Project Information Document (PID)

Concept Stage | Date Prepared/Updated: 04-Dec-2019 | Report No: PIDC27229

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Bangladesh	P171144		Bangladesh Urban Health, Nutrition and Population Project (P171144)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
SOUTH ASIA	May 04, 2020	Sep 30, 2020	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Economic Relations Division	The Ministry of Local Government, Rural Development and Cooperatives, The Ministry of Health and Family Welfare	

Proposed Development Objective(s)

To (i) improve delivery of primary health, nutrition and population (HNP) and environmental health services for selected urban populations, and (ii) develop and strengthen government capacities and systems for delivery of these services.

PROJECT FINANCING DATA (US$, Millions)

SUMMARY

Total Project Cost	300.00
Total Financing	300.00
of which IBRD/IDA	300.00
Financing Gap	0.00

DETAILS

World Bank Group Financing

International Development Association (IDA)	300.00
IDA Credit	300.00

Environmental and Social Risk Classification	Concept Review Decision
Substantial	Track II-The review did authorize the preparation to continue

B. Introduction and Context

Country Context

1. With a population of 165 million, annual per capita income in Bangladesh is US$1,750 (2018), well above the lower middle-income threshold which Bangladesh crossed in 2014. Annual economic growth has averaged 6.5 percent since 2010 and the proportion of the population under the poverty line (daily consumption of US$1.90 per capita) has declined to 15 percent (2016). As Bangladesh transitions to an upper middle-income economy, its population is rapidly urbanizing. The 2011 census indicated that 23 percent of the population lived in urban areas; with an estimated annual growth rate of 3.3%, this will rise to a majority by around 2030. At the same time, these figures are derived from administrative boundaries that may under-estimate the true extent of urbanization. Using an alternative measure – the agglomeration index – it is estimated that in 2010, the proportion of the population living in urban areas was about 40 percent.[1] Urban local governments are composed of 12 City Corporations (representing about half of the country's urban population) and over 300 Municipalities (*Paurashavas*).[2] Urbanization both accompanies and contributes to economic growth through agglomeration effects. Economic benefits of agglomeration come about through improved access to labor, suppliers, markets and services, easier knowledge exchange, and increased specialization and economies of scale. At the same time, congestion costs counteract the benefits of agglomeration, as increasing size and density of cities raises costs and affects living standards. Congestion costs can be reduced by government investment and services, thereby facilitating the beneficial social and economic impacts of urbanization.[3]

2. While contributing to maximizing the benefits of urbanization, investment in health services for urban populations is necessary to achieve overall development goals. Bangladesh's score of 0.48 on the World Bank's 2018 Human Capital Index means that under current education and health conditions, a child born today will be 48 percent as productive as she could potentially be.[4] Investment in the human capital of urban populations in Bangladesh will be important to improvement in human capital overall in the country. Bangladesh achieved a number of Millennium Development Goals and has committed to reaching the Sustainable Development Goals by 2030. Sustainable Development Goal 3 is to ensure health lives and promote well-being for all at all ages. It encompasses the target of achieving universal health coverage, including financial risk protection. Sustainable Development Goal 11 is to make cities and human settlements safe, inclusive, safe, resilient and sustainable. It includes the target of ensuring access for all of adequate,

[1] Ellis, Peter and Mark Roberts. 2016. Leveraging Urbanization in South Asia: Managing Spatial Transformation for Prosperity and Livability. World Bank.
[2] In addition, there are over 200 other towns and *Upazila* centers that are under the rural administrative structures.
[3] Ellis and Roberts, 2016.
[4] World Bank. 2018. Bangladesh: Human Capital Index Rank 106 out of 157. October.

safe and affordable housing and basic services, and of upgrading slums. Government investment in urban health services will be necessary to achieve these objectives.

Sectoral and Institutional Context

3. Overall, Bangladesh has made significant progress on health, nutrition and population (HNP) outcomes. Between 2011 and 2017-18, the estimated under-five mortality rate declined from 53 to 45 per 1,000 live births, the prevalence of stunting among under-five children improved from 41 to 31 percent, the estimated maternal mortality ratio declined from 248 to 174 per 100,000 births, and the total fertility rate remained steady at 2.3.[5] Consistent with patterns observed worldwide, average HNP outcomes in Bangladesh are generally better for urban populations than rural populations. For example, in 2014, under-five mortality among urban populations was 37 per 1,000, compared to 49 per 1,000 among rural populations, while the prevalence of child stunting in urban areas was 31 percent, compared to 38 percent in rural areas.[6]

4. However, some revealing exceptions have been measured. A 2012 household morbidity survey found higher frequency of fever and measles among urban populations compared to rural populations, possibly reflecting crowding, poor water and sanitation conditions, and weaknesses in immunization services in urban areas. At the same time, non-communicable diseases (high blood pressure, heart disease and diabetes) were more often reported by urban populations, possibly reflecting lifestyle differences. For example, 20 percent of household members were reported to suffer from high blood pressure (hypertension) in urban areas, compared to 10 percent in rural areas.[7]

5. Such averages mask large inequalities within urban areas, as the urban poor suffer significantly worse HNP outcomes. A 2013 survey found that among households living in slums in City Corporations, 50 percent of under-five children were stunted, compared to 33 percent among households living outside of slums. Among households living in slums, the under-five mortality rate was 57 per 1,000 live births, which can be compared to the urban average of 37 measured by the 2014 BDHS.

6. Like HNP outcomes, average service utilization indicators in urban areas are generally better than rural averages. For example, in 2016, 48 percent of mothers in urban areas had four or more antenatal care visits, compared to 26 percent in rural areas. Among urban populations, 35 percent of children ages 6-23 months were fed according to three recommended infant and young child feeding practices, compared to 29 percent among rural populations. At the same time, there are some exceptions to this pattern. In 2016, use of modern contraception was similar in urban and rural areas, at around 55 percent of married women.[8] Also, in that year, coverage of all recommended vaccinations among children age 23 months was higher in rural areas (96 percent) than in urban areas (93 percent), an unusual pattern both in Bangladesh and elsewhere.[9]

[5] 2011 Bangladesh Demographic and Health Survey, unofficial results of 2017-18 Bangladesh Demographic and Health Survey, and World Bank Databank (for modeled estimates of maternal mortality ratios). (The total fertility rate is the average number of births a group of women would have by the time they reach age 50 if they were to give birth at the current age-specific fertility rates).
[6] 2014 Bangladesh Demographic and Health Survey.
[7] 2012 Health and Morbidity Status Survey.
[8] 2016 Utilization of Essential Service Delivery Survey.
[9] 2016 Bangladesh Expanded Programme on Immunization (EPI) Coverage Evaluation Survey.

7. There appears to be some gender disparity within the urban population. For example, in 2015, 80 percent of male children by age 12 months had valid full vaccination coverage compared to 77 percent of female children.[10] At the same time, there are socio-economic inequalities in access to services within the urban female population. For example, in 2013, 29 percent of pregnant women residing in City Corporation slums had four or more antenatal care visits compared to 58 percent of pregnant women residing in non-slum areas. Similarly, 37 percent of pregnant women residing in slums delivered at a health facility compared to 66 percent of pregnant women residing in non-slum areas.[11]

8. On average, in Bangladesh, urban populations use private for-profit health services more often. In 2014, 57 percent of urban mothers received antenatal care from private for-profit providers, compared to 50 percent of rural mothers. In urban areas, 36 percent of births were delivered in private for-profit health facilities, compared to 18 percent in rural areas. Sometimes the difference can be slight, as treatment of childhood fever was sought in the private sector by around 70 percent of cases in both urban and rural areas.[12] While these private providers are often pharmacies, there is significant use of formal health care providers, even by the poor; in 2013, 29 percent of children with acute respiratory infection who lived in slums received care from pharmacies, while 56 percent received care from formal providers.[13]

9. The urban poor have low access to government health services; government health facilities are infrequent in slum areas in particular. A study of six slum areas in Dhaka found that 82 percent of health service delivery points were private for-profit, compared to 12 percent managed by the government and 6 percent managed by non-governmental organizations (NGOs).[14] Nonetheless, household survey data indicate that the urban poor are often more likely than the urban population as a whole to seek care from government and NGO services, likely due to lower cost of care. For example, in 2013, two-thirds of mothers living in slums received antenatal care from government or NGO services, compared half or less of mothers in other urban areas.[15]

10. Greater reliance on private for-profit health care providers by urban populations results in higher out-of-pocket payments by households for health care (although these payments are also very high for rural populations). In 2012, it was estimated that in urban areas, 68 percent of total health spending was out-of-pocket and 17 percent was government health spending (compared to 61 and 26 percent respectively in rural areas). In taka terms, compared to rural populations, urban populations were estimated to spend more out-of-pocket on all categories of providers, particularly retailers (mostly pharmacies) and to a lesser extent hospitals.[16]

11. High household out-of-pocket spending on health services is a reflection of low government spending on health, estimated at around one percent of gross domestic product (around US$7 per capita) annually, one of the lowest proportions globally.[17] Despite this, Bangladesh has achieved impressive results in terms

[10] 2015 Bangladesh EPI Coverage Evaluation Survey.
[11] 2013 Bangladesh Urban Health Survey.
[12] 2014 Bangladesh Demographic and Health Survey.
[13] 2013 Bangladesh Urban Health Survey.
[14] Adams, Alayne M., Rubana Islam and Tanvir Ahmed. 2015. “Who serves the urban poor? A geospatial and descriptive analysis of health services in slum settlements in Dhaka, Bangladesh.” Health Policy and Planning 30: i32–i45.
[15] 2013 Bangladesh Urban Health Survey.
[16] 2012 Bangladesh National Health Accounts.
[17] World Bank. 2019. Policy Note: Mobilizing Resources for Sustainable Health Financing. August.

of HNP outcomes, particularly in comparison to other countries in the region. Various factors are thought to explain this paradox, including female education and workforce participation, water and sanitation improvements, the country's "pluralistic" health system and in particular the strength of the NGO sector, and good coverage of highly-effective interventions such as oral rehydration therapy and immunization.[18] The focus of government health policy and financing is the government-run HNP service delivery system, which encompasses a tiered network of services from tertiary hospitals, through District Hospitals and Upazila (sub-district) Health Centers, to Union-level facilities and village-level Community Clinics. However, like in other countries in the region, this network of government HNP services has not developed in urban areas, where the government's focus is mostly on tertiary hospitals, largely leaving out-patient services to the private sector.

12. One of the factors contributing to a gap in government primary health care services in urban areas of Bangladesh has been the division of responsibilities between the Ministry of Health and Family Welfare (MoHFW) and the urban local governments. Under the government's Rules of Business (1996), the MoHFW is responsible for health services nationally, without any specified geographical limitation. Under 2009 legislation governing urban local governments, Municipalities and City Corporations are assigned overall responsibility for "health management," with various more specific responsibilities in health promotion, prevention and treatment of infectious diseases, and management of health and centers, hospitals and dispensaries, and registration of private health services.[19] It is notable that these responsibilities are not defined as exclusive to the urban local governments, and indeed, the MoHFW manages urban hospital services, that also provide significant primary and outpatient services, along with a limited number of urban primary-level facilities.

13. With important exceptions, urban local governments have not developed the necessary capacities and systems to finance and deliver HNP services to meet the needs of their populations. Exceptions include: (i) implementation of infectious disease vector (mosquito) control; (ii) delivery of immunization services (in collaboration with the MoHFW); (iii) operation of a network of over 40 health facilities established in the 1990s by the Chattogram City Corporation; and (iv) implementation in a number of City Corporations and Municipalities of an externally-financed series of projects supporting HNP services provided by NGOs, managed by the Local Government Division of the Ministry of Local Government, Rural Development and Cooperatives (MoLGRDC).[20] (Under the government's 1996 Rules of Business, the MoLGRDC has responsibility for providing support to local governments in fulfilling their functions). Other NGO-managed HNP services in urban areas are supported directly by Development Partners.

14. In addition, under the 2009 legislation, the responsibilities of urban local governments include other areas with significant impact on public health for which they have put in place systems and capacity, in particular water supply, sanitation, waste management, and food safety regulation.

15. Since 1998, with coordinated support from Development Partners, the MoHFW's national programs and service delivery have been structured as a Sector-Wide Approach (SWAp), encompassing a series of multi-year strategies, programs and budgets. The current fourth sector program, for the period 2017-22, has

[18] Ahmed, Syed Masud, Timothy G. Evans, Hilary Standing, and Simeen Mahmud. 2013. "Harnessing Pluralism for Better Health in Bangladesh." The Lancet 382: 1746–1755.
[19] Local Government (City Corporation) Act (2009) and Local Government (Municipality) Act (2009).
[20] Asian Development Bank. 2018. Project Agreement for the Urban Primary Health Care Services Delivery Project - Additional Financing.

a total projected budget of almost US$15 billion, and is supported by the US$700 million Health Sector Development Project (P160846), financed by the World Bank, the Global Financing Facility and five other Development Partners.[21] The national SWAp provides an example that can be applied to the urban context for collaboration by a variety of stakeholders.

Relationship to CPF

16. The primary focus of the World Bank's Country Partnership Framework (CPF) for Bangladesh (Report No. 103723-BD, dated March 8, 2016) is to address constraints to growth and competitiveness.[22] Social inclusion is one of three focus areas of the CPF, since human development provides a foundation for economic growth while protection of the poor is necessary for inclusive growth. The CPF aims to consolidate HNP gains while continuing to improve equity and address emerging challenges. The CPF also emphasizes support to policy dialogue and reform, including support to strengthening governance and fiduciary systems. Results-based financing is specified as a mechanism to support such next-generation work on policy and system reform, particularly in the social sectors.[23]

17. The CPF sets out selectivity criteria for World Bank support: (i) consistency with the government's Seventh Five Year Plan, (ii) support to priorities identified by the World Bank's Systematic Country Diagnostic, and (iii) alignment with the World Bank's comparative advantage. First, the Government of Bangladesh's Seventh Five Year Plan (2016-2020), asserts, "The healthy population is an engine for economic growth." It identifies the need to ensure primary health care services for the urban population, particularly slum and street dwellers. In this regard, the Seventh Five Year Plan emphasizes the need to strengthen referral systems and expand coverage of HNP services in urban areas by the MoHFW and the MoLGRDC.[24] Second, human development figures among the "foundational" priorities, and urbanization is one of the "transformational" priorities identified by the World Bank's Systematic Country Diagnostic. Third, the World Bank's value-added in the HNP sector is discussed in the Economic Analysis section below. Finally, the proposed financing operation would support the World Bank HNP Global Practice's objective of contributing to achieving universal health coverage.

C. Proposed Development Objective(s)

18. The proposed project development objective is to: (i) improve delivery of primary health, nutrition and population (HNP) and environmental health services for selected urban populations, and (ii) develop and strengthen government capacities and systems for delivery of these services.

Key Results

19. The following possible PDO indicators will be further developed during project preparation. (Table 1)

[21] Netherlands, Sweden, Canada, United Kingdom, and Gavi, The Vaccine Alliance.
[22] The CPF was originally for the World Bank's fiscal years 2016-20 but has been extended to 2021.
[23] World Bank. 2016. International Development Association, International Finance Corporation, Multilateral Investment Guarantee Agency Country Partnership Framework for Bangladesh for the Period FY16-FY20. Report No. 103723-BD.
[24] Government of Bangladesh. 2015. Seventh Five Year Plan FY2016-FY2020: Accelerating Growth, Empowering Citizens. Dhaka: General Economics Division, Planning Commission.

Table 1. Possible PDO indicators

(i) Improve delivery of primary HNP and environmental health services	*(ii) Develop and strengthen government capacities and systems for delivery of these services*
1. Full immunization coverage among targeted urban populations (ages 0-12 months, disaggregated by gender) 2. Among targeted urban populations, number of children receiving nutrition services (ages 0-5 years, disaggregated by gender) 3. Among targeted urban populations, number of diabetes patients whose care is managed according to protocols (disaggregated by gender) 4. Among targeted urban populations, number of beneficiaries receiving behavior change communication interventions to improve hygiene	5. In targeted urban areas, number of health facilities supported by the project that are delivering a defined package of services 6. In targeted urban areas, number of NGO and private sector health care providers offering services purchased with financing from the project 7. In targeted urban areas, number of health facilities for which medical waste is managed according to standards

D. Concept Description

20. To achieve its objectives, the project will reflect the following strategic orientations:

a. *Develop platforms and institutions*. As reflected by its two-pronged objective, the overall project strategy would be to support improvements in primary-level HNP and environmental health services in selected urban areas in a way that establishes the basis for potential increased and sustained government support to these services in urban centers across the country in the medium term. In other words, the project would support strategies and implementation mechanisms that would be most likely to continue to be funded, managed and expanded by the government, with the ambition of helping catalyze the necessary large and sustained government support needed to sustainably improve urban HNP and environmental health services.

b. *Build on existing systems and capacities in a pragmatic and flexible way*. In achieving this within a reasonable timeframe, the project must be pragmatic and flexible, working with the existing legislative framework, systems and capacities. This would entail providing support to existing government HNP and environmental health services in selected urban areas, whether currently managed by the MoHFW or urban local governments, developing partnership arrangements for close collaboration between the MoHFW, the MoLGRDC and urban local governments to improve existing HNP services, and supporting expansion of services through this collaboration. The project would be flexible in supporting different approaches in different contexts.

c. *Support new strategies to address service delivery constraints*. In improving and expanding urban HNP services, the project would also test the scalability and sustainability of new and innovative strategies to address constraints that affect existing government health services. The project should not contribute to simple replication of existing constraints to government HNP service delivery. The project would work to improve service availability, quality and accountability, by testing strategies in the areas of service management, quality, public-private partnerships, health financing, and citizen engagement. Again, in line with the strategic orientation above, such strategies are those that clearly hold the possibility of being taken to scale by government in the medium term.

21. As mentioned, the project will target selected areas of the City Corporations of Dhaka South, Dhaka North and Chattogram, each of which present differing contexts (notably the relative HNP service delivery capacities of the MoHFW and City Corporations), requiring flexibility in strategies and implementation mechanisms. Within each City Corporation, areas targeted for project support will be determined by a mix of factors, including poverty levels, access to existing HNP services, presence of potential platforms for service improvements, and coordinated targeting with existing and planned World Bank-financed projects for urban development (Dhaka City Neighborhood Upgrading Project, P165477) and sanitation (Dhaka Sanitation Improvement Project, P161432).

22. The project will encompass two components as follows.

Component 1. Improve urban primary HNP services

23. Component 1 will support improved delivery of primary HNP services in targeted urban areas through investments in existing platforms, expansion of services, and innovation. The project will support improved delivery of the MoHFW's Essential Services Package, including not only the maternal and child health and infectious disease services that are currently provided by MoHFW services nationally, but also expanded services for diagnosis, referral and management of non-communicable diseases.[25] Nutrition counselling and growth monitoring services delivered through the health system will be developed, along with community outreach and behavior change communication. The project will contribute to reducing inequalities in service delivery, particularly disparities relating to gender, by improving coverage of poor populations, sensitizing health care providers, and raising awareness of the beneficiaries through behavior change communication.

24. The project will invest in existing government platforms for delivery of primary HNP services. These include hospital out-patient services which are often over-crowded and, depending on the situation, require investments, reorganization, expansion and decongestion. There are also a range of existing government primary health care facilities that similarly require investments and service delivery improvements in order to expand coverage and quality of services. In Dhaka, most potential platforms are managed by the MoHFW, although there are some hospitals managed by the Dhaka South City Corporation while EPI Centers are jointly managed by the MoHFW and the two City Corporations. In Chattogram, both the MoHFW and the Chattogram City Corporation manage a number of hospitals and primary health care facilities that are potential platforms for service delivery improvements supported by the project.

Component 2. Improve urban environmental health services

25. This component will support behavior change communication to promote hygiene (targeted to areas will include those supported by the World Bank-financed Dhaka Sanitation Improvement Project, P161432). Consultations with households and stakeholders highlighted inadequate water supply, sanitation and hygiene practices in poor and slum areas, and consequent high prevalence of diarrheal diseases. Behavior change communication strategies on hygiene will be coordinated with those on nutrition that will target communities and households with support from the project.

[25] The Essential Services Package is currently structured by the types of MoHFW facilities (from Community Clinics through District Hospitals) that operate in rural areas. It will need to be modified for the facilities and capacities available in urban areas.

26. The project will also support development and implementation of a comprehensive strategy for management of infectious disease outbreaks in urban areas, notably requiring mechanisms for close collaboration between the City Corporations, the MoHFW and the MoLGRDC. Possible areas of interventions will be vector (mosquito) management to deal with disease outbreaks, disease surveillance systems, outbreak response capacities, and diagnosis and treatment services. Some of these functions would be implemented by urban local governments (for example, vector management), some by MoHFW (for example, outbreak response), and some by both, depending on the context (for example, diagnosis and treatment services, disease surveillance).

27. The project will also support improvement in medical waste management (requiring close collaboration between MoHFW and the City Corporations). A public-private partnership strategy will be pursued for contracting-out medical waste management to the private/NGO sector.

Legal Operational Policies	Triggered?
Projects on International Waterways OP 7.50	No
Projects in Disputed Areas OP 7.60	No

Summary of Screening of Environmental and Social Risks and Impacts

Environmental Risk Rating **Substantial**

28. The project will mainly provide HNP services environmental health services, in selected areas of the City Corporations of Dhaka South, Dhaka North and Chattogram. The proposed project is not envisaged to involve any major civil works, such as new construction or significant rehabilitation of existing buildings in the three targeted cities. It will, however, involve minor repairs and will be done by government agencies in accordance with national and local laws and procedures. The key environmental impact is the generation of medical, solid and liquid wastes from health services and, minor construction related impact from infrastructure rehabilitation. The healthcare workers, patients, waste handlers, waste-pickers and general population may be exposed to health risks from medical, solid and liquid waste. An Environmental and Social Management (ESMF) will be prepared and will include an overall assessment, which will describe the current (baseline) status of the provision of HNP services and medical waste management, anticipated impacts of the proposed project and mitigation measures. The ESMF will identify the needs for enhanced capacity building (training and awareness raising) for the healthcare workers based at health facilities in the areas to be covered by the project, and development and implementation of waste management plans and systems in all tiers of health facilities at the three targeted cities. The project will require the development and implementation of a Medical Waste Management Plan (MWMP) and a Solid and Liquid Waste Management Plan (SLWMP), and guidelines for preparing these documents will be included in the proposed ESMF. The specific timeframe and details of the plans to be required for the project as well as training, awareness raising, and capacity development of health care workers and waste handlers will be included in the Environmental and Social Commitment Plan (ESCP).

29. Based on available information, the status of medical waste management and practices in the country is not adequate. The project will support improvement in medical waste management, which will need close

collaboration between the MoHFW and the relevant City Corporations. Given that the proposed project activities will potentially increase generation of medical, solid and liquid wastes in health facilities and the existing waste management practices being inadequate, the environmental risk is rated Substantial. However, this risk classification will be reviewed on a regular basis and changed (if necessary). Any change to the classification will be disclosed on the World Bank's website.

Social Risk Rating **Moderate**

30. The project will bring social benefit by providing better HNP and environmental health services to urban poor in selected urban areas. Social impacts caused by the project may include management of labor and potential risk related to gender-based violence (GBV). The expected impacts are predictable, site specific, have minimal adverse impacts, mitigable and the capacity will be strengthened to address the issues within the implementing agencies. The expected social impacts can be mitigated through implementation of appropriate environmental code of practice and environmental management plan, social management plans and Labor Management Procedure. Given the project description at this stage, and based on the experience of the ongoing health project, and the nature of social impacts of the project, the social risk for the proposed project is rated as Moderate.

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APPROVAL

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