INITIAL POVERTY AND SOCIAL ANALYSIS

Country:	Bangladesh	Project Title:	Urban Primary Health Care Services Delivery Project - Additional Financing
Lending/Financing Modality:	Project Loan	Department/ Division:	South Asia Department/ Human and Social Development Division

I. POVERTY IMPACT AND SOCIAL DIMENSIONS

A. Links to the National Poverty Reduction Strategy and Country Partnership Strategy

The priorities of the Government's *Seventh Five Year Plan FY2016-FY2020*[1] places emphasis on the need of primary health care for urban residents including slum and street dwellers. It specifically highlights the need for the Ministry of Health and Family Welfare and the Ministry of Local Government, Rural Development and Cooperatives to establishing a coordination mechanism that will help smooth the delivery of urban health services. Furthermore, the proposal is fully aligned with the *National Urban Health Strategy* (2014) which outlines ten key actions: (1) universal health coverage for urban population with a pro-poor focus; (2) strengthen preventive and primary health care management system; (3) ensure urban poverty reduction; (4) achieve National Population Policy targets; (5) achieve national nutrition targets; (6) adopt innovative service delivery using modern technology, management policy and practices; (7) improve institutional governance and capacity development; (8) strengthen health service program of the city corporations and municipalities; (9) financing and resource mobilization; and (10) attain sustainability. The proposed project is also aligned with ADB Bangladesh *Country Partnership Strategy 2016-2018* which also identifies urban primary health care as a specific priority. *National Vision 2021* of the Government envisions a country where all citizens enjoy a quality of life assured with basic health care and adequate nutrition. The *Perspective Plan (2010-2021)* stipulates necessary actions to increase coverage of all types of health care and family planning services, to strengthen health administration and to increase the number of skilled professionals in the health, nutrition and population sector. *Health Policy* (2011) emphasizes sustainable reductions in severe malnutrition, high mortality and fertility, promoting healthy lifestyles, and reducing risk factors to human health from environmental, economic, social and behavioral causes with a sharp focus on improving the health of the poor. The plight of the poor in the urban health sector cannot be undermined. The Government recognizes the severity of this issue and emphasizes the human dimension of poverty, i.e., deprivation in health, deprivation in nutrition including water and sanitation, as well as related gender gaps in the *National Urban Health Strategy* (2014).

B. Poverty Targeting

☐General Intervention ☐Individual or Household (TI-H) ☐Geographic (TI-G) ☒Non-Income MDGs (TI-M1, M2, etc.)
The project directly targets MDGs 4, 5 and 6 including poverty, specifically poor than average individuals and households identified using an urban poverty scorecard in Bangladesh. The project is aligned with the *National Urban Health Strategy* (2014), to ensure broad-based and inclusive access to health in urban areas, where the main benefits of the project would largely accrue to women and children in the project areas.

C. Poverty and Social Analysis

1. Key issues and potential beneficiaries.

The project will focus on primary health care (PHC) which mainly benefits the poor and the vulnerable groups in urban areas with no access to PHC services, especially for maternal and child health and control of communicable diseases. Health centers will be established near urban slums, especially near garment factories and special economic zones, and will concentrate on the poor and vulnerable population. Bangladesh has already attained Millennium Development Goal (MDG) 4 in reducing child mortality rate. Bangladesh's under-five mortality rate has dropped to 46 per 1,000 live births in 2014 from 144 per 1,000 live births in 1990, which is a 68% reduction against the target of 66%. The infant mortality rate is 32 per 1,000 live births, and the neonatal mortality rate is 24 per 1,000 live births. Bangladesh has performed well in reducing maternal mortality ratio (MMR) (MDG 5). From 569 deaths per 100,000 live births in 1990, the number has reduced to 176 per 100,000 live births in 2015, close to achieving the MDG 5 target of 143 deaths per 100,000 live births.[2]

2. Impact channels and expected systemic changes.
The impact will be strengthened and sustainable urban primary health system in all city corporations and selected municipalities. The outcome will be improved health status of the urban population under the project. The project will

[1] Government of Bangladesh, Planning Commission, Ministry of Planning. 2015. Seventh Five Year Plan FY2016–FY2020. Dhaka.
[2] World Health Organization. 2015. Trends in Maternal Mortality: 1990 to 2015: Estimates by WHO, UNICEF, UNFPA, the World Bank and the United Nations Population Division. Geneva

increase access to quality primary health care services for the urban poor including women and children. The project will continue to construct primary health care centers and comprehensive reproductive health care centers where such facilities do not exist in the project area.

3. Focus of (and resources allocated in) the PPTA or due diligence.

There is an unmistakable linkage between poverty and health, particularly in the absence of traditional or social support networks coupled with poor, unhygienic living conditions. Often jobless and consequently with no financial stability, the urban poor fail to access any health care. Women, children, the elderly, and the disabled become especially vulnerable. Their access to health services are influenced by the costs of health services, lack of information about service availability and their entitlements, opportunity costs of health care related to distance to facilities and the resulting loss of income, inconvenient service timing, and taboos and social prejudice against modern health care which motivate them to utilize traditional medicine and over-the counter medicines from the corner pharmacies. Since public facilities are inadequate, the proposed project will serve the unmet demand by expanding its service area to include the underserved population. Effective targeting of the poor (slum dwellers) and the very poor (floating population) will be undertaken.

II. GENDER AND DEVELOPMENT

1. What are the key gender issues in the sector/subsector that are likely to be relevant to this project or program?

Maternal mortality ratio (MMR) was estimated to be 176 maternal deaths per 100,000 live births in 2015, less than one-third of the ratio of 569 in 1990. Despite progress made, MMR remains high, reflecting a range of factors including access to health care (only 55% had access to antenatal care from a trained provider, and only 32% of births were assisted by a skilled provider), also issues such as nutrition (almost 50 percent of pregnant women are anemic). Women's health concerns extend to other issues. For instance, the *2014 Bangladesh Demographic and Health Survey* found women of reproductive age who participate less in decision-making in their households: (1) are less likely to use any contraceptive method (modern or traditional); (2) have higher unmet need for family planning; and (3) are less likely to access antenatal, postnatal care and delivery assistance from a medically trained provider.

2. Does the proposed project or program have the potential to make a contribution to the promotion of gender equity and/or empowerment of women by providing women's access to and use of opportunities, services, resources, assets, and participation in decision making?

☒ Yes ☐ No

More than 75% of the health services are likely to be used by women since most project services were covered under the essential service package plus (ESP+) which are for reproductive, maternal, and child health. The project will increase the number of poor women and adolescents benefiting from health services by increasing the number of health facilities, increased outreach, and the quality of health services. The facilities will provide choice of temporary and permanent contraction and reduce unwanted deliveries and their associated morbidity and mortality. The project will explore and support the rights of women and girls in this context and develop mechanisms to secure these rights.

3. Could the proposed project have an adverse impact on women and/or girls or widen gender inequality?

☐ Yes ☒ No

The capacity-building and behavior change and outreach project components will focus on strengthening the abilities of government and partner NGOs to understand the characteristics, needs, and dynamics of the urban poor, and to design effective community services in slums and impoverished areas. The needs of women and girls will be a priority. A gender action plan will be prepared to strengthen gender mainstreaming in project implementation.

4. Indicate the intended gender mainstreaming category:

☒ GEN (gender equity) ☐ EGM (effective gender mainstreaming)

☐ SGE (some gender elements) ☐ NGE (no gender elements)

III. PARTICIPATION AND EMPOWERMENT

1. Who are the main stakeholders of the project, including beneficiaries and negatively affected people? Identify how they will participate in the project design.

Primary stakeholders include selected staff from Ministry of Local Government, Rural Development and Cooperatives, Ministry of Health and Family Welfare, project implementation units, NGOs involved in project implementation, donor consortium, CBOs, representatives and officers of city corporations and municipalities, and representatives of the poor and vulnerable groups. Stakeholders will also include all relevant line ministries and other private health services providers. During PPTA, stakeholder consolations will be held and their views and recommendations will be incorporated when and where possible. The team will organize consultations and workshops with communities, NGOs, and other relevant stakeholders when and as needed.

2. How can the project contribute (in a systemic way) to engaging and empowering stakeholders and beneficiaries, particularly, the poor, vulnerable and excluded groups? What issues in the project design require participation of the poor and excluded?

Stakeholder analysis will be conducted during PPTA. The analysis will identify key stakeholders and plan the project activities. During project implementation, participatory processes will be incorporated into mapping target beneficiaries from urban slum and low-income areas, and into monitoring health services through the ward urban health care coordination committees at the health facilities. Stakeholders and beneficiaries also participate in household poverty scorecards to be updated regularly. Consultation and participation will also be managed through behavior change, communication, and marketing activities involving NGOs, CBOs, and other stakeholders.

3. What are the key, active, and relevant civil society organizations in the project area? What is the level of civil society organization participation in the project design? ☒ (H) Information generation and sharing

☒ (H) Consultation ☐ Collaboration ☐ Partnership

Consultations with NGOs, city/municipal and ward urban health care coordination committees will be conducted to prepare the project design.

4. Are there issues during project design for which participation of the poor and excluded is important? What are they and how shall they be addressed? ☒ Yes ☐ No

PPTA due diligence will be conducted and pro-poor and demand-side approaches will be examined.

IV. SOCIAL SAFEGUARDS

A. Involuntary Resettlement Category ☐ A ☐ B ☒ C ☐ FI

1. Does the project have the potential to involve involuntary land acquisition resulting in physical and economic displacement? ☐ Yes ☒ No

Land acquisition is not expected as most of the land will be either government owned or donated. During PPTA implementation verification of information and due diligence will be duly conducted.

2. What action plan is required to address involuntary resettlement as part of the PPTA or due diligence process?

☐ Resettlement plan ☐ Resettlement framework ☐ Social impact matrix

☐ Environmental and social management system arrangement ☒ None

B. Indigenous Peoples Category ☐ A ☐ B ☒ C ☐ FI

1. Does the proposed project have the potential to directly or indirectly affect the dignity, human rights, livelihood systems, or culture of indigenous peoples? ☐ Yes ☒ No

2. Does it affect the territories or natural and cultural resources indigenous peoples own, use, occupy, or claim, as their ancestral domain? ☐ Yes ☒ No

The city corporations and municipalities covered by the project do not overlap with any areas inhabited by small ethnic communities. In any case, the project is rather inclusive and targets the poor, vulnerable, and other excluded groups. Due diligence will be conducted to prepare project design.

3. Will the project require broad community support of affected indigenous communities? ☐ Yes ☒ No

4. What action plan is required to address risks to indigenous peoples as part of the PPTA or due diligence process?

☐ Indigenous peoples plan ☐ Indigenous peoples planning framework ☐ Social Impact matrix

☐ Environmental and social management system arrangement ☒ None

V. OTHER SOCIAL ISSUES AND RISKS

1. What other social issues and risks should be considered in the project design?

☐ Creating decent jobs and employment ☐ Adhering to core labor standards ☐ Labor retrenchment

L Spread of communicable diseases, including HIV/AIDS ☐ Increase in human trafficking L Affordability

☐ Increase in unplanned migration ☐ Increase in vulnerability to natural disasters ☐ Creating political instability

☐ Creating internal social conflicts ☐ Others, please specify ___________________

The project will support affordable health care for the poor and vulnerable. At least 30% of services will be provided free to them. With possible grant funding, the project will be able to further enhance testing and treatment for communicable diseases including malaria, dengue, TB, HIV/AIDS, etc.

2. How are these additional social issues and risks going to be addressed in the project design? n/a

VI. PPTA OR DUE DILIGENCE RESOURCE REQUIREMENT

1. Do the terms of reference for the PPTA (or other due diligence) contain key information needed to be gathered during PPTA or due diligence process to better analyze (i) poverty and social impact; (ii) gender impact, (iii) participation dimensions; (iv) social safeguards; and (v) other social risks. Are the relevant specialists identified?

☒ Yes ☐ No

2. What resources (e.g., consultants, survey budget, and workshop) are allocated for conducting poverty, social and/or gender analysis, and participation plan during the PPTA or due diligence?

A PPTA of $700,000 from ADB's Technical Assistance Special Funds for preparing the project is proposed. In addition, a capacity development technical assistance grant of around $1 million may be proposed as attached technical assistance to the loan where various interventions including responding to climate change, regional health security, and human resources for health in the region will be explored.