guide/lead in carrying out Social Impact Assessment among the targeted communities, carry out consultations with the stakeholders, provide support in setting up the project’s grievance redress management system, and supervise and monitor the social mobilization and participation of the stakeholders in the project areas. The specific responsibilities of the specialist will be, but not limited to, the following:

Social Impact Assessment

* Assist/guide/lead/design Social Impact Assessment (SIA) at the field level among the targeted beneficiaries together with the field level implementation agencies (NGOs, other organizations, etc)
* Make sure that the surveys and consultations are done on schedule and adequate resources and appropriate expertise are applied.
* Monitor conduct of the SIA on site to ensure that the surveys are comprehensive, and the consultations are conducted in compliance with the World Bank’s guidelines.
* Make sure that proper consultations are carried out with the project affected persons (PAPs) and other relevant stakeholders including the host communities.

Implementation Beneficiary Engagement and Other Issues

* Review the work program and implementation schedule of the Implementing NGO
* Support and guide the PIU/Civil surgeon Office in Cox’s Bazar in the implementation of the SIAs.
* Provide support to the PIU in setting up the project’s grievance redress mechanism and communication plan
* Support and participate in grievance redress procedure and keep detailed records of grievances and the hearings, and assist to report the outcomes as per the guidelines provided in the SMF.
* Support and Guide in monitoring the cases of labour influx during the implementation of the SIAs and initiate relevant measures to prevent potential negative impacts.
* Carry out monitoring and evaluation on social safeguards implementation on behalf of the PIU
* Prepare monthly/quarterly/six-monthly/annual safeguards monitoring reports on the project and share these reports with World Bank for time comments/feedback, and
* Any other tasks assigned by MOHFW.
1. **Qualification and Experience**

The Social Expert should have Post-graduate qualification with about 8 years of work experience of which at least 4 years should be directly related to the relevant tasks of social development. The specialist must have demonstrated sound technical expertise in international good practices on social safeguards and have proven track record of providing social safeguard oversight functions. Knowledge of World Bank/ Asian Development Bank or similar development partners’ processes and guidelines on social safeguards will be necessary. S/he must have excellent proficiency both in written and spoken English and Bangla. Knowledge of the local Chitagongnian dialect will be an asset.

## Gender Expert

Duration of contract: 3 Years

Duty Station: Cox’s Bazar

1. **Role and Responsibilities**

The overall responsibility of the Gender Specialist/Expert will be to assist the PIU in the implementation of the SMF, in particular gender-related interventions, for the Component 4 for the FDMNs. S/he support/guide/lead in carrying out Social Impact Assessment among the targeted communities, carry out consultations with the stakeholders and supervise and monitor the gender component of the project. The specific responsibilities of the specialist will be, but not limited to, the following:

Social Impact Assessment

* Assist the Social Expert in carrying out Social Impact Assessment (SIA) at the field level on the gender related interventions/activities
* Make sure that the surveys and consultations are done on schedule and adequate resources and appropriate expertise are applied.
* Make sure that proper consultations with the women and adolescent girls are carried out all through the project cycle.

Preparation and Implementation of the Component Specific Gender Action Plan

* H/she will develop Gender Action Plan specific to the context of Component 4 to support the FDMNs and ensure/monitor its effective implementation
* Together with the Communities and Outreach Expert and the Social Expert, and other staffs in the PIU to prepare/design tools and instruments for behavior change communication on sexual and reproductive health and other health related issues.
* To design appropriate measures to stop or at least minimize the incidences of gender-based violence among the beneficiary communities
* Carry out monitoring and evaluation on gender related activities of the component on behalf of the PIU
* Ensure that the monthly/quarterly/six-monthly/annual safeguards monitoring reports on the project duly include progress on the gender related activities of the component.
* Any other tasks assigned by MOHFW.
1. **Qualification and Experience**

The Gender Expert should have Post-graduate qualification with about 8 years of work experience of which at least 4 years should be directly related to the relevant tasks with any renowned national or international organizations. The specialist must have demonstrated sound technical expertise on gender with proven track record of working on gender-based violence, social inclusion and protection issues. S/he must have excellent proficiency both in written and spoken English and Bangla. Knowledge of the local Chitagongnian dialect will be an asset.

## Communication and Outreach Expert

Duration of contract: 3 Years

Duty Station: Cox’s Bazar

1. **Role and Responsibilities**

The incumbent will work in PIU and will be responsible for the following, besides any other tasks/responsibilities that might be given to him by the project management from time to time;

* Develop the Project Communication, Stakeholders’ Engagement and Outreach Strategy and Plan specific to the context of the Component 4
* Monitor and ensure the implementation of the above strategy/plan.
* Set up the system for grievance management following the project SMF guidelines.
* Be overall responsible for overseeing and management of the grievances and complaints from the beneficiaries or any other project-related stakeholders arising out the implementation of the project activities
* Track and document in detail any cases of grievances/complaints and following the receipt of these complaints/grievances, facilitate the resolution of such grievances through the project GRMs.
* Undertake field visit and organize focus group discussions with the project stakeholders/beneficiaries to explain to them the project’s GRM in local languages
* Coordinate the meetings of various committees established for responding to the cases of grievances from the project’s stakeholders.
* Support Project Director to respond to queries from stakeholders and to receive feedback from the beneficiaries on the project’s interventions
* Ensure that the monthly/quarterly/six-monthly/annual safeguards monitoring reports on the project duly include Project GRM related activities and as well information on beneficiary feedback and engagement with the stakeholders.
* Any other jobs/responsibilities assigned by the project management.
1. **Qualification and Experience**

The Communication and Outreach Expert should have Post-graduate qualification in journalism or social science with about 8 years of work experience of which at least 4 years should be directly related to the relevant tasks with any renowned national or international organizations. S/he must have excellent proficiency both in written and spoken English and Bangla. Knowledge of the local Chitagongnian dialect will be an asset.

## Monitoring & Evaluation Expert

Duration of contract: 3 Years

Duty Station: Cox’s Bazar

1. **Role and Responsibilities**

The incumbent will work in PIU and will be responsible for the following, besides any other tasks/responsibilities that might be given to him by the project management from time to time;

* Develop the Project Monitoring Strategy/Plan specific to the context of the Component 4
* Monitor and ensure the implementation of the above strategy/plan.
* Develop relevant monitoring tools for the component’s implementation progress.
* To initiate and lead periodic evaluation of the component’s activities
* Prepare regular project monitoring report
* Any other jobs/responsibilities assigned by the project management.
1. **Qualification and Experience**

The Monitoring Expert should have Post-graduate qualification in social science with about 8 years of work experience of which at least 4 years should be directly related to the relevant tasks with any renowned national or international organizations. S/he must have excellent proficiency both in written and spoken English and Bangla. Knowledge of the local Chitagongnian dialect will be an asset.

# Annex - 4: General Labor Influx Screening

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| **Key Screening questions** | **Aspects to Consider** |
| Will the project potentially involve an influx of workers to the project location, and will the influx be considered significant for the local community? | How many foreign and local workers will be needed for the remaining period of the project, with what skill set? Can the project hire workers from the local workforce?What is the size and skill level of the existing local workforce? If the skill level of the local workforce does not match the needs of the project, can they be trained within a reasonable timeframe to meet project requirements? How will the workers be accommodated? Will they commute or reside on site or outside of the camp? If so, what size of camp will be required? |
| Is the project located in a rural or remote area? | What is the size of local population in the project area?What is the size of the FDMN community?Is the project located / being carried out in an area that is not usually frequented by outsiders? What is the frequency and extent of contact between the local community and outsiders? Are there sensitive environmental conditions that need to be considered? |
| Based on the socioeconomic, cultural, religious and demographic qualities of the local community, FDMNs and the incoming workers, is there a possibility that their presence or interaction with the local community could create adverse impacts? | Is it likely that the incoming workers and the local community come from a shared socio-economic, cultural, religious or demographic background?  What is the level of existing resources, and will the incoming workers use or create competition for these resources?What is the expected duration of the incoming workers’ presence in the community? Given the characteristics of the local community, are there any specific adverse impacts that may be anticipated? |
| Consultation with Community People | Has the project authority and contractors conducted any consultation meetings with the community people and FDMNs?Are local people aware about the labors?Has the project authority involved the local community with the project? |