Health, Nutrition And Population Sector Development Program

Ministry of Health and Family Welfare

Environment and Social System Assessment (ESSA)

May 2024

Acronyms and Abbreviations

BMWM	Biomedical Waste Management
BOD	Biological Oxygen Demand
BUHNP	Bangladesh Urban Health, Nutrition and Population
COD	Chemical Oxygen Demand
CC	City Corporation
CCC	Chattogram City Corporation
DCC	Dhaka City Corporation
DNCC	Dhaka North City Corporation
DSCC	Dhaka South City Corporation
DoE	Department of Environment
EA	Environmental Assessment
ECA	Ecological Critical Area
ECA	Environmental Conservation Act
ECC	Environmental Clearance Certificate
ECR	Environment Conservation Rules
EHS	Environmental, Health and Safety
EIA	Environmental Impact Assessment
EMIS	Environmental Management Information System
EMP	Environmental Management Plan
EMU	Environmental Management Unit
ERP	Emergency Response Plan
ES	Environmental Screening
ESA	Environmental and Social Assessment
ESCP	Environmental and Social Commitment Plan
ESDU	Environmental Social Development Unit
ESF	Environmental and Social Framework
ESIA	Environmental and Social Impact Assessment
ESMF	Environmental and Social Management Framework
ESMP	Environmental and Social Management Plan
ESMU	Environment and Social Management Unit
ESR	Environmental Screening Report
ESS	Environmental and Social Standards
E-waste	Electronic waste
GAP	Gender Action Plan
GBV	Gender Based Violence
GDR	General Department of Resettlement
GRC	Grievance Redress Committee
GRM	Grievance Redress Mechanism
HIES	Household Income and Expenditure Survey
IEE	Initial Environmental Examination
ILO	International Labor Organization
IoL	Inventory of Loss

IP	Indigenous Peoples
IVC	Inventory Verification Committee
JVC	Joint Verification Committee
LAO	Land Acquisition Officer
LAP	Land Acquisition Plan
LMI	Learning Management Infrastructure
HORMP	Human and Occupational Resources Management Plan
M&E	Monitoring and Evaluation
MIS	Management Information System
MoEFCC	Ministry of Environment, Forest and Climate Change
MoF	Ministry of Finance
MoFL	Ministry of Fisheries and Livestock
MoHFW	Ministry of Health and Family Welfare
MoLGRDC	Ministry of Local Government, Rural Development and Cooperatives
MWW	Medical Waste Management
NGOs	Non-Government Organizations
OHS	Occupational Health and Safety
OHSM	Occupational Health and Safety Management
OHSP	Occupational Health & Safety Plan
PA	Protected Area
PAH	Project Affected Households
PAP's	Project Affected Persons
PAU	Project Affected Unit
PMO	Project Management Office
PCU	Project Coordinating Unit
PPE	Personnel Protective Equipment
SEP	Stakeholders Engagement Plan
SEC	Small Ethnic Community
WB	World Bank

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Executive Summary

The proposed Program Development Objective (PDO) is "to improve access and utilization of quality health and nutrition services and building climate resilience in select geographical areas." The proposed Program will build on existing and global experiences and lessons learned to deepen engagement in the health sector. Furthermore, the approach will renew focus on the existing and emerging health conditions by reorienting and reorganizing healthcare provision at the primary levels.

The ESSA provides a comprehensive review of relevant government systems and procedures that address environmental and social issues associated with the Program. The ESSA describes the extent to which the applicable government environmental and social policies, legislations, program procedures and institutional systems are consistent with the six 'core principles' of the World Bank's Policy for PforR Financing and recommends actions to address the gaps and to enhance performance during Program implementation.

The Ministry of Health and family Welfare (MoHFW) will implement the 5th HPNSP (2024-2029) with the aim of accelerating progress towards achieving Universal Health Coverage and health related SDGs by 2030. The overall objective is to "expand quality Health, Nutrition and Population (HNP) services and strengthen required systems along with governance for improved efficiency and equity". The government's 5th HPNSP will cover all the eight geographical divisions of Bangladesh. The Bank's PforR will cover the Chattogram and the Sylhet Divisions only.

The two divisions of the MoHFW -Health Services Division (HSD) and Medical Education and Family Welfare Division (ME&FWD) - encompass current entities, including the DGHS, DGFP, Directorate General of Health Economics Unit, Directorate General of Nursing and Midwifery and Directorate General of Medical Education.

As per Bank guidance PforRs will not support any activity that are likely to have significant adverse impacts that are sensitive, diverse, or unprecedented on the environment and/or affected people and therefore are not eligible for financing and are excluded from the Program.

The PforR Program is not likely to impact any Biodiversity, natural habitat or cultural heritage. There will also be no major civil construction, land acquisition or displacement. The main environmental concern is likely to be slight increase in generation of medical waste and lack of conditions, arrangement and practice to dispose them properly. Medical Waste Management (MWM) has been previously identified as a significant challenge in the health sector in Bangladesh as highlighted in several reports and assessments. Medical wastes cause numerous health risks directly or indirectly. However, the PforR provides an opportunity to enhance systems to ensure provision of safe, clean and hygienic health services while also providing an opportunity to improve measures for medical waste recycling, management and minimization.

The Program covers areas of Chattogram Division where a number of small ethnic community members reside. Given their cultural, language, socioeconomic difference from the mainstream society and inaccessibility of their housing/ accommodation they may be excluded from consultation

and service delivery. Further, vulnerable and disadvantaged people, including women, person with disability, children, people living in poverty may also face exclusion from consultation and project benefits. Throughout the Program, there will be interaction between medical health professionals, service providers and beneficiaries (mostly women, newborn and children) in areas which may be difficult to be monitored. This may potentially give rise to SEA/SH concern. Without adequate supervision, guideline and code of conducts—SEA/SH issues may occur and also may not be reported. This is likely to impact the vulnerable people in the communities.

The medical waste generated through the activities is likely to pose risks to the adjacent community members and health professionals. Poor infection control and occupational health and safety practices due to lack of usage of Personal Protective Equipment (PPE) and lack of training, awareness and understanding of health risks of such poor practices can contribute to increased risk of infection in healthcare facilities.

However, the PforR will support the GOB in improving maternal and child HNP services in Sylhet and Chattogram (areas lagging behind in terms of overall health indicators), as well as strengthen the entire health systems. This will impact the health and wellbeing of the people in the lagging areas ultimately the outcome would be a healthy generation impacting positive socioeconomic health. The Program will also support NCD engagement that will include people with hypertension and diabetes. This will ultimately result in service uptake and lower the cost of health expenses in the long run.

The MoHFW has a long experience in implementing Programs and Projects. The current fourth Health Sector Program is successfully being implemented by the MoHFW. Further a number of IPF Projects also have been undertaken by the MoHFW under the Bank financing. Throughout the Programs and Projects, the capacity of MoHFW have been enhanced to address and manage ES risks and impacts. Adequate legal provisions are there to safeguard against adverse impacts of pollution activities (Environment conservation Act 1995, ECR 1997) and for the management of medical waste (MW Rules 2008). The Department of Environment is mandated to take necessary actions for violations of the provisions of the abovementioned acts and rules. Additionally, there are Health care Waste Management (HCWM) guidelines issued by DGHS that basically addresses operational procedures for handling and disposal of various types of medical wastes. However, the track record of enforcement of such legal instruments is not hopeful. There is lack of coordination among various ministries and agencies in collecting and disposing medical waste. There are inadequate facility for onsite storage of medical waste at the HCF at all level and in most of the cases, there are no central disposal area where these waste can be disposed. There is urgent need to setting a proper collection and disposal system for HCW at the District, upazila and union level. Under this backdrop, the existing medical waste management rule was felt necessary to be changed. Attempt on this was undertaken but yet to materialize.

Findings indicate that the legal and policy framework as well as the political commitments to gender and social inclusion have laid down the foundation addressing gender and social exclusion issues in the health sector and integrating Gender, Equity, Voice and Accountability (GEVA) and social inclusion into systems and services. An initial institutional structure for GEVA and social inclusion mainstreaming has also been established at the Ministry level. However, weak institutional capacity, including insufficient allocation of financial and human resources to reach vulnerable groups; incipient stages of

GEVA and social inclusion mainstreaming; shortage of skilled workers, drug stocks, ancillary health facilities, referral services, and other services required by vulnerable groups; centralized programming which undermines localized management of resources according to the local priorities and needs; high opportunity cost (e.g., wage loss) while seeking care and high out of pocket expenditure; harmful cultural practices and stigma associated with particular services (e.g., family planning); inability of women to make independent decisions on matters related to their own health, especially sexual and reproductive health; inappropriate attitude and behavior of health service providers; inconveniently located or distant health facilities, are some of the factors that impede effective health service delivery to vulnerable groups despite the fairly strong institutional and policy framework for mainstreaming GEVA and social inclusion. To address SEA/SH cases, Bangladesh has a number of laws including National Action Plan to prevent violence against women and children 2013-2025, Women and Children Repression Prevention Act, 2000, (2003) and (Amndmnt) Bill, 2020. The District and Upazilla Level health facilities also have One Stop Crisis Centers and cells to provide psychosocial, medical and referral services.

The health sector support program to be implemented by the MoHFW need various ranges and types of stakeholders to make the health service delivery a success. Some of the stakeholders would provide direct support, some would be involved in an indirect capacity, and some would be on the recipient end. Range of stakeholders for the Program includes UN agencies, international vendors, national level health professionals and health workers, various local and central government agencies, media, local leaders and finally the beneficiaries. Consulting with them yielded a number of inputs including need for inclusive health care, management of medical waste at the facilities, access to GRM etc.

The MoHFW maintains an online Grievance Redress Service (GRS) that is being adopted to all Programs and Projects undertaken by MoHFW. It addresses grievances, right to information, complaints, complements and recommendations. The online GRS has provisions of filing complaints through web-based system, telephone number and SMS. Further each health care facilities have complaints box for up taking complaints. The GRS is publicly available, and one can see how the complaints are being solved including timeframe.

The Program ESSA analysis presented in this assessment report identified the potential ES risks, opportunities and analyzed the compatibility of the program with respect to the Core principles. Following recommended actions have been made for improving the social and environmental management systems, where appropriate.

Table E 1: Measures to Strengthen Environment and Social Management

Objective	Measures	Responsibility and Timeframe	Indicator
Environmental Systems Management:			
Healthcare waste management practice and implementation strengthening	MoHFW would establish onsite health care waste treatment/disposal facilities at the District, Upazila and union level HCF for proposer disposal of heath care waste and appoint adequate technical staff for operation and maintenance of the onsite disposal facilities.	MoHFW 18 months from effectiveness	Onsite health care waste treatment/disposal facilities established and human resources assigned
	MOHFW will supply adequate PPE for the workers dealing with medical waste and ensure adequate budget for supply of PPE and training for the workers.	MohFW 06 months from effectiveness	Budget provision and PPE supply ensured
	MOHFW would complete the revision of the Medical Waste Management Rules 2008 for better health care waste management in the country.	MoHFW 18 months from effectiveness	Medical Waste Management Rules 2008 revised
	Develop and implement an operational manual and SOP to manage MWM at Upazilla and Union Health facilities;	MoHFW 12 months from effectiveness	Operational manual developed
	Ensure proper record-keeping, assigning a focal person for supervision of MWM activities, and constructing burial pits for sharps and infectious wastes.	MoHFW 06 months from effectiveness	Focal person assigned and record keeping system established
	Monitoring and bi-annual reporting on the implementation of MWM, particularly focused on the Upazila and Union Health Complex	MoHFW 06 months from effectiveness	Reporting system developed and reports generated
Budget Provision	Allocate sufficient budget at Upazilla and Union health facilities to manage health care wastes for capacity development, operation and maintenance and manpower assignment.	MoHFW 06 months from effectiveness	Budget provision allocated
Social Systems Management:			
Inclusion of the disadvantaged, vulnerable, gender and the small ethnic communities	Ensure continuous stakeholder identification and consultation to ensure essential services reach those hard-to-reach areas, to disadvantaged and the vulnerable people, ethnic communities being cognizant of gender norms and those associated with small ethnic communities.	DGFP and DGHS Continuous	Number of consultation meeting and number of people reached
	Carryout information, education and communication campaign to raise awareness about health issues and the service availability to ensure marginalized people are willing to and have access at health service	DGFP and DGHS Continuous	Number of consultation meeting and number of people reached
SEA/SH risk mitigation	Develop awareness raising media material (poster, leaflet) and distribute/ display in all tiers of health facilities;	DGFP and DGHS 06 months from effectiveness	Media material developed
	Dedicate/ connect to national SEA/SH Helpline, provide a telephone number, SMS and email to raise issues with SEA/SH	DGFP and DGHS 06 months from effectiveness	Helpline established

	Train dedicated manpower in health facilities to deal with SEA/SH case Develop Code of Conduct for all health facility workers	DGFP and DGHS 06 months from effectiveness	Manpower selected and trained, code of conduct developed
Strengthening GRM	DLI # 10, which focuses on strengthening the Grievance Redressal Mechanism of the MOHFW, to be made be accessible to all beneficiaries. Raise awareness among the communities about the existence of such system at community level.	DGFP and DGHS 06 months from effectiveness	GRM established and promulgated
	GRM manual to be developed and promulgated to all health sector staffs assigned to receive and manage grievances.	DGFP and DGHS 06 months from effectiveness	GRM manual developed

Chapter 1: Background

1.1 Introduction and Context

Bangladesh has made rapid social and economic progress in recent decades, reaching lower middle-income status in 2015. Stable macroeconomic conditions drove 6.4 percent average annual real Gross Domestic Product (GDP) growth between 2010 and 2023. Over the same period, poverty and extreme poverty declined by 19.6 and 6.8 percentage points to 30 percent and 5 percent, respectively.[1] Women's life expectancy in Bangladesh increased from 59.5 years in 1990 to 74.6 years in 2017 and from 57.3 to 71.8 for males over the same period. Though Bangladesh has been one of the world's top performers on the Millennium Development Goals, the rate of progress of some of the Sustainable Development Goals (SDG) targets has stagnated. While Bangladesh is "on track or maintaining SDG achievement" in seven out of fourteen indicators for SDG-3, six have stagnated or not increased at the required rate.

The secondary and tertiary level health facilities generally provide most health services despite representing only 20 percent of the health infrastructure. While these facilities provide basic primary healthcare and specialized care, the high volume of patients results in overcrowding and exhaustion of the system, leading to high out-of-pocket expenses and impeding access to specialized care for those in need. At the upazila levels and below, the facilities are typically fraught with HR vacancies and inadequate supply of medications, among other issues. This merits a reorientation and refocus of service delivery through the primary health facilities with requisite financing.

1.2 Health Sector in Bangladesh

Over the last few decades, Bangladesh achieved significant progress in key health and nutrition outcomes which has been termed as "good health at low cost". However, progress has been uneven and COVID-19, accelerating climate change, the Rohingya conflict, and other crises have reversed gains and put significant strains on the health system. Despite economic gains and progress, malnutrition remains a critical issue that threatens health outcomes and human capital. Nearly one in five women are undernourished, one in three women aged 15-49 have anemia, and one in six babies are born with a low birth weight in Bangladesh. Poor quality maternal health services, including lack of midwives at birth, over-use of cesarean section, and no functional referral system for timely referral to definitive care for complications, is prevalent. The national average for institutional deliveries is 65% and substantially lower amongst the poorest quintile (42%). Also, non-communicable diseases are now responsible for two thirds of mortality (68%) and disease burden (64%). The prevalence of diabetes and hypertension among adults (18+ years) is high and rising, currently at 14% and 29% respectively.

The proposed Program Development Objective (PDO) is "to improve access and utilization of quality health and nutrition services and building climate resilience in select geographical areas." The proposed Program will build on existing and global experiences and lessons learned to deepen

[1] Based on the international poverty line of US$3.65 and US$2.15 per day (using 2017 purchasing power parity) for poverty and extreme poverty, respectively.

engagement in the health sector. Furthermore, the approach will renew focus on the existing and emerging health conditions by reorienting and reorganizing healthcare provision at the primary levels.

1.3 The Scope of ESSA

The ESSA provides a comprehensive review of relevant government systems and procedures that address environmental and social issues associated with the Program. The ESSA describes the extent to which the applicable government environmental and social policies, legislations, program procedures and institutional systems are consistent with the six 'core principles' of the World Bank's Policy for PforR Financing and recommends actions to address the gaps and to enhance performance during Program implementation.

- Core Principle 1: General Principle of Environmental and Social Management. This core principle aims to promote environmental and social sustainability in Program design; avoid, minimize, or mitigate adverse impacts, and promote informed decision-making relating to the Program's environmental and social impacts.

- Core Principle 2: Natural Habitats and Physical Cultural Resources. This core principle aims to avoid, minimize, or mitigate adverse impacts on natural habitats and physical cultural resources resulting from the Program.

- Core Principle 3: Public and Worker Safety. This core principles aims to protect public and worker safety against the potential risks associated with: (i) construction and/or operation of facilities or other operational practices under the Program; (ii) exposure to toxic chemicals, hazardous wastes, and other dangerous materials under the Program; and (iii) reconstruction or rehabilitation of infrastructure located in areas prone to natural hazards.

- Core Principle 4: Land Acquisition. This core principle aims to manage land acquisition and loss of access to natural resources in a way that avoids or minimizes displacement, and assist affected people in improving, or at the minimum restoring, their livelihoods and living standards.

- Core Principle 5: Small Ethnic and Vulnerable Communities (a terminology used by the GOB as it does not use the term "Indigenous Peoples"). This core principle aims to give due consideration to the cultural appropriateness of, and equitable access to, Program benefits, giving special attention to the rights and interests of the small ethnic and vulnerable communities (tribal people) and to the needs or concerns of vulnerable groups.

- Core Principle 6: Social Conflict. This core principle aims to avoid exacerbating social conflict, especially in fragile states, post-conflict areas, or areas subject to territorial disputes.

1.4 Specific Objectives of ESSA

The specific objectives of ESSA are:

- To identify the potential environmental and social impacts/risks applicable to the Program interventions
- To review the policy and legal framework related to management of environmental and social impacts of the Program interventions
- To assess the institutional capacity for environmental and social impact management within the Program system
- To assess the Program system performance with respect to the core principles of the PforR instrument and identify gaps in the Program's performance
- To include assessment of monitoring and evaluation systems for environment and social issues
- To describe actions to fill the gaps that will input into the Program Action Plan (PAP) in order to strengthen the Program's performance with respect to the core principles of the PforR instrument

1.5 Approach to ESSA

The assessment team used various approaches to review the ES systems that are relevant to Fifth Health Sector Program. It includes analysis of information/ data on previous assessments and reports on the status of different aspects of healthcare system and its management of ES issues (e.g. medical waste management, gender disparity, access to health care by vulnerable groups) and national consultations with all key stakeholders related to healthcare system management.

The data gathered from these multiple sources were processed to allow for triangulation. National level consultations are being done with stakeholders for feedback on the implementation of provisions to enhance transparency and accountability and other related environment and social issues. One of the key purposes of the consultations was to provide detailed local information and views on experiences related to healthcare waste management from the key relevant stakeholders.

Chapter 2: Program Description

2.1 Introduction

The GoB and development partners (DPs), including the World Bank, have supported the MoHFW through a sector-wide approach (SWAp) since 1998, adopting a series of multiyear strategies, programs, and budgets. The ongoing Fourth Health, Population, and Nutrition Sector Program (January 2017 to June 2024) has a financing of US$14 billion, with 83 percent financed by the government. The ongoing Health Sector Support Project (P160846) has a financing of $646 million ($500 million IDA, $15 million grant from the Global Finance Facility for Women, Children and Adolescents (GFF), and $131 million grant from a multi-donor trust fund. The World Bank's Urban Health and Nutrition Project (P171144) and the Bangladesh Road Safety Project (P173019) are both supporting the government's 4th health sector program and will continue to support the 5th HNPSP.

The MOHFW is finalizing their 5th HPNSP (2024-2029) with the aim of accelerating progress towards achieving Universal Health Coverage and health related SDGs by 2030. The overall objective is to "expand quality Health, Nutrition and Population (HNP) services and strengthen required systems along with governance for improved efficiency and equity". The government's 5th HPNSP will cover all the eight geographical divisions of Bangladesh. Priority strategies include among others: i) increasing coverage along with access to and utilization of quality PHC services in both rural and urban areas; ii) strengthening the availability and utilization of critical services to reduce newborn, infant, child and maternal mortality; iii) increasing access, availability, and quality of family planning services; iv) increasing the coverage and quality of nutrition services through the life cycle approach; v) expanding and improving NCD services including mental health while ensuring equitable access for the vulnerable; and vi) reducing fiduciary risks and improving accountability and transparency through strengthening the Public Financial Management (PFM).

The government's Fifth HNP Sector Program will build 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 health program comprises 38 operational plans implemented by five directorates with a combined estimated budget of $8 billion over the next five years. Overall performance monitoring will be done through a Result Framework that includes 6 goal and 21 intermediate level indicators.

2.2 Program Development Objectives (PDO)

The proposed Program Development Objective (PDO) is to improve access and utilization of quality health and nutrition services and building climate resilience in select geographical areas. In supporting part of the government's Fifth HNP Sector Program, which is national in scope covering the entire country, the proposed World Bank's PforR will focus on two lagging divisions of Sylhet and Chattogram.

2.3 Result Areas and Disbursement-Linked Indicators

The three components of the government's Fifth HNP Sector Program will lead to results that are reflected by the PDO - improvements in HNP system management as well as service delivery, utilization and equity. The DLIs under each Results Area have been selectively chosen to reflect work towards meeting these three cross-cutting challenges. The three result areas are:

Results Area 1: Enhancing access and utilization of health and nutrition services that is climate-responsive

Result Area 2: Health system strengthening, responsive to the evolving needs of the population

Result Area 3: Building resilient health systems to prepare and respond to climate change

Table 1: List of DLIs and Description

DLI 1	Maternal health care services expanded.
Description and activities	Maternal health care services expanded by increasing institutional deliveries in Upazila Health Complexes (UzHC) and Union Health and Family Welfare Centers (UH&FWC). Sylhet and Chattogram divisions have 4 and 11 districts respectively. Baseline number of institutional deliveries in UzHCs and UH&FWCs in Sylhet and Chattogram divisions in 2023 Calendar Year (CY) are 155,624. The activities would include assignment of appropriate skilled health professionals (nurses, midwives, and physicians) and procurement of logistics and medicines to offer client-friendly and safe maternal and newborn services.
DLI 2	Vaccination coverage and equity enhanced.
Description and activities	Valid full vaccination coverage by the age of 23 months means childhood vaccines have been received following the Expanded Program of Immunization (EPI) recommended age and dose interval for each antigen. Equity will be addressed by ensuring that all districts in these lagging divisions of Sylhet and Chattogram divisions increase their full vaccination coverage for male and female children. At baseline, seven districts in Sylhet and Chattogram divisions have achieved 88% valid full vaccine coverage for all recommended antigens among children age of 23 months. Activities will include birth registration by health assistants; informing and educating parents regarding immunization and outreach sessions; ensuring a consistent supply of vaccines and other logistics, including maintenance of the cold chain; and scaling up outreach immunization sessions in satellite clinics and elsewhere especially for lagging and most climate-vulnerable communities.
DLI 3	Quality family planning services expanded.
Description and activities	Increase the contraceptive prevalence rate for longer-acting methods of injectable, implant, and IUD. The 2023 CY baseline for Sylhet is 636,756 (Injectable: 602,973; Implant: 26,649; IUD: 7,134) and for Chattogram is 1,997,371 (Injectable: 1,870,753; Implant: 83,770; IUD: 42,848) users. The target is to increase the total use of longer-acting methods up to 10% from the baseline in each of Sylhet and Chattogram divisions by 5 years. Activities will include demand generation activities in communities; providing information to women attending postnatal care; identifying the women who might benefit from longer-acting methods; the careful selection of the right longer-acting method through proper

	counseling for shared decision-making; providing the specific methods by the trained service providers; and follow up including managing any complications or side-effects
DLI 4	Maternal nutrition services are expanded at the community level
Description and activities	Maternal nutrition service is the distribution of at least 60 multiple micronutrient supplements (MMS) for newly registered pregnant women aged 15-49 years at least once during any antenatal care (ANC) service at the community clinics (CC) Activities will include changing the national policy to adopt MMS provision for pregnant women; developing a roll-out plan that is informed by climate-driven food insecurity; financing the procurement of MMS; procurement and supply-chain management; orienting community health care providers (CHCPs); and dispensing MMS during ANC.
DLI 5	Strengthened NCD diagnosis and registration services in primary care
Description and activities	Adults diagnosed and registered for hypertension and diabetes type 2 in Upazila Health Complexes, disaggregated by condition (hypertension and type 2 diabetes) Activities will include conducting screening; setting up NCD corners at UzHCs; ensuring the availability of equipment to screen and diagnose NCDs; and registering those that are diagnosed and providing them with health education regarding nutrition and physical activity, other climate-informed advice (e.g., dangers of dehydration during hot days and of using salinized water and how to safely store medications during hot spells and floods), and essential NCD medications as required.
DLI 6	Approve and endorse policy and increase availability of midwives at union level facilities
Description and activities	The DGFP Union Health and Family Welfare Center (UHFWC) currently have no positions for midwives in the organogram. DGFP agreed to request appropriate government authorities to create the posts, recruit, and retain two midwifery posts in the upgraded UHFWCs. All midwives will complete 3 years diploma course and be registered by the Bangladesh Nursing and Midwifery Council. Activities will include expansion of quality maternal and newborn services at the Union level by posting at least two midwives at selected UHFWC
DLI 7	Proportion of primary care facilities managing functional and timely referral for maternal and newborn complications
Description and activities	In rural Bangladesh, public sector primary care facilities involved in institutional delivery (UzHC) need to be linked with facilities providing Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) through a functional referral system based on national guidelines. For this DLI, primary care facilities will include UzHCs that do not provide cesarean section, blood transfusion, or services for small and sick newborns, referring to district/general hospitals. Functional referral is based on national policy guidance. Timely means that patients are managed and transferred as quickly as possible. Activities will include the operationalization of the referral system guidance by developing standard operating procedures, training, and using data and communication exchange between the referring and higher-level facility.
DLI 8	Improved access to essential NCD drugs in primary care
Description and activities	Currently regular supply of NCD drugs at the PHC level is lacking. This DLI is to support the establishment of a continuous supply of NCD drugs at public PHC level facilities like Upazilla Health Complex to overcome the current high OOP expenses for clients. Activities under this DLI will strengthen procurement and supply chain management of essential NCD drugs at the UzHC and CC, including through digitization of the procurement and logistics management systems.
DLI 9	Strengthened Grievance Redress Mechanism (GRM) system

Description	This DLI reflects further development of MoHFW's GRS for both DGHS and DGFP so that it can track each grievance, its corresponding response(s), and time taken for response(s). For DGFP, results will include an assessment of the current system, approval of response guidelines by the DGFP, and annual report on grievances and responses published on the DGFP website. The annual reports will include data on the number of grievances and responses. For DGHS, it will further strengthen the GRS running under the MIS of DGHS. The results will include percentage of valid complaint resolved by DGHS among valid complaints received in the system. Activities will include a Standard Operating Procedure/Operating Manual will be prepared and approved; capacity building of staff will be conducted; the GRM system will be integrated into the MIS of DGFP for reporting of grievances including receiving, responding, and addressing separately for each facility; and the system will be rolled out.
DLI 10	Strengthened resilience of primary care facilities in Sylhet and Chattogram divisions to address climate change driven health risks and emergencies.
Description	This DLI focuses on enhancing the preparedness of Upazila Health Complexes to be prepared for and effectively manage climate-driven health risks and emergencies. The activities to achieve this DLI will include: developing health facility (UzHC) contingency plans based on local vulnerabilities, capacities, and needs for climate-resilient health service delivery; and having a sufficient number (at least 4) of health care workers (doctors and nurses/midwives) at Upazila Health Complexes that have been trained on how to detect and respond to climate-driven health risks (at least dengue, malaria, heat, and salinity (pre-eclampsia/ eclampsia).

In addition, several DLIs reflect work on emerging challenges, specifically in the areas of adolescent health and nutrition services, non-communicable diseases, and urban HNP services, These DLIs focus on assessment, planning and initial implementation; this work will lead to definition of results reflecting further implementation to be supported by possible additional financing.

2.4 Institutional and Implementation Arrangements

The PforR will use Government systems for assessing, managing and monitoring of environmental and social (ES) risks along with the recommended measures included in the Program Action Plan (PAP). The program will rely on existing institutional and implementation arrangements that are in place to manage the sector and to implement the government's 5th HPNSP. The MoHFW is responsible for the implementation of the sector program as a whole, including the achievement of the results to be supported by the proposed World Bank Program. The two divisions of the MoHFW -Health Services Division (HSD) and Medical Education and Family Welfare Division (ME&FWD) - encompass current entities, including the DGHS, DGFP, Directorate General of Health Economics Unit, Directorate General of Nursing and Midwifery and Directorate General of Medical Education. Line Directors are responsible for the development and implementation of the 39 Operational Plans, including budgets that together constitute the Program Implementation Plan (PIP).

The existing sector wide approach arrangements will be maintained to ensure sector-wide coordination and aid effectiveness. These include a local consultative subgroup for health that meets every six months, jointly chaired by the MoHFW leadership and the Chair of the HNP Development Partner Consortium. The HNP Development Partner Consortium is the forum for effective coordination of development partners in the sector, with a Chair and Co-chair elected every two years. Thematic task groups, with membership from the MoHFW and development partners, review implementation progress of the sector program in various technical areas.

The Planning Wing of the HSD and the ME&FWD are responsible for planning, monitoring, and reporting on the progress of the sector program. These entities will serve as the primary points of contact for monitoring and communicating to the World Bank on routine project-related matters. A DLI Monitoring Committee, coordinated by the Planning Wing of the Health Service Division (HSD) and the Medical Education and Family Welfare Department (ME&FWD), including other relevant officials of the two divisions of the MoHFW, pooled funding development partners (if any), and other parts of the government, will be responsible for monitoring progress toward the achievement of the DLIs. It will also support Line Directors in implementation, assist in producing the internal reports on DLI achievement to be submitted for verification, and coordinate with the independent verification agent.

2.5 Program Boundary

The Program will target two (Chattogram and Sylhet) divisions and will: (i) enhance equitable access and utilization for key primary care services (maternal health, newborn and nutrition, child immunization, family planning, and NCDs); (ii) enhance quality of care through systems strengthening; and (iii) improve the climate resilience of the health system. The World Bank's Program boundary is as follows:

Table 2. Government program and PforR

	Government program	Program supported by the PforR	Reasons for non-alignment
Objective	Expand quality HNP services and strengthen required systems along with governance for improved efficiency and equity.	Enhance equitable access and utilization of quality health and nutrition services by strengthening the public health systems and building its resilience in select geographical areas.	Aligned
Duration	2024-2029	2024-2029	Aligned
Geographic coverage	All the country (8 divisions)	Two lagging divisions (Sylhet and Chattogram)	The selected divisions are included within the broader government program to bolster health outcomes within the overarching framework of the government's health sector strategy and will build on the investments made by the previous World Bank's Health Sector Support Project (HSSP; P160846) that targeted the same two divisions.
Overall Financing	$8 billion	$403 million (include GFF $25m grant)	Given the Program finances a sub-set of activities in two of eight divisions, the finance envelope of the Program is lower than the overall government program envelope.

Chapter 3: National Environmental and Social Policy, Legal Framework

This section describes the existing environmental and social management system of the GOB along with an overview of the policy and legal framework. This includes a profile of the key institutions and their role with respect to management of environmental and social aspects of the Program.

3.1 Institutional Framework for Environmental and Social Management

3.1.1 Government Agencies

The main Government institutions with key responsibilities for environmental and social management in the health sector are described below.

Ministry of Health and Family Welfare (MOHFW)

The MOHFW plays a pivotal role in improving the health of the people including mental, physical and social wellbeing, for overall national development with the increased participation of the private sector and non-government institutions in the implementation of programs. The ministry envisions creating conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of people health. It is a vision that recognizes health as a fundamental human right and therefore the need to promote health and reduce suffering in the spirit of social justice.

Under the Ministry, there are four Directorates and a good number of Divisions/bodies with specific charter of duties. Amongst those, Directorate General of Health services (DGHS) and Directorate General of Family Planning (DGFP) are primarily involved with service delivery while National Institute of Population Research and Training (NIPORT) develops capacity of human resources and generates evidence for improving health, population and nutrition programs and policies in Bangladesh.

MOHFW with the help of its subordinate departments and agencies are responsible for collection and source segregation of the medical waste in the public HCFs, onsite treatment of harmful medical waste and disposal of hazardous waste to designated disposal area in consultation with the responsible local government bodies such as City Corporation or Pouroshovas.

DGHS Controls the following operation of the healthcare facilities:

- Licensing authorities for the healthcare facilities
- Inspections and auditing of the healthcare facilities
- Public hospitals management
- Proving the logistic support, training, and
- Managing human resources in Health Service

DGFP is responsible for the following operations:

- Management Information Systems
- Family Planning Field Services Delivery
- Clinical Contraception Services Delivery
- Maternal, Child, Reproductive and Adolescent Health
- Planning, Monitoring and Evaluation of Family Planning
- Information, Education and Communication (IEC)
- Procurement, Storage and Supplies Management- FP

Gender, Equity, Voice and Accountability (GEVA)**.** The GOB has made it a priority to eliminate discrimination against women and girls and promote gender equity. The MOHFW addressed the issue

under the third sector program and reviewed the existing Gender Equity Strategy and revised various gender related issues including human resource planning, development and management at facility level, housing, promotion for women workforce, etc. MOHFW's priority interventions for GEVA includes:

- 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.

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 survivors of gender-based violence. The objectives are:

- **Strategic Objective 1:** Introduce gender-sensitive policies, plans and evidence-based approaches

- **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.

- **Strategic Objective 3.** To ensure gender mainstreaming in all programs with MOHFW and other ministries and organizations through equitable planning and budgeting.

- **Strategic Objective 4.** To ensure gender balanced human resources (service providers) in health sector with appropriate skills to deliver gender sensitive, non-discriminatory services.

- **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.

- **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.

The GNSPU is committed to provide required attention to adolescent friendly and Sexual and Reproductive Health and Rights (SRHR) services and gender-based violence. However, GNSPU lacks required technical expertise and human resource to implement the activities to Gender Equity Strategy. Moreover, due to inadequate manpower, and minimum expertise of the Line Directorates, GNSPU is yet to start the basic works including Gender Reporting, Gender Auditing etc. The Planning Wing at the MOHFW need to incorporate such programs developed under 'Gender Equity Action Plan

(2014-2024) in the PIP and OP and allot required budget to make the GNSPU effective, while MOHFW may be requested to address the HRH issue of GNSPU.

National Institute of Population Research and Training (NIPORT). National Institute of Population Research and Training (NIPORT), working under MOHFW, develops human resource and generates evidence for improving health, population and nutrition programs and policies in Bangladesh. NIPORT is the only training institute under the MOHFW that provides residential training for program personnel. NIPORT has well-equipped training facilities from national level to the Upazila level. In addition to the facilities at NIPORT head office in Dhaka, there are 12 Family Welfare Visitors' Training Institutes (FWVTIs) at the division or the district levels, 20 Regional Training Centers (RTCs) at the Upazila level and 31 Field Training Centers (FTCs) attached to FWVTIs. The FWVTIs and RTCs are geographically located in such a way so that the trainees can easily reach the centers, participate the training courses and stay there comfortably. The research division of NIPORT is housed within the head office.

Ministry of Environment, Forest and Climate Change (MoEFCC)/Department of Environment (DoE)

MoEFCC is the responsible ministry to deal with environmental issues. The Department of Environment (DoE) working under MoEFCC is responsible for the following tasks that have linkage with the ESSA. These are:

- Issuing Environmental Clearance Certificate (ECC) for establishment of any health care facilities in the country.
- Inspections of the waste management facilities at the time of the renewal of the ECCs.
- Implementation of the Medical Waste (Management & Treatment) Rules 2008.

Ministry of Local Government, Rural Development and Cooperatives (MoLGRDC)

MoLGRDC along with City Corporations and Poursavas are responsible for the following:

- Providing out-house waste management services including medical waste management (in house waste management is done by medical facilities).
- Providing public health, waste management (conservancy) and water supply in the urban areas
- City Corporation and Pourasava run Satellite Clinics in the earmarked areas.
- Local Government Division (LGD) is responsible for Urban area PHC.

In Bangladesh, the City Corporations/MoLGRDC are responsible for out-house management of medical waste. At present the out-house management system is operational in Dhaka (North and South) and Chattogram City Corporations. In these cities, there is agreement between city corporation and service providers, e.g. NGOs. These NGOs are responsible for collection, treatment and disposal of waste and are registered with the DoE as per the medical waste (Management and Treatment) rule 2008.They do not pay any fees to the city corporations and do not get any financial support from city corporations. They meet the expenses through the service charges it collects directly from the healthcare facilities with whom it enters into a service contract for transport, treatment and disposal of the medical waste.

Bangladesh Medical Research Council (BMRC)

Bangladesh Medical Research Council (BMRC) was established in 1972 by order of the President as an Autonomous Body under MOHFW. The objectives, rules & regulations of the Council were formulated by resolution of the MOHFW in 1974 & 1976.As per resolution of the Government, BMRC is the focal point for Health Research. The objectives of BMRC are to identify problems and issues relating to medical and health sciences and to determine priority areas in research on the basis of health care needs, goals, policies and objectives. BMRC has a General Body with 54 members representing post-graduate medical institutes, medical colleges, universities, learned societies, medical institutions, health related organizations, various divisions and departments of ministries dealing with medical education, services and research. The General Body elects the Executive Committee. It is headed by the Chairman, Executive Committee, elected from among the members of the General Body. The Mission of the Council is to create effective and quality health care facilities for the whole population of the Country by promoting health research through strengthening of research facilities, training and dissemination of research results. The main activities of the Council include: organization and promotion of scientific research in various fields of Health Science, training of manpower in the field of health research and dissemination of research results for proper utilization.

Bangladesh Medical and Dental Council

The Bangladesh Medical & Dental Council (BM&DC) is a statutory body with the responsibility of establishing and maintaining high standards of medical education and recognition of medical qualifications in Bangladesh. It registers doctors to practice in Bangladesh, in order to protect and promote the health and safety of the public by ensuring proper standards in the practice of medicine.

Bangladesh Nursing and Midwifery Council (BNMC)

BNMC is the Regulatory Body and Focal Point from which all activities relating to nursing are managed. This includes all involved in nursing and midwifery education and practices. Though regulation of Nursing education and practices is the responsibility of the BNMC, the council works closely with the Directorate of Nursing services (DNS) under MoHFW in regulating Nursing and Midwifery Services.

3.1.2 NGOs and Other Stakeholders

In addition to the GOB efforts, there are UN agencies and NGOs that are working in providing HNP services/interventions in different hard to reach areas including the tribal areas. These NGOs and programs are important entry points to enhance compliance with social safeguards best practices. Main agencies and NGOs include UNDP, UNICEF and BRAC. Among these, recently completed Chattogram Hill Tracts Development Facility (CHTDF) of UNDP worked in 15 Upazilas of the CHT in close collaboration with the HDC and the MOHFW. The strategies include a network of female outreach workers or Community Health Service Workers (CHSWs) who are recruited and posted in their own remote para after two months of Residential training. They provide basic health care including diagnosis and treatment of malaria, mobilize communities for immunization, family planning services and refer cases to satellite clinics and other health facilities. There are satellite clinics that provide an important link between community health service provided at the community level and the services delivered through government health facilities at the upazila and district levels.

CHTDF covered Rowangchari, Thanchi, Alikodom, Ruma and Lama Upazilas of Bandarban Hill District, Rajastali, Langudu, Barkal, Billaichari, Juraichari and Baghaichari (for Baghaichari 2 mobile teams) upazilas of Rangamati Hill District and Matiranga, Panchari and Laxmichari and Mahalchariupazilas of Khagrachari Hill District.

3.2 Policy and Legal Framework

Bangladesh has a number of policies, instruments and laws that support environmental and social management and the environmental and social assessment processes. The ESSA reviewed the existing regulations and policies, their legal and practical applicability at the program level as well as the institutional capacity, and the effectiveness of implementation in practice. GOB has enacted various Acts and Regulations relating to clean environment, public health protection, and health care waste management.

3.2.1 Environmental Policy and Legal Framework

The GOB's environmental laws and policies are deemed adequate for both protection and conservation of resources, although enforcement capacity needs to be improved significantly. The assessment highlights that the Program may generate medical waste and GOB has comprehensive laws and policies for management of medical waste.

National Environmental Policy 1992

The concept of environmental protection through national efforts was first recognized and declared in Bangladesh with the adoption of the Environment Policy, 1992 and the Environment Action Plan, 1992. The major objectives of Environmental policy are to i) maintain ecological balance and overall development through protection and improvement of the environment; ii) protect country against natural disaster; iii) identify and regulate activities, which pollute and degrade the environment; iv) ensure environmentally sound development in all sectors; v) ensure sustainable, long term and environmentally sound base of natural resources; and vi) actively remain associate with all international environmental initiatives to the maximum possible extent.

Bangladesh Environmental Conservation Act (ECA), 1995 amended 2002

This umbrella Act includes laws for conservation of the environment, improvement of environmental standards, and control and mitigation of environmental pollution. It is currently the main legislative framework document relating to environmental protection in Bangladesh, which repealed the earlier Environment Pollution Control ordinance of 1977. The first sets of rules to implement the provisions of the Act were promulgated in 1997 (see below: "Environmental Conservation Rules 1997"). The Department of Environment (DoE) implements the Act. A Director General (DG) heads DoE. Under the Act, operators of industries/projects must inform the Director General of any pollution incident. In the event of an accidental pollution, the Director General may take control of an operation and the respective operator is bound to help. The operator is responsible for the costs incurred and possible payments for compensation.

Environment Conservation Rules 1997/2023

The ECR 1997, adopted under ECA, focused on the environmental clearance process for industries or other development activities. The Rules also included the national environmental quality standards for ambient air and water (based on various uses), and standards with the limits on pollution emissions and discharges. In 2023, MoEFCC approved the new ECR (ECR 2023), which strengthened requirements and clarified procedures for industries and project units to assess and manage environmental and social impacts associated with their activities. The new ECR updated the water quality and sewerage standards, as well as waste emissions and liquid waste standards for industries and projects. However, the new Rules do not include noise and odor standards, which were envisaged in the ECR 1997. Standards for ambient air were moved to the Air Pollution Control Rules (APCR), 2022. The new ECR, as in the 1997 version, kept limited provisions on DoE's responsibilities of policy formulation, data collection, environmental quality monitoring and enforcement. The ECR 2023 detailed provisions for project scoping, categorization, site clearance, environmental assessment (including social issues), cross-sector and stakeholder consultations, among others. Additionally, the ECR 2023 regulated access to information and stakeholder participation throughout the environmental clearance process, particularly for those activities that require a full Environmental Impact Assessment (EIA). Any proponent planning to set up or operate a health care facility is required to obtain an "Environmental Clearance Certificate" from the Department of Environment (DoE), under the Environment Conservation Act 1995 amended in 2002. Any HCF having more than 100 beds is a Red Category project under the current rules for which a detailed EIA report is required including detail environmental management plan for health care waste management under the current rules. The wastewater generated from healthcare facilities are subjected to the discharge standards set in ECR 2023.

Environment Court Act, 2000

The aim and objective of the Act is to materialize the Environmental Conservation Act, 1995 through judicial activities. This Act established Environmental Courts (one or more in every division), set the jurisdiction of the courts, and outlined the procedure of activities and power of the courts, right of entry for judicial inspection and for appeal as well as the constitution of Appeal Court.

Guidelines on Infection Prevention and Control (IPC) and Biosafety 2016

WHO Bangladesh has supported the development of updated guidelines on infection prevention and control (IPC) and biosafety for health care providers. The guidelines focus on measures to ensure patient safety as well as the safety of health care and laboratory personnel.

Medical Waste (Management and Treatment) Rules 2008

The Medical Waste (Management and Treatment) Rules 2008 forms the base of management of all medical waste in the country. The rules are applicable only to waste management facility/operators i.e. those involved in transportation, treatment and disposal of medical waste. The law provides for guidance on the collections, storage treatment and disposal of medical waste for management facilities/operators. The institutions or agencies involved in collection, transport, storage, have to obtain authorization from the DoE. Inconsistencies were found in the Rule particularly regarding the roles and responsibilities of various agencies such as city corporation, DoE, ministry of heath who are directly or indirectly involved with the management of healthcare waste and a revision of the rules have been undertaken by the Government.

Manual for Hospital Waste Management 2001

DGHS has developed a manual for hospital waste management in 2001 which was later updated. The manual is aimed for the hospital managers, health providers, policy makers and all the administrators, with an interest for and with responsibility to ensure hospital wastes are disposed of efficiently and economically as far as possible with a minimal environmental and health impact.

Medical Waste Management Issues in the GOB 8th 5-year Plan (FYP)

The rising density of infectious and hazardous medical waste is posing serious threats to environmental health and requires special attention with specific treatment and management prior to its final disposal. The problem is growing with an ever-increasing number of hospitals, clinics, and diagnostic laboratories. Apart from Dhaka and Chattogram, there is no proper and systematic inhouse and out-house medical waste management in the country. Even the existing systems in Dhaka and Chattogram are not comparable with the systems operated in advanced countries. Among the array of activities that will be implemented under 8th FYP, it is mentioned that the GOB will take the following steps to counteract the harmful effects of pollution due to medical wastes:

a. GOB will take measures to improve medical waste management in the country by delivering specific disposal training and with strict enforcement of separate collection & disposal systems.
b. GOB will establish environmentally acceptable treatment centers for infectious wastes in each divisional city.
c. Strict compliance of Medical Waste Rules along with in-house and off-the-house management should be established.

3.2.2 Social Policy and Legal Framework

The GOB's health related laws and policies are quite adequate to ensure social safeguards' compliances following relevant core principles. 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 (Small Ethnic Communities) have been brought to the fore in development discourses, and also reflected in various acts, policies, strategies and programs, including in the health sector.

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

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)

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 (HPNSDP) 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

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

National Health Policy (NHP) 2011

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 and IPs and Social Conflicts).

Bangladesh Population Policy 2012 (BPP)

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

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

Bangladesh Labor Act, 2006

This Act pertains to the occupational rights and safety of factory workers and the provision of a comfortable work environment and reasonable working conditions. In the Chapter VI of this law safety precaution regarding explosive or inflammable dust/ gas, protection of eyes, protection against fire, works with cranes and other lifting machinery, lifting of excessive weights are described. And in Chapter VIII, provision of safety measures like appliances of first aid, maintenance of safety record book, rooms for children, housing facilities, medical care, group insurance etc. are illustrated.

Chapter 4: Potential Environmental and Social Impacts of the Program

4.1 Introduction

This section presents the environmental and social benefits, risks and impacts of the Program. The risks have been identified using the *Environmental and Social Risk Screening Format* included in the World Bank's Policy for PforR Financing that determined the boundary of assessment. The ES Risk of the program has been identified as *Moderate*. It also covers the likely environmental and social effects, the environmental and social context, institutional capacity, and the reputational and political risk.

4.2 Excluded Activities

As per Bank guidance PforRs will not support any activity that are likely to have significant adverse impacts that are sensitive, diverse, or unprecedented on the environment and/or affected people and therefore are not eligible for financing and are excluded from the Program.

More specifically, PforRs will not finance:

Significant conversion or degradation of critical natural habitats or critical cultural heritage sites

Air, water, or soil contamination leading to significant adverse impacts on the health or safety of individuals, communities, or ecosystems

Workplace conditions that expose workers to significant risks to health and personal safety

Land acquisition and/or resettlement of a scale or nature that will have significant adverse impacts on affected people, or the use of forced evictions;8 Large-scale changes in land use or access to land and/or natural resources

Adverse E&S impacts covering large geographical areas, including transboundary impacts, or global impacts such as greenhouse gas (GHG) emissions

Significant cumulative, induced, or indirect impacts

Activities that involve the use of forced or child labor

Marginalization of, discrimination against, or conflict within or among, social (including ethnic and racial) groups

Activities that would (a) have adverse impacts on land and natural resources subject to traditional ownership or under customary use or occupation; (b) cause relocation of small ethnic communities from land and natural resources that are subject to traditional ownership

Screening of the PforR activities revealed that none of the activities planned under the program fall under the above criteria to be excluded from financing.

4.3 Potential Environmental Risk and Impact

The environmental risk is rated as Moderate. The PforR Program is not likely to impact any Biodiversity or natural habitat. Further, given there will be no major civil construction therefore, no significant construction related impact (OHS, Community Health and Safety, Traffic, dust and construction waste generation) is likely to be generated. The main environmental concern is likely to be slight increase in the generation of medical waste and lack of conditions, arrangement and practice to dispose them properly. Nationwide, although medical wastes account for a very small fraction (about 1%) of the total solid wastes generated in Bangladesh (World Bank, 2002), if it is not handled properly and gets mixed with domestic solid waste, the whole waste stream becomes potentially hazardous. A report by International Committee of Red Cross (2011) states that 75% to 90% of the hospital wastes are similar to household refuse and municipal waste and do not entail any particular hazard. The other 10% to 25% is called hazardous medical waste or special waste. Nationwide, the estimated generation of medical waste in Bangladesh without considering the surge due to Covid-19 and other unusual medical emergencies would be approximately 50,000 tons (1.25 kg/bed/day) in 2025, out of which 12,435 tons were predicted to be hazardous waste.

Medical Waste Management (MWM) has been previously identified as a significant challenge in the health sector in Bangladesh as highlighted in several reports and assessments (The Environmental Assessment and Action Plan for HPNSDP in 2011-10, EMP implementation status report of 2014 etc.). The major findings from the assessment are the following:

- The Medical Waste generators by and large do not maintain any proper record of the different streams of MW generated. Inadequate number of color-coded bins, often improperly placed, results in different waste streams getting mixed.
- The segregation of waste is delegated to the ward boys and the sweepers who do not have formal training. The nurses or the ward-in-charge who has received MWM training are not being able to supervise or transfer their knowledge adequately resulting in MWM practices not being implemented.
- There is lack of uniformity in color-coding and segregation procedures among the facilities.
- Needles and syringes were not destroyed before disposal. The needle cutters were not functional (blades becoming blunt after one or two uses) and more often the needle-cutters are usually kept inside the cupboards and are not used. It was also observed that bins used for sharps are not properly designed as per international standards. There is a general reluctance of destroying the sharps and needles.
- The IEC materials were not visible at the appropriate places in the facilities.
- The waste trolleys have become defunct and instead the trolleys used for ferrying patients were used for transporting the waste from the wards.
- The temporary storage of the different streams of Medical Waste is not done properly at the HCFs especially in the Public Hospitals.
- The use of PPE such as gloves, masks, boots, etc. is partial. The employees/waste pickers also do not undergo immunization at regular periods, as is required under the Infection Control guidelines.

Bangladesh Urban Health, Nutrition and Population (BUHNP) Project, which is in the initial stage of implementation has addressed the issue of MWM but the scope of the project is limited to urban areas. Under the previous sector programs, the DGHS took initiatives to address some of these issues related

to MWM in the health sector. In this regard, the DGHS developed an online record-keeping, reporting and monitoring system for in-house waste management, conducted training on MWM at various levels, explored the feasibility of different out-house waste management options in several hospitals in the country. DGHS has also developed new IEC materials promoting awareness campaign on MWM. However, due to weak institutional capacity, inadequate monitoring and lack of awareness and enforcement, the issues associated with medical waste management are still persisting.

Medical wastes cause numerous health risks directly or indirectly. There is risk of spread of infection through poorly managed (i) sharp waste (e.g., hypodermic needles, scalpels etc.); (ii) chemical waste (e.g., reagents, solvent etc.); pathological waste (e.g., human tissues, body parts, fetus, etc.); (iii) infectious waste (e.g., blood and body fluids etc.); (iv) pharmaceutical waste (e.g. outdated medications, etc.); and (v) waste with high heavy metal content (e.g., batteries, thermometers etc.).Unhygienic and unsanitary conditions at healthcare facilities can increase the risk and potential for patients to get Hospital Acquired Infections.

This PforR will finance a slice of the GOB's Fifth Sector Program to support provision of services at the upazila and below levels. Such activities might increase generation of medical waste and the improper management of this may pose significant environmental risk. In Bangladesh, at the upazila level, the low amount of waste generated does not encourage outhouse facilities to be developed as it is not financially viable. Moreover, although the policies and regulations related to Health Care Waste Management (HCWM) are there, the healthcare waste management and monitoring/enforcement institutions are weak at the central level. The institutional limitations are percolated downwards and also likely to be reflected in the primary healthcare facilities.

4.4 Management of Environmental Risk and Impact

Currently the medical waste is inadequately managed in healthcare facilities primarily due to weak institutional monitoring mechanism and inadequate enforcement of existing rules and guidelines, there is scope for improving the scenario and thereby generate a visible positive outcome from this project. Activities associated with the service-delivery can increase the use of syringes and sharps, recyclable fluid bags, and consequently increase sharp wastes, recyclable wastes, infectious wastes as well as increase the risk of infection and contamination. Through effective implementation of HCWM activities in line with the GOB's Medical Waste Management (MWM) Rules 2008, the risks can be adequately mitigated. Specific activities will include capacity building of relevant personnel, proper segregation of waste, disposal of sharps and introducing deep burial pits for sharps and infectious wastes/body parts.

4.5 Potential Environmental Benefits and Opportunities

The PforR provides an opportunity to enhance systems to ensure provision of safe, clean and hygienic health services while also providing an opportunity to improve measures for medical waste recycling, management and minimization. Followings are some of the benefits of the Program:

- This may reduce the disease burden associated with infection and improve the quality of life.
- It will also reduce the risk of vector-borne diseases from solid medical waste dumping sites and pollution of water bodies, which could have a community-wide impact.

4.6 Potential Social Risks and Impact

The social risk for the PforR is rated as Moderate. The PforR Program does not include any land acquisition, physical or economic displacement. It also does not impact any cultural heritages. Since there is no civil work, the risks associated with labor influx is also not expected. Further construction related impact on the labor and the community is also negligible.

The Program covers areas of Chattogram Division where a number of small ethnic community members reside. Given their cultural, language, socioeconomic difference from the mainstream society and inaccessibility of their housing/ accommodation they may be excluded from consultation and service delivery. Further, vulnerable and disadvantaged people, including women, person with disability, children, people living in poverty may also face exclusion from consultation and project benefits.

Throughout the Program, there will be interaction between medical health professionals, service providers and beneficiaries (mostly women, newborn and children) in areas which may be difficult to be monitored. This may potentially give rise to SEA/SH concern. Without adequate supervision, guideline and code of conducts—SEA/SH issues may occur and also may not be reported. This is likely to impact the vulnerable people in the communities.

As is illustrated under environmental impact, the medical waste generated through the activities is likely to pose risks to the adjacent community members and health professionals. Poor infection control and occupational health and safety practices due to lack of usage of Personal Protective Equipment (PPE) and lack of training, awareness and understanding of health risks of such poor practices can contribute to increased risk of infection in healthcare facilities. When the health care workers and patients are exposed to the hospital environment and do not use appropriate personal protective equipment (PPE) they become vulnerable to different diseases.

Poor practices with regard to general (non-infectious) waste, such as inadequate storage, poor collection and untimely disposal can attract stray animals and rag pickers and become breeding grounds for vector-borne, water-based and fecal-oral infections. There is also the risk of contamination of water bodies through inadequate disposal of drug waste, expired pharmaceuticals, heavy metals such as mercury, phenols and disinfectants which can potentially affect a larger community beyond the hospital workers and rag-pickers.

DGHS has a well-functioning GRS system which is the outcome of previous health sector support program. However, at service provision and decision-making levels, a more robust GRS system is necessary to address the grievances.

4.7 Potential Social Benefits and Opportunities

The results areas to be supported by the PforR would have positive impacts through its support to civic engagement, increasing voice and accountability, as part of the stakeholder engagement strategy for the Program.

The PforR will support the GOB in improving maternal and child HNP services in Sylhet and Chattogram (areas lagging behind in terms of overall health indicators), as well as strengthen the entire health

systems. This will impact the health and wellbeing of the people in the lagging areas ultimately the outcome would be a healthy generation impacting positive socioeconomic health.

The Program will also support NCD engagement that will include people with hypertension and diabetes. This will ultimately result in service uptake and lower the cost of health expenses in the long run.

This Program also aims to develop GRS for both DGHS and DGFP so that it can track each grievance, its corresponding response(s), and time taken for response(s). This will provide access to various channels for the beneficiaries to raise concerns about the health services and provide opportunities for improvements at all tiers of health facilities. Health system will ultimately be able to listen to people and adjust their system and efficiency to meet their needs.

4.8 Contextual Risk

The contextual risk factors are impacted by instable political situation and governance, environmental, climate and disaster risk impacting service delivery, sensitive ES setting under which activities will be implanted, social fragility and conflict risk. The country has stable political situation and governance structure for last decades that supports health delivery to all its citizens. Previous HNP sector programs have been designed to reach the vulnerable and the disadvantaged population, which has improved infrastructure, service delivery, training and HR assignments. The country is not in a fragile and conflict situation. Likely disaster (earthquake, storms, climate change) may occur intermittently but may not directly and significantly impact service provisions to population. Therefore, contextual risk may be rated as Low.

4.9 Institutional Capacity Risk

MoHFW has been planning and implementing all the HNP sector programs including a number of projects under WB funding. Chapter 5 illustrates the capacity and legal framework impacting service planning and delivery. Given its experience, legal framework, health infrastructure and organizational capacity the institutional capacity risk may be rated as moderate.

4.10 Reputational Risk

The PforR plans to provide health service to the citizens aiming at providing access to maternal and child health care and hypertension and diabetes to wide range of population. This will positively impact health outcome for the citizens, and as have been seen in the past, benefits the overall wellbeing for the population. There is likely to be no complaints and grievances about the Program or organized national or international advocacy campaigns against the Program or its activities. Reputational risk thus rated as low.

Chapter 5: Assessment of Borrower System, Capacity and Performance

5.1 The Implementing Agency and Institutional Arrangements.

The PforR will use Government systems for Program implementation, including management of environmental risk and impact. The program will rely on existing institutional and implementation arrangements that are in place to manage the sector and to implement the government's 5th HPNSP. The MoHFW is responsible for the implementation of the sector program, including the achievement of the results to be supported by the proposed World Bank Program. The two divisions of the MoHFW – the Health Services Division (HSD) and Medical Education and Family Welfare Division (ME&FWD) encompass current entities, including the Directorate General of Health Service (DGHS), Directorate General of Family Planning (DGFP), Directorate General of Health Economics Unit, Directorate General of Nursing and Midwifery and Directorate General of Medical Education. Line Directors are responsible for the development and implementation of Operational Plans, including budgets that together constitute the Program Implementation Plan (PIP).

The Planning Wing of the HSD and the ME&FWD are responsible for planning, monitoring, and reporting on the progress of the sector program. These entities will serve as the primary points of contact for monitoring and communicating to the World Bank on routine project-related matters. A DLI Monitoring Committee, coordinated by the Planning Wing of the HSD and the ME&FWD, including other relevant officials of the two divisions of the MoHFW, pooled funding development partners (if any), and other parts of the government, will be responsible for monitoring progress toward the achievement of the DLIs. It will also support Line Directors in implementation, assist in producing the internal reports on DLI achievement to be submitted for verification, and coordinate with the independent verification agent.

5.2 Environmental and Social Risk Management.

The MoHFW has a long experience in implementing Programs and Projects. The current fourth Health Sector Program is successfully being implemented by the MoHFW. Further a number of IPF Projects also have been undertaken by the MoHFW under the Bank financing. Throughout the Programs and Projects, the capacity of MoHFW have been enhanced to address and manage ES risks and impacts.

The ES risks for the PforR centers around generation of waste and its impact on the health professionals, workers handling healthcare waste and the communities, risk of exclusion of beneficiaries from access to service, risk of potential SEA/SH and functioning of the grievance redress system.

5.3 Assessment of ES risks and Impacts (Core principle 1).

Nationwide, the estimated generation of medical waste in Bangladesh without considering the surge due to Covid-19 and other unusual medical emergencies would be approximately 50,000 tons (1.25 kg/bed/day) in 2025, out of which 12,435 tons were predicted to be hazardous waste. The country's management practice has been inadequate, with no safe practice for segregating,

transporting, treating, and disposing of waste. The challenge is also prevalent in regions mainly consisting of a vulnerable population. The number of waste management facilities (including five medical waste management facilities in the Cox's Bazar district's Teknaf, Ukhiya, Chakaria, Ramu, and Pekua health complexes between 2015 and 2021 by ICRC and as a part of this effort has set up medical waste management services to support health complexes in Cox's Bazar district) are in operation. There are legal provisions are there to safeguard against adverse impacts of pollution activities (Environment conservation Act 1995, ECR 1997/2023) and for the management of medical waste (MW Rules 2008). However, though there are current legislation addressing medical wastes, facilities in lower tier of health system lack infrastructure, equipment and manpower.

The Department of Environment is mandated to take necessary actions for violations of the provisions of the abovementioned acts and rules. Additionally, there are Health care Waste Management (HCWM) guidelines issued by DGHS that basically addresses operational procedures for handling and disposal of various types of medical wastes. However, the track record of enforcement of all the rules and regulations is not satisfactory. There are issues with inter agency co-ordination in collection, transportation and disposal of heath care waste and initiative was undertaken to revise the Medical Waste Management Rules 2008 to resolved the issues which is yet to materialize. In the Upazial and union health care facilities under the proposed operational area of the Program I,e Sylhet and Chattogram Division, most of the HCF do not have any onsite health care waste treatment facility. There are no designated sanitary landfills in these regions with provision of treatment/safe disposal of health care waste. Hence, GoB should ensure establishment of onsite healthcare waste treatment/disposal facilities at all the participating health care facilities until a central disposal area is established at the Upazila/District level in consultation with the responsible local government agencies and ensure adequate technical staff for its operation and maintenance.

Information materials and technical resources/manuals, modules of training for MWM are available, online record-keeping, reporting and monitoring system for in-house waste management have been developed by DGHS. These can aid in mitigating adverse environmental impacts from handling healthcare wastes.

There is lack of clear articulation of institutional responsibilities and resources to support healthcare waste management. Weak institutional capacity, including insufficient allocation of financial and human resources in MWM could offset the progress and improvement in the quality of health service delivered; and could potentially result in unacceptable health and performance indicators. The proposed PforR will not support any structural measures (incinerators, development of out-house HCWM facilities in Sylhet and Chattogram).

Stakeholders have been identified and being consulted with regarding the risks associated with the project.

The MoHFW already has a well-functioning grievance redress system which is accessible, online and feedback loops are provided. Further one of the DLIs include strengthening the GRM for both the divisions of MoHFW.

5.4 Risk and Impact on Natural Habitat and Physical Cultural Resources (Core principle 2).

This is not applicable since the activities of the PforR are not likely to impact any natural habitat and physical cultural resources.

5.5 Community and Worker Safety from Construction of Facilities, Hazardous Material, Reconstruction of Infrastructure in Natural Hazard Areas (Core principle 3).

There will be no major civil work/ facility construction or reconstruction under the PforR. However, health professionals and community members are likely to be subject medical waste, some of which are likely to be hazardous.

The following poor operational practices and non-compliance issues related to HCWM can create safety concerns for workers (nursing staff, ward boys) and general public (patients, people living in surrounding area, scavengers and rag-pickers):

- Poor practices related to infection control and management of healthcare waste, including inadequate segregation, and unmethodical methods of collection, storage and disposal
- Lack of awareness of healthcare staff and workers with regard to occupational safety and infectious waste management practices, inadequate transfer of knowledge to ward boys and sweepers from the healthcare staff
- Involvement of unauthorized persons in waste handling, pilferage, reluctance to destroy/dispose the needles/sharps, improperly designed sharps bins, lack of uniformity of color-coding of bins among healthcare facilities creating confusion, lack of visibility of IEC materials, defunct waste trolleys, lack of adequate PPEs available in large government hospitals -in public healthcare facilities. Improper disposal of medical waste exposes general public to infection-related risks
- Lack of waste management infrastructure, system and equipment in lower tier health centers and facilities.

5.6 Land Acquisition and Loss of Access to Natural Resources (Core Principle 4).

This is not applicable since the PforR will not include any land acquisition and loss of access to natural resources.

5.7 Concerns Regarding Small Ethnic Community and Vulnerable People (Core Principle 5).

The PforR Program will include benefits and access to service to people in Chattogram and Sylhet Divisions. The area also includes a number of ethnic communities. Given the vast geographic region and people living in remote and inaccessible areas it may be possible that some of the intended beneficiaries will be excluded from access to service. Further, interaction with health service providers and the women beneficiaries may also give rise to SEA/SH issues.

Findings indicate that the legal and policy framework as well as the political commitments to gender and social inclusion have laid down the foundation addressing gender and social exclusion issues in the health sector and integrating Gender, Equity, Voice and Accountability (GEVA) and social inclusion into systems and services. An initial institutional structure for GEVA and social inclusion mainstreaming has also been established at the Ministry level. However, weak institutional capacity, including

insufficient allocation of financial and human resources to reach vulnerable groups; incipient stages of GEVA and social inclusion mainstreaming; shortage of skilled workers, drug stocks, ancillary health facilities, referral services, and other services required by vulnerable groups; centralized programming which undermines localized management of resources according to the local priorities and needs; high opportunity cost (e.g., wage loss) while seeking care and high out of pocket expenditure; harmful cultural practices and stigma associated with particular services (e.g., family planning); inability of women to make independent decisions on matters related to their own health, especially sexual and reproductive health; inappropriate attitude and behavior of health service providers; inconveniently located or distant health facilities, are some of the factors that impede effective health service delivery to vulnerable groups despite the fairly strong institutional and policy framework for mainstreaming GEVA and social inclusion.

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.

GoB has articulated relevant Policies for addressing the small ethnic and vulnerable community and the VG healthcare issues following Core Principle 5. GoB is focused on Tribal HNP Plan (THNPP), thus providing the interface for effective implementation of HNP program in tribal areas and for tribal people. Internal administrative and regulatory mechanisms need to be flexible to allow oversight of the UHC and related facilities. The small ethnic and vulnerable communities inhabited areas being different from other parts of Bangladesh, demand that being different from other areas of Bangladesh, a mechanism should be developed allowing more people's participation. Access to healthcare is a major concern for the small ethnic communities due to geographical and cultural practices. Since they reside in difficult terrain, most of the moves are on foot and this impedes the movement of the children, pregnant women and the elderly to the CC and the UHC for seeking PHC. However, 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. Here the focus should be to take PHC to the doorsteps of the inhabitants rather than they reach the CC and the UHC.

To address SEA/SH cases, Bangladesh has a number of laws including National Action Plan to prevent violence against women and children 2013-2025, Women and Children Repression Prevention Act, 2000, (2003) and (Amndmnt) Bill, 2020. The District and Upazilla Level health facilities also have One Stop Crisis Centers and cells to provide psychosocial, medical and referral services.

5.8 Exacerbating Social Conflict (Core Principle 6).

This is not relevant since the PforR is not expected to exacerbate social conflicts.

Chapter 6: Stakeholder Consultation and Grievance Redress Management

6.1 Identification of Stakeholders.

The health sector support program to be implemented by the MoHFW need various ranges and types of stakeholders to make the health service delivery a success. Some of the stakeholders would provide direct support, some would be involved in an indirect capacity, and some would be on the recipient end. Following are the range of stakeholders for the Program:

Table 3. Stakeholder Groups

Stakeholder group	Interest/cause in engagement
International level	
UN Agencies (IOM, UNICEF, UNFPA etc)	A number UN agencies are providing health related support to Cox;s bazar under WB funded Projects. Their good practices and experiences may be essential in service delivery
International Vendors and Contractors	Could be interested in purely business purpose of supplying medical equipment and other services including construction related activities planned for the project.
National level	
Administrative body of MOHFW including DGHS and DGFP	Implementor, legislative and executive authority for the Program. Functions of supervision and monitoring
Ministry of Women and Children Affairs (MOWCA)	Responsible for 'Multi-Sectoral Program on Violence Against Women (MSPVAW).
Civil Surgeon and his staffs, Superintendent District Hospitals, Upazila Health & Family Planning Officer (UH&FPO) and staffs of UHCs, Union Level Health Facilities SACMO/FWV and other staffs, and CHCPs, HAs and FWAs at the Community Clinics	Service Providers who would be directly assigned by the Program and would provide enhanced HNP, gender and OCC related support amongst the service recipients. The Health Staffs involved in treating patients would also be adversely affected while handling the hazardous material. The medical waste, when not disposed off efficiently and effectively, would also affect the health staffs and patients alike.
Program Beneficiaries and Communities	Service Recipients at Chottogram and Sylhet Divisions. Besides, they would also be affected by the Program in different form.
Different government Agencies like District Administration District Police, Municipal Corporation, Electric Supply, WASA, PWD, DoE etc.	Would be responsible to support DGHS and DGFP representative for the successful implementation of the Program.
Mass media (Print and Electronic)	They are intermediaries for informing the general public about the planned activities of the Program and for information disclosure
Program employees and vendors, suppliers, contractors, sub-contractors and labors	Different workers in health facilities, suppliers and vendors will be engaged with this Program.

Civic organizations	Different civil organizations would be interested with the Program as during the implementation and operational stage
Local level	
Local community leaders	Represents interests of affected communities and vulnerable groups.
Local government and administrative bodies - including District Parishod Chairman, Upazila Chairman, Union Porishod Chairman, UP Members etc.	They could be champions in mobilization of GoB's efforts and raising awareness on family planning and response against SEA/SH in the community.

6.2 Stakeholders Consultation

The stakeholder consultations provide valuable inputs on how existing systems may be improved with strategic steps and inputs and examines the current state of Bangladesh's (GoB) healthcare system with a focus on its compliance with social and environmental safeguards.

The stakeholder consultation analysis draws on consultations with government officials, development partners, NGOs, academics and service beneficiaries. The consultation is an ongoing process and will continue throughout the program implementation. The findings highlight areas of progress, particularly in access to services for the disadvantaged and the vulnerable groups. However, critical challenges remain, including a severe shortage of healthcare professionals, a cumbersome public procurement system hindering timely access to supplies, and bureaucratic resistance towards innovative inclusion practices. The consultation proposes recommendations to address these challenges, emphasizing the importance of evidence-based policymaking, increased stakeholder collaboration, and full implementation of the Gender Equity and Action Plan (GEVA).

Focused group discussions and individual interviews were conducted with government officials from various ministries and directorates, development partners, NGOs, academics working in the healthcare sector as well as beneficiaries. The discussions explored the GoB's current practices, achievements, and challenges regarding social and environmental safeguards.

Progress and Challenges in Access to Care

Stakeholders acknowledged significant progress in ensuring access to services for vulnerable and disadvantaged groups such as small ethnic communities. This advancement reflects a commitment to social inclusion within the healthcare system. However, a critical challenge identified was the acute shortage of healthcare personnel at all levels. This deficit includes specialists, midwives, nurses, and other crucial staff. Furthermore, the lengthy public procurement process of the GoB emerged as a significant roadblock. Due to bureaucratic procedures, timely acquisition of essential medical supplies and medications is hampered, impacting service delivery. This situation highlights the need for streamlining the procurement system to ensure efficient and timely access to resources.

Ensuring Inclusion under the Program

Development partners commended the government's dedication to inclusivity within the healthcare sector. However, concerns were raised regarding bureaucracy that often stalls innovative approaches designed to improve inclusivity. Service providers, facing limitations imposed by bureaucracy, may be hesitant to implement new methods. Moreover, the combination of a shortage of skilled staff and a high patient volume significantly complicates efforts to make healthcare services more citizen-friendly. This challenge necessitates a multi-pronged approach, including increased manpower, streamlined service delivery processes, and the adoption of innovative solutions.

To ensure inclusion of the vulnerable and the disadvantaged in the health service provision, the program will Identify barriers to inclusion, including specific challenges faced by vulnerable and disadvantaged groups in accessing healthcare. This could include physical barriers (inaccessible clinics), language barriers, transportation issues, cultural sensitivities, or stigma associated with certain health conditions. The program will carry out targeted outreach programs to inform these communities about available services and encourage them to seek healthcare. This will involve partnering with community leaders, utilizing trusted messengers, or translating materials into relevant easy-to-understand languages. Further, healthcare workers will be trained in cultural competency to provide sensitive and respectful care that considers the unique needs and beliefs of diverse populations. The Program includes regular and continuous monitoring and data collection on healthcare utilization by different demographics. This will help identify gaps in service and track progress towards achieving greater inclusion. The community engagement will involve vulnerable and disadvantaged communities in planning and decision-making processes for healthcare services. This will ensure their needs and concerns are directly addressed.

Strengthening Policy and Collaboration.
NGOs and academics emphasized the need for more frequent inclusion in policy dialogues related to healthcare. They believe increased collaboration would lead to a more robust exchange of ideas and inform the development of evidence-based policies. Integrating research findings and data-driven approaches into healthcare decision-making is crucial for improving service quality and effectiveness.

GEVA's Positive Impact and the Need for Continued Support

All stakeholders unanimously agreed on the positive contributions of GEVA. The program has demonstrably improved the integration of gender equality and inclusivity within the healthcare system. However, full implementation of the 2014-2024 Gender Equity and Action Plan is vital to further solidify these gains and ensure compliance with international best practices.

This plan necessitates adequate monetary resources and staffing to guarantee its success. Increased investment in human resources, training programs, and awareness campaigns are crucial for promoting gender equality and inclusivity within the healthcare system.

Improvement of Waste Management Practices

Everyone consulted unanimously opined that the current MWM practices, infrastructure and system deserve much focus and intervention. Good practices in MWM not only ensures health and safety at the medical facilities but also to outside communities. People engaged must be trained on MWM,

facilities to be installed and good practice to be followed as is illustrated in GoB waste management policies.

6.3 Grievance Redress Mechanism

The MoHFW maintains an online Grievance Redress Service (GRS) that is being adopted to all Programs and Projects undertaken by MoHFW. It addresses grievances, right to information, complaints, complements and recommendations. The Right to Information Act (RTI) of 2009 in Bangladesh is a legal instrument that gives citizens the right to information from public authorities. The act's objectives are to ensure transparency and accountability in public, autonomous, and statutory organizations, as well as in private organizations. The act also aims to establish good governance and reduce corruption in both the public and private sectors.

The online GRS has provisions of filing complaints through web-based system, telephone number and SMS. Further each health care facilities have complaints box for up taking complaints. The GRS is publicly available, and one can see how the complaints are being solved including timeframe.

However, owing to the very nature and social standing of the disadvantaged and the vulnerable groups and small ethnic communities, most prefer not to complain against any wrongdoing by the HRH fearing repercussion. The existing system needs to be promulgated to the communities, staffs need to be trained on uptake and management of grievances. The 5th HNP Sector Program has a DLI that includes strengthening the GRM system. This DLI reflects further development of MoHFW's GRS for both DGHS and DGFP so that:

a. It can track each grievance, its corresponding response, and time taken for response.
b. **For DGFP**, results will include an assessment of the current system, approval of response guidelines by the DGFP, and annual report on grievances and responses published on the DGFP website. The annual reports will include data on the number of grievances and responses.
c. **For DGHS**, it will further strengthen the GRS running under the MIS of DGHS. The results will include percentage of valid complaint resolved by DGHS among valid complaints received in the system.

The current system, though one of the finest among all Ministries in Bangladesh needs to address the following:

a. Promulgation of the existence of the system through media, micing, door to door visits and health center posters etc
b. Complainants need to be informed on person though the provided telephone number, including the current system of posting on the website.
c. Posting reason for delays in solving the issue in the website
d. Publish yearly lesson learnt series from previous years status and types of complaints

These will be the responsibility of DGFP and DGHS and progress will be reported annually.

Chapter 7: Recommended Measures to Strengthen Systems Performance

7.1 Introduction

The Program ESSA analysis presented in preceding chapters identified the potential ES risks, opportunities and analyzed the compatibility of the program with respect to the Core principles. Based on the above findings, this section outlines recommended actions for improving the social and environmental management systems, where appropriate. These options for improvement of the environmental and social management system (ESMS) have been discussed with the implementing agencies.

7.2 Measures to Strengthen System Performance for Environmental and Social Management

Table 4: Measures to Strengthen Environment and Social Management

Objective	Measures	Responsibility and Timeframe	Indicator
Environmental Systems Management:			
Healthcare waste management practice and implementation strengthening	MoHFW would establish onsite health care waste treatment/disposal facilities at the District, Upazila and union level HCF for proposer disposal of heath care waste and appoint adequate technical staff for operation and maintenance of the onsite disposal facilities.	MoHFW 18 months from effectiveness	Onsite health care waste treatment/disposal facilities established and human resources assigned
	MOHFW will supply adequate PPE for the workers dealing with medical waste and ensure adequate budget for supply of PPE and training for the workers.	MohFW 06 months from effectiveness	Budget provision and PPE supply ensured
	MOHFW would complete the revision of the Medical Waste Management Rules 2008 for better health care waste management in the country.	MoHFW 18 months from effectiveness	Medical Waste Management Rules 2008 revised
	Develop and implement an operational manual and SOP to manage MWM at Upazilla and Union Health facilities;	MoHFW 12 months from effectiveness	Operational manual developed
	Ensure proper record-keeping, assigning a focal person for supervision of MWM activities, and constructing burial pits for sharps and infectious wastes.	MoHFW 06 months from effectiveness	Focal person assigned and record keeping system established
	Monitoring and bi-annual reporting on the implementation of MWM, particularly focused on the Upazila and Union Health Complex	MoHFW 06 months from effectiveness	Reporting system developed and reports generated
Budget Provision	Allocate sufficient budget at Upazilla and Union health facilities to manage health care wastes for capacity development, operation and maintenance and manpower assignment.	MoHFW 06 months from effectiveness	Budget provision allocated
Social Systems Management:			
Inclusion of the disadvantaged, vulnerable, gender and the	Ensure continuous stakeholder identification and consultation to ensure essential services reach those hard-to-reach areas, to disadvantaged and the vulnerable people, ethnic communities being cognizant of gender norms	DGFP and DGHS Continuous	Number of consultation meeting and number of people reached

small ethnic communities	and those associated with small ethnic communities.		
	Carryout information, education and communication campaign to raise awareness about health issues and the service availability to ensure marginalized people are willing to and have access at health service	DGFP and DGHS Continuous	Number of consultation meeting and number of people reached
SEA/SH risk mitigation	Develop awareness raising media material (poster, leaflet) and distribute/ display in all tiers of health facilities;	DGFP and DGHS 06 months from effectiveness	Media material developed
	Dedicate/ connect to national SEA/SH Helpline, provide a telephone number, SMS and email to raise issues with SEA/SH	DGFP and DGHS 06 months from effectiveness	Helpline established
	Train dedicated manpower in health facilities to deal with SEA/SH case Develop Code of Conduct for all health facility workers	DGFP and DGHS 06 months from effectiveness	Manpower selected and trained, code of conduct developed
Strengthening GRM	DLI # 10, which focuses on strengthening the Grievance Redressal Mechanism of the MOHFW, to be made be accessible to all beneficiaries. Raise awareness among the communities about the existence of such system at community level.	DGFP and DGHS 06 months from effectiveness	GRM established and promulgated
	GRM manual to be developed and promulgated to all health sector staffs assigned to receive and manage grievances.	DGFP and DGHS 06 months from effectiveness	GRM manual developed

ANNEX

SCREENING AND ES RISK AND IMPACT ASSESSMENT AS PER CORE PRINCIPLE

DLIs	Explanation	Core Principle 1 (ES Assessment)	Core Principle 3 (Community and Worker Safety)	Core Principle 5 (Vulnerable and Ethnic Community)
DLI 1 Maternal health care services expanded.	Maternal health care services expanded by increasing institutional deliveries in Upazila Health Complexes (UzHC) and Union Health and Family Welfare Centers (UH&FWC).	**Environmental.** Program design must assess status of MWM and mitigation measure through adopting good MWM practice. **Social.** Program design needs to be inclusive of disadvantaged and the vulnerable people	**Environmental.** Risk of medical waste generation and impact on the health workers and communities **Social.** Community health and safety concern MW	**Environmental.** None **Social.** Risk of exclusion from service delivery. Potential of SEA/SH cases
DLI 2 Vaccination coverage and equity enhanced.	Valid full vaccination coverage by the age of 23 months. Equity will be addressed by ensuring that all districts in these lagging divisions of Sylhet and Chattogram divisions increase their full vaccination coverage for male and female children.	**Environmental.** Need for Program design to be sustainable including mitigation measure design through adopting good MWM practice. **Social.** Program design needs to be inclusive of disadvantaged and the vulnerable people	**Environmental.** Risk of medical waste generation and impact on the health workers and communities **Social.** Community health and safety concern from MW	**Environmental.** None **Social.** Risk of exclusion from service delivery. Potential of SEA/SH cases
DLI 3 Quality family planning services expanded.	Increase the contraceptive prevalence rate for longer-acting methods of injectable, implant, and IUD.	**Environmental.** Need for Program design to be sustainable including mitigation measure design through adopting good MWM practice. **Social.** Program design needs to be inclusive for sustainability	**Environmental.** Risk of medical waste generation and impact on the health workers and communities **Social.** Community health and safety concern from MW	**Environmental.** None **Social.** Risk of exclusion from service delivery. Potential of SEA/SH cases
DLI 4 Maternal nutrition services are expanded at the community level	Maternal nutrition service is the distribution of at least 60 multiple micronutrient supplements (MMS) for newly registered pregnant women aged 15-49 years at least once during any antenatal care (ANC) service at the community clinics (CC)	**Environmental.** None significant **Social.** Program design needs to be inclusive for sustainability	**Environmental.** None significant **Social.** Community health and safety concern	**Environmental.** None significant **Social.** Risk of exclusion from service delivery. Potential of SEA/SH cases

DLI 5 Strengthened NCD diagnosis and registration services in primary care	Adults diagnosed and registered for hypertension and diabetes type 2 in Upazila Health Complexes, disaggregated by condition (hypertension and type 2 diabetes)	**Environmental**. None significant **Social.** Program design needs to be inclusive for sustainability	**Environmental**. None significant **Social.** None significant	**Environmental.** None significant **Social**. Risk of exclusion from service delivery.
DLI 6 Approve and endorse policy and increase availability of midwives at union level facilities	To create the posts, recruit, and retain two midwifery posts in the upgraded UHFWCs.	**Environmental**. None significant **Social.** None significant	**Environmental**. None significant **Social.** None significant	**Environmental.** None significant **Social**. None significant
DLI 7 Proportion of primary care facilities managing functional and timely referral for maternal and newborn complications	Primary care facilities will include UzHCs that do not provide cesarean section, blood transfusion, or services for small and sick newborns, referring to district/general hospitals.	**Environmental**. None significant **Social.** Program design needs to be inclusive for sustainability	**Environmental**. None significant **Social.** None significant	**Environmental.** None significant **Social**. Risk of exclusion from service delivery.
DLI 8 Improved access to essential NCD drugs in primary care	To support the establishment of a continuous supply of NCD drugs at public PHC level facilities like Upazilla Health Complex to overcome the current high OOP expenses for clients.	**Environmental**. None significant **Social.** None significant	**Environmental**. None significant **Social.** None significant	**Environmental.** None significant **Social**. Risk of exclusion from service delivery.

DLI 9 Strengthened Grievance Redress Mechanism (GRM) system	Development of MoHFW's GRS for both DGHS and DGFP so that it can track each grievance, its corresponding response(s), and time taken for response(s).	**Environmental**. None significant **Social.** GRM/GRS may not be accessible. Channels, procedure and process needs to be circulated	**Environmental**. None significant **Social.** None significant	**Environmental.** None significant **Social**. Vulnerable and disadvantaged group and ethnic communities may be left out of consultation for awareness about the existence of such system
DLI 10 Strengthened resilience of primary care facilities in Sylhet and Chattogram divisions to address climate change driven health risks and emergencies.	To enhance the preparedness of Upazila Health Complexes to be prepared for and effectively manage climate-driven health risks and emergencies. The activities to achieve this DLI will include: developing health facility (UzHC) contingency plans based on local vulnerabilities, capacities, and needs for climate-resilient health service delivery	**Environmental**. Climate resilient design will allow facilities and service to absorb climate related shocks **Social.** None significant	**Environmental**. None significant **Social.** None significant	**Environmental.** None significant **Social**. Vulnerable and disadvantaged group and ethnic communities will be able to access services in the time of climate related shocks