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Report No: PADHP00066

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROGRAM APPRAISAL DOCUMENT

ON

A PROPOSED CREDIT

IN THE AMOUNT OF SDR 284.7 MILLION
(US$379 MILLION EQUIVALENT),

AND

A GRANT FROM THE GLOBAL FINANCING FACILITY

IN THE AMOUNT OF US$25 MILLION

TO THE

PEOPLE'S REPUBLIC OF BANGLADESH

FOR THE

HEALTH, NUTRITION AND POPULATION SECTOR DEVELOPMENT PROGRAM-FOR-RESULTS
(P180283)

November 25,2024

Health, Nutrition and Population Global Practice
South Asia Region

CURRENCY EQUIVALENTS

Exchange Rate Effective October 31, 2024

Currency Unit =	Bangladeshi Taka (BDT)
BDT 119.50 =	US$1
US$ 1.33 =	SDR 1

FISCAL YEAR
July 1 - June 30

Regional Vice President:	Martin Raiser
Regional Director:	Stefano Paternostro
Country Director:	Abdoulaye Seck
Practice Manager:	Feng Zhao
Task Team Leaders:	Bushra Binte Alam, Mickey Chopra

ABBREVIATIONS AND ACRONYMS

ACG	Anti-Corruption Guidelines
ADB	Asian Development Bank
ANC	Antenatal Care
BDHS	Bangladesh Demographic Health Survey
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CES	Coverage Evaluation Survey
CGA	Controller General of Accounts
CMSD	Central Medical Storage Depot
CPF	Country Partnership Framework
CPR	Contraceptive Prevalence Rate
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DHIS2	District Health Information System
DLI	Disbursement-Linked Indicator
DLR	Disbursement-Linked Result
e-GP	Electronic Government Procurement
e-LMIS	Electronic Logistics Management Information System
EPI	Expanded Programme of Immunization
ESSA	Environmental and Social Systems Assessment
FA	Financing Agreement
FM	Financial Management
FMAU	Financial Management and Audit Unit
FY	Fiscal Year
GDP	Gross Domestic Product
GEVA	Gender, Equity, Voice, and Accountability
GFF	Global Financing Facility
GHG	Greenhouse Gas
GoB	Government of Bangladesh
GRS	Grievance Redress System
GRM	Grievance Redress Mechanism
HCF	Healthcare Facilities
HIES	Household Income and Expenditure Survey
HNP	Health, Nutrition, and Population
HPNSP	Health Population and Nutrition Sector Program
HSD	Health Services Division
HSSP	Health Sector Support Project
iBAS	Integrated Budgeting and Accounting System
IFA	Iron and Folic Acid
IFSA	Integrated Fiduciary Systems Assessment
IMED	Implementation Monitoring and Evaluation Division
IMF	International Monetary Fund
IPF	Investment Project Financing

IRR	Internal Rate of Return
IT	Information Technology
IUD	Intrauterine Device
IVA	Independent Verification Agency
ME&FWD	Medical Education and Family Welfare Division
MICS	Multiple Indicator Cluster Survey
MIS	Management Information System
MMR	Maternal Mortality Ratio
MMS	Multiple Micronutrient Supplementation
MoF	Ministry of Finance
MoHFW	Ministry of Health and Family Welfare
MoPA	Ministry of Public Administration
MWM	Medical Waste Management
NAP	National Adaptation Plan
NCD	Noncommunicable Disease
NDC	Nationally Determined Contribution
NGO	Nongovernmental Organization
OCAG	Office of the Comptroller and Auditor General
OOP	Out-of-Pocket Payment
PAP	Program Action Plan
PDO	Program Development Objective
PEF	Program Expenditure Framework
PFM	Public Financial Management
PforR	Program-for-Results
PHC	Primary Health Care
PPE	Personal Protective Equipment
RA	Results Area
RMNCAH	Reproductive Maternal Neonatal Child and Adolescent Health
SDGs	Sustainable Development Goals
SEA/SH	Sexual Exploitation and Abuse/Sexual Harassment
SFIs	Serious Financial Irregularities
SOP	Standard Operating Procedure
SWAp	Sector-Wide Approach
UH&FWC	Union Health and Family Welfare Center
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children's Fund
UzHC	Upazila Health Complex
VSL	Value of Statistical Life
WDI	World Development Indicators
WHO	World Health Organization

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DATASHEET

BASIC INFORMATION

Project Beneficiary(ies)	Operation Name		
Bangladesh	Health, Nutrition and Population Sector Development Program		
Operation ID	Financing Instrument	Does this operation have an IPF component?	
P180283	Program-for-Results Financing (PforR)	No	

Financing & Implementation Modalities

[ ] Multiphase Programmatic Approach (MPA)	[ ] Fragile State(s)
[ ] Contingent Emergency Response Component (CERC)	[ ] Fragile within a non-fragile Country
[ ] Small State(s)	[ ] Conflict
[ ] Alternative Procurement Arrangements (APA)	[ ] Responding to Natural or Man-made Disaster
[ ] Hands-on Expanded Implementation Support (HEIS)	

Expected Approval Date	Expected Closing Date
19-Dec-2024	30-Jun-2029
Bank/IFC Collaboration	
No	

Proposed Program Development Objective(s)

To improve access and utilization of quality health and nutrition services and build health system resilience in select geographical areas.

Organizations

Borrower:	PEOPLE'S REPUBLIC OF BANGLADESH		
Contact	Title	Telephone No.	Email
Mr.Farid Aziz	Additional Secretary	01715959013	wingchief02@erd.gov.bd
Implementing Agency:	Ministry of Health and Family Welfare		
Contact	Title	Telephone No.	Email
M A Akmall Hossain Azad	Secretary	223357199	secretary@hsd.gov.bd

COST & FINANCING (US$, Millions)

Maximizing Finance for Development

Is this an MFD-Enabling Project (MFD-EP)? No

Is this project Private Capital Enabling (PCE)? No

SUMMARY

Government program Cost	**9,650.00**
Total Operation Cost	**900.00**
Total Program Cost	900.00
Total Financing	**900.00**
Financing Gap	**0.00**

Financing (US$, Millions)

World Bank Group Financing

International Development Association (IDA)	379.00
IDA Credit	379.00

Non-World Bank Group Financing

Counterpart Funding	496.00
Borrower/Recipient	496.00
Trust Funds	25.00

Global Financing Facility	25.00

IDA Resources (US$, Millions)

	Credit Amount	Grant Amount	SML Amount	Guarantee Amount	Total Amount
National Performance-Based Allocations (PBA)	379.00	0.00	0.00	0.00	379.00
Total	**379.00**	**0.00**	**0.00**	**0.00**	**379.00**

Expected Disbursements (US$, Millions)

WB Fiscal Year	2025	2026	2027	2028	2029	2030
Annual	90.00	67.02	71.10	88.10	80.00	7.78
Cumulative	90.00	157.02	228.12	316.22	396.22	404.00

PRACTICE AREA(S)

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change; Gender; Social Protection & Jobs; Governance

CLIMATE

Climate Change and Disaster Screening

Yes, it has been screened and the results are discussed in the Operation Document

SYSTEMATIC OPERATIONS RISK- RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Substantial

2. Macroeconomic	Substantial
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Moderate
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Overall	Moderate

POLICY COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

LEGAL

Legal Covenants

Sections and Description
Section I.A.2 of Schedule 2 to the Financing Agreement (FA) and Section I.A.2 of Schedule 2 to the GFF Grant Agreement (GA). The Recipient shall, not later than six (6) months after the Effective Date, establish and thereafter maintain throughout the duration of the Program the DLI Monitoring Committee, with composition and terms of reference satisfactory to the Association vested with the responsibility of: (i) monitoring progress towards the achievement of the DLIs, and supporting line directors in implementation; and (ii) coordinating with other departments of the MoHFW and various agencies involved in the Program.
Section I.C.1(b) of Schedule 2 to the FA and Section I.C.1(b) of Schedule 2 to the GFF GA. The Recipient, through Ministry of Health and Family Welfare (MoHFW), shall: (b) provide annual Financial Statements of Program

Expenditures using the Economic Codes in the selected Operational Plans, within six (6) months after the end of each Fiscal Year (FY), for the purpose of Program Financing in accordance with Sections 5.09 and 8.06(b) of the General Conditions.
Section II of Schedule 2 to the FA and Section II of Schedule 2 to the GFF GA. Excluded Activities: The Recipient shall ensure that the Program excludes any activities which: A. in the opinion of the Association, are likely to have significant adverse impacts that are sensitive, diverse, or unprecedented on the environment and/or affected people; or B. involve the procurement of: (1) works, estimated to cost $50,000,000 equivalent or more per contract; (2) goods, estimated to cost $30,000,000 equivalent or more per contract; (3) non-consulting services, estimated to cost $30,000,000 equivalent or more per contract; or (4) consulting services, estimated to cost $15,000,000 equivalent or more per contract. C. involve civil works, new constructions, high-valued medical equipment procurement, land acquisitions, salary allowances, administrative costs, fuel costs, capital grants and taxes.
Section III.A. of Schedule 2 to the FA and Section III.A. of Schedule 2 to the GFF GA. The Recipient, through MoHFW, shall furnish to the Association each Program Report not later than six (6) months after the end of each FY, covering the FY. Except as may otherwise be explicitly required or permitted under this Agreement or as may be explicitly requested by the Association, in sharing any information, report or document related to the activities described in Schedule 1 to this Agreement, the Recipient shall ensure that such information, report or document does not include Personal Data.
Section III.B.1(a) of Schedule 2 to the FA and Section III.B.1(a) of Schedule 2 to the GFF GA. The Recipient, through Ministry of Planning, shall: (a) undertake a verification process to certify the fulfillment of the Disbursement Linked Results set out in Annex to Schedule 2 to this Agreement. To this end the Recipient, shall select and engage by the earlier of the date which is four (4) months after the Effective Date and the first date on which the Recipient undertakes a verification and thereafter maintain throughout the period of implementation of the Program, the services of one or more Independent Verification Agent(s) with qualification and experience and under terms of reference satisfactory to the Association, in order to: (i) support the Program's monitoring and evaluation; (ii) verify the data and other evidence supporting the achievement of the Disbursement Linked Results set out in Annex to Schedule 2 to this Agreement and recommend corresponding payments to be made, as applicable.

Conditions

Type	Citation	Description	Financing Source
Effectiveness	Article 4.01. of the GFF GA	The Grant Agreement shall not become effective until evidence satisfactory to the Bank has been furnished to the Bank that the conditions specified below have been satisfied, namely, the Financing Agreement has been executed and delivered and all conditions precedent to its effectiveness or to the right of the Recipient to make withdrawals under it (other than the effectiveness of the Grant	Trust Funds

		Agreement) have been fulfilled.	

I. STRATEGIC CONTEXT

A. Country Context

1. **Bangladesh experienced rapid economic and social progress in recent decades, reaching lower middle-income status in 2015.** Stable macroeconomic conditions underpinned an average annual real Gross Domestic Product (GDP) growth of 6.4 percent 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] However, the pace of poverty reduction has slowed, and urban inequality has widened.

2. **An interim government led by Nobel Laureate Dr. Muhammad Yunus was sworn in on August 8, 2024,** after former Prime Minister Sheikh Hasina resigned and left the country amid a student-led mass uprising. The events surrounding the resignation caused severe economic disruptions, including a surge in inflation, and a decline in industrial and service sector activities, exports and remittance inflows. Economic activities and the law-and-order situation have been gradually improving since the transition.

3. **The current account deficit almost halved to US$6.5 billion (1.4 percent of GDP) in FY24 from US$11.6 billion in FY23**, as the trade deficit improved, and remittance inflows grew by 10.7 percent. In May 2024, Bangladesh Bank adopted a crawling peg exchange rate system and devalued the exchange rate. At the end of October 2024, FX reserves stood at US$19.8 billion (3.2 months of import coverage).

4. **Inflation remained elevated, driven by rising food inflation.** Due to high food and import prices, inflation averaged 9.7 percent in FY24 and reached 9.9 percent in September 2024. Monetary policy has remained tight, as the policy rate was increased thrice in FY25 to 10.0 percent. Vulnerabilities in the financial sector have worsened.

5. **The fiscal deficit narrowed to 3.7 percent of GDP in FY24.** Revenue collection remains one of the lowest in the world at 8.0 percent of GDP. The interim government has recently formed an advisory committee to initiate reforms in the National Board of Revenue (NBR). Expenditure, driven by a moderation in current and capital expenditure, is estimated to have declined to 11.7 percent of GDP. The ratio of public debt to GDP declined marginally to 36.8 percent but remained sustainable with a low risk of debt stress.

6. **Real GDP growth is projected to decline to 4.1 percent in FY25 but could range between 3.2 and 5.2 percent.** The wide range of projections reflects the unavailability of credible data in recent months and significant uncertainties around the outlook. These uncertainties are expected to keep investment and industrial growth subdued in the short term. Recent floods are expected to moderate agriculture growth. Growth is expected to rise gradually, benefiting from critical financial sector reforms, increased revenue mobilization, the improved business climate, and trade. External sector pressure is expected to ease gradually, supported by robust remittance growth and improvement in exports. The fiscal deficit is expected to remain below 5 percent of GDP, with a moderate increase in revenues. Downside risks to the outlook have increased substantially. Increased political instability, poor corporate governance, and the potential insolvency of some banks could worsen an already weak financial sector. Persistently elevated inflation, weak global demand, energy shortages, and climate shocks could lower the growth outlook further and exacerbate vulnerability to falling into poverty.

7. **Structural reforms are needed to support faster growth over the medium term.** To achieve the goal of becoming an upper-middle income country, priorities include building a competitive business environment, diversifying exports, increasing human capital, building efficient infrastructure, deepening the financial sector, and attracting private investment. These reforms would strengthen international competitiveness as Bangladesh prepares for graduation from

[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.

Least Developed Countr status in 2026, which will reduce concessional financing and preferential market access for its exports. Bangladesh is not subject to Debt Limits Conditionality under the Sustainable Development Finance Policy (SDFP).

8. **Bangladesh is highly vulnerable to the effects of climate change.** The Global Climate Risk Index ranked it as the seventh most affected country between 2000-2019,[2] with high susceptibility to extreme weather events such as cyclones, floods, and storm surges. According to the Bangladesh Country Climate and Development Report, recurring flooding in Bangladesh affects a greater share of the population than any other natural hazard, impacting more than one million people annually. Once every three to five years, up to two-thirds of the country is inundated by floods. More recently, a major flood in the southeastern region of Bangladesh impacted over three million people in August 2024. Addressing these climate risks will support sustainable economic development and prevent vulnerable populations from being left behind.

B. Sectoral and Institutional Context

9. **Bangladesh achieved significant progress in key health and nutrition outcomes, but progress remains uneven and is stalling for many.** For example, while the maternal mortality ratio (MMR) in 2023 reduced to 136 per 100,000 live births,[3] the rate of reduction has slowed, still far from the global Sustainable Development Goal (SDG) target of 70. Furthermore, according to the most recent 2022 household survey, there are significant spatial and socioeconomic inequities. The use of modern contraceptive methods is the lowest nationally in Chattogram (49 percent) and Sylhet (44 percent) divisions.[4] Institutional delivery rates are also subpar in Chattogram (61 percent) and Sylhet (52 percent), trailing behind the national average of 65 percent.

10. **Despite economic gains and progress, malnutrition remains a critical issue that threatens health outcomes and human capital.** In 2023, nearly one in five women are undernourished, one in three women ages 15–49 is anemic, and one in six children are born with a low birth weight. Generating demand for antenatal care (ANC), by including multiple micronutrient supplementation (MMS) and awareness raising, for example, could prevent these poor outcomes. Maternal health and nutritional status are pivotal in determining infant birth weight. Acting now is critical as Bangladesh is also vulnerable to climate change, which threatens to increase levels of malnutrition, worsening outcomes across the life course, including low birth weight rates, poor neonatal and infant outcomes, childhood stunting, and long-term risks of climate-sensitive noncommunicable diseases (NCDs) such as hypertension and diabetes.

11. **NCDs are now responsible for the majority of deaths (68 percent) and disease burden (64 percent).**[5] The prevalence of diabetes and hypertension among adults (18+ years) is high in Bangladesh, at 14 percent and 29 percent, respectively, in 2017.[6] There are substantial gaps in NCD service provision in the public sector, with only half of the facilities providing services for common NCDs including diabetes and hypertension. This results in significant breakpoints across the continuity of care; only half of women and one-third of men living with hypertension are diagnosed, while among

2 German watch (2021) Global Climate Risk Index 2021·

3 Sample Vital Registration System 2023.

4 Bangladesh Demographic and Health Survey 2022: Key Indicators Report. Dhaka, Bangladesh, and Rockville, Maryland, USA: National Institute of Population Research and Training and ICF International.

5 Kabir, A., N. Karim, and B. Billah. 2022. "Preference, and Willingness to Receive Non-Communicable Disease Services from Primary Healthcare Facilities in Bangladesh: A Qualitative Study." *BMC Health Serv Res* 22 (1473).

6 Bangladesh Demographic and Health Survey 2017–18: Key Indicators. Dhaka, Bangladesh, and Rockville, Maryland, USA: National Institute of Population Research and Training and ICF International.

those who are diagnosed, less than one-third of women and one-quarter of men are on treatment with their hypertension under control.[7]

12. **Underpinning these trends is an underdeveloped health system.** Poor quality maternal health services, including lack of midwives at birth, overuse of cesarean section, and poor functioning referral systems to timely definitive care for complications, are prevalent. Only 18 percent of women receive quality ANC, and only one-third of the health facilities providing intrapartum care can offer blood transfusion. Overall, primary health care (PHC) facility performance is about 60 percent, contributing to a high incidence of preventable complications, high usage of more costly and climate-intensive services,[8] and high (68.5 percent) total out-of-pocket payments (OOP), mainly due to the purchase of pharmaceutical drugs (64.6 percent of total OOP).[9] This is compounded by inefficient resource allocation; over 75 percent of doctors and nurses work at tertiary healthcare levels compared to only 10.2 percent and 8.2 percent at the primary level, respectively. Financial allocations to PHC were reduced from 21 to 15 percent of the Government's health expenditure between 2010 and 2020.[10] The financial management (FM) system faces ongoing challenges, including the slow release of funds and inadequate spending capacity.

13. **Climate change is creating new challenges for the health system and acting as a risk multiplier across the full spectrum of health priorities and the health system, potentially reversing gains and exacerbating inequities.** The frequency of extreme weather events in Bangladesh increased by 46 percent between 2000 and 2020.[11] Rising temperatures are leading to more intense and unpredictable rainfalls and a higher probability of catastrophic cyclones, causing disruptions to health and well-being and health service delivery. The poorest and most vulnerable, including women, are the most affected. For example, utilization of ANC services in rural Bangladesh is reduced among women of households that have experienced climate-related displacements.[12] Displacement, loss of livelihoods, and compromised access to health care services during emergencies amplify communities' vulnerability. Climate change also perpetuates the persistent threats of vector-borne diseases, malnutrition, and waterborne diseases, among other health risks.

14. **The Government of Bangladesh (GoB) and development partners (DPs), including the World Bank, have supported the Ministry of Health and Family Welfare (MoHFW) through a sector-wide approach (SWAp) since 1998, adopting a series of multiyear strategies, programs, and budgets.** The Fourth Health, Population, and Nutrition Sector Program (4th HPNSP) (January 2017–June 2024) has a total envelope of US$17.37 billion, with 83 percent financed by the GoB and 17 percent by DPs. The recently closed Health Sector Support Project (HSSP, P160846) had financing of US$646 million from the International Development Association (IDA), Multi-Donor Trust Fund (TF0A6941), and Global Financing Facility (GFF, TF0A4355). It aimed to develop the basic building blocks of health, nutrition, and population (HNP) systems management and delivery of select essential health services in the Sylhet and Chattogram divisions. Though notably impeded by the COVID-19 pandemic, the program delivered some critical nutrition and maternal and child health results. The proposed operation will build on the HSSP. It will continue to work in the same geographical location with a renewed focus on the existing and emerging health conditions by reorienting and reorganizing health care provision at the primary

[7] "GBD 2015 Healthcare Access and Quality Collaborators. Healthcare Access and Quality Index Based on Mortality from Causes Amenable to Personal Healthcare in 195 Countries and Territories, 1990–2015: A Novel Analysis from the Global Burden of Disease 2015 Study." *The Lancet,* 2017 May 18, 2017.

[8] PHC services are not only more cost-efficient, but they are also more carbon cost-efficient (that is, reduced GHG emissions) than more complex hospital care.

[9] Bangladesh National Health Accounts 1990–2020, Health Economics Unit, MoHFW, Bangladesh.

[10] MoHFW (Ministry of Health and Family Welfare). 2023. Bangladesh National Health Accounts 1997–2020. Health Economics Unit (HEU), MoHFW, Government of the People's Republic of Bangladesh.

[11] Mahmud et al. 2021. "Climate Afflictions." World Bank Group.

[12] Haque, et al. 2020. "Climate-Related Displacement and Antenatal Care Service Utilization in Rural Bangladesh." *International Perspectives on Sexual and Reproductive Health* 46: 175–185.

levels. Moreover, it will target higher hanging fruits such as NCDs and climate resilience along with critical policy-level issues such as the recruitment of midwives at the PHC level facilities and the introduction of MMS for pregnant women during ANC visits, the first instance in the history of World Bank operations. The World Bank-financed Urban Health, Nutrition and Population Project (P171144) is mobilizing resources toward the 4th HPNSP and will continue to support the 5th HPNSP. Moreover, other World Bank-financed projects, such as the Bangladesh Enhancing Investments and Benefits for Early Years (BEIBEY) Project (P178133), will be leveraged to strengthen the overall impact of the proposed operation.

C. Relationship to the CPF and Rationale for Use of Instrument

15. **The Program is consistent with the World Bank Country Partnership Framework (CPF) FY23–27; discussed by the Board of Executive Directors on April 27, 2023 (Report No. 181003-BD).** Human development is one of the foundational priorities in the CPF. The Program will contribute to improved socioeconomic inclusion and enhanced climate resilience. Improving socioeconomic inclusion will be achieved by increasing the coverage, quality, and equity of PHC and maternal nutritional services. This will be done by increasing resources and reorganizing the PHC system to meet the population's needs. The climate resilience of the health system will also be enhanced by building capacity and readiness at the PHC level.

16. **The proposed Program-for-Results (PforR) is consistent with the adaptation and mitigation goals of the Paris Alignment, and Bangladesh's Nationally Determined Contribution (NDC, updated 2021).**[13] The updated NDC commits to a 20 percent reduction in greenhouse gas (GHG) emissions by 2030 compared to a business-as-usual scenario (15 percent conditionally on international support). Additionally, the proposed PforR is expected to substantially contribute to improving climate adaptation and resilience and is not anticipated to contribute to GHG emissions, which is aligned with the Paris Agreement, country climate policies, and the GoB's commitment to GHG reduction target. The National Adaptation Plan (NAP, 2023–2050)[14] outlines climate change impacts on health, the most vulnerable groups, and adaptation and mitigation measures to address climate risks. For instance, the NAP commits to advancement of climate-resilient water, sanitation, and hygiene infrastructure in vulnerable rural and urban areas. The proposed PforR activities are consistent with and do not hinder Bangladesh's climate commitments regarding the country's formal agreement on climate adaptation and mitigation.

17. **A PforR is considered the appropriate financing instrument for this operation.** The HSSP (P160846, closed in June 2024) used Investment Project Financing (IPF) with disbursement-linked indicators (DLIs), which helped the MoHFW prepare for the results-based financing approach. 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 health care provision at the primary levels. The GoB aims to enhance efficiency, effectiveness, and impact of its current health sector program; using the PforR instrument to support the proposed operation will provide a greater focus on outcomes through better alignment of expenditures and incentives with results. The GoB's fiduciary systems are making continued efforts to bring systemic changes, and the MoHFW has a track record that shows good implementation capacity. The MoHFW has developed a well-defined program with reliable annual budgets. The Government has already outlined the results focus through clearly defined results areas (RAs) and a program framework with prioritized interventions for the 5th HPNSP, 2024–2029. It will build on and strengthen the MoHFW's existing institutional capacity and fiduciary systems, which is critical for the health system to move to the next level and is well aligned with the principles of a PforR operation.

[13] Ministry of Environment, Forest, and Climate Change (August 26, 2021). Nationally Determined Contributions (NDCs) 2021 Bangladesh.
[14] Ministry of Environment, Forest, and Climate Change (October 2022). National Adaptation Plan of Bangladesh (2023–2050).

II. PROGRAM DESCRIPTION

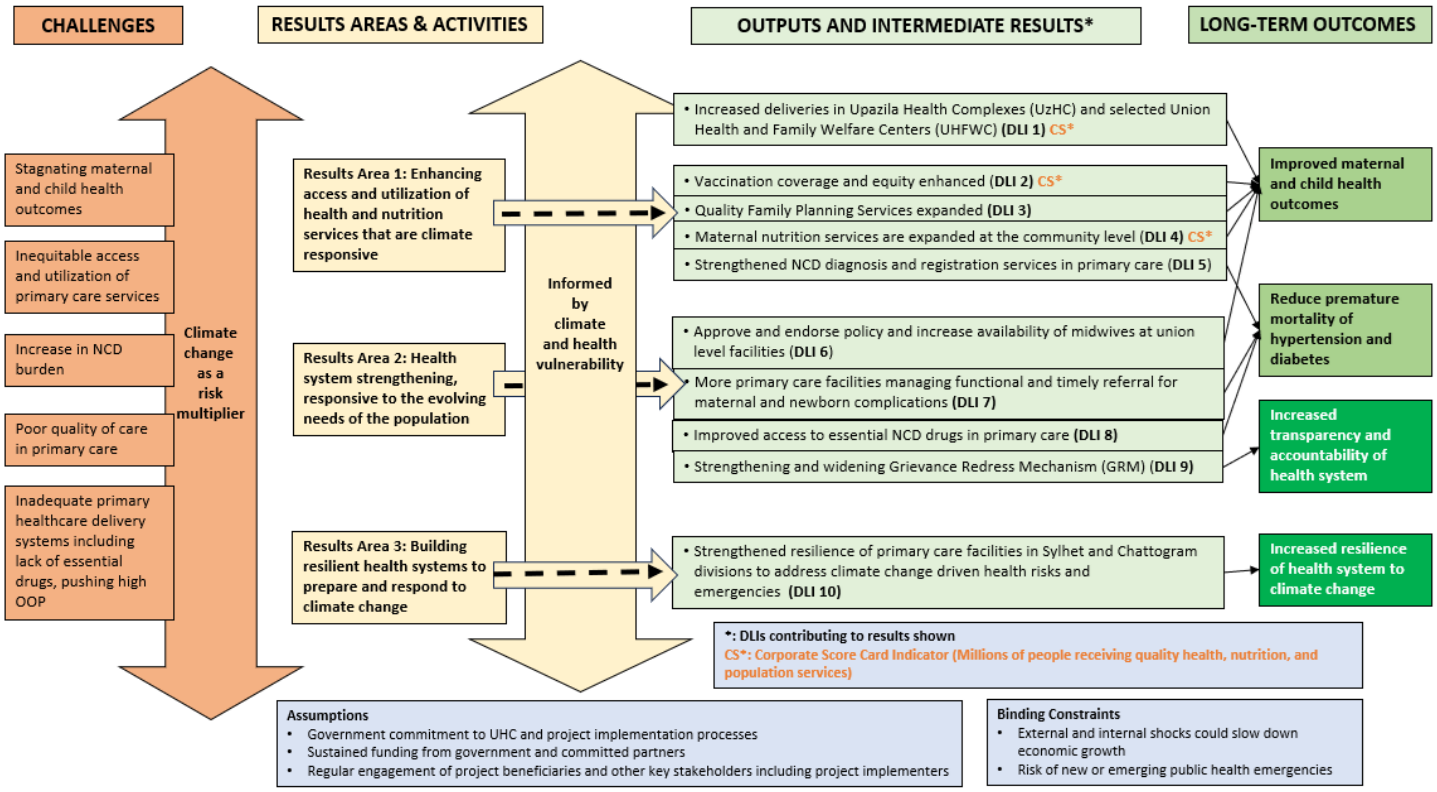
A. Government Program

18. **The MoHFW is finalizing its 5th HPNSP (2024–2029) to accelerate progress toward achieving universal health coverage (UHC) and health-related SDGs by 2030.** The overall objective of the Government's program is to "expand quality health, nutrition and population services and strengthen required systems along with governance for improved efficiency and equity." The 5th HPNSP will cover all eight geographical divisions of Bangladesh. Priority strategies include, among others, (a) increasing coverage along with access to and utilization of quality PHC services in both rural and urban areas; (b) strengthening the availability and utilization of critical services to reduce newborn, infant, child, and maternal mortality; (c) increasing access, availability, and quality of family planning services; (d) increasing the coverage and quality of nutrition services through the life cycle approach; (e) expanding and improving NCD services including mental health while ensuring equitable access for the vulnerable; and (f) reducing fiduciary risks and improving accountability and transparency through strengthening the public financial management (PFM) and audit systems. The 5th HPNSP will encompass 38 operational plans with a total budget of US$9.65 billion over the next five years.

B. Theory of Change

19. **The PforR will enhance access and utilization of health and nutrition services in Bangladesh that are climate responsive (RA1), strengthen health systems to respond to the needs of the population (RA2), and build the resilience of the health system to prepare and respond to climate change (RA3).** Access and utilization will be expanded by strengthening PHC services focusing on the lagging geographical areas of Chattogram and Sylhet division. This includes renewed efforts to reach the last mile, address emerging challenges and to introduce and scale up innovative interventions. Furthermore, considering the Bangladesh context, a climate lens will be applied to ensure PHC services are climate informed and responsive. The PforR will improve quality by supporting the delivery of the right services for the clients, at the right level of the health system, by the right providers, and at the right time. This includes deploying midwives to the union level, strengthening the supply chain of essential NCD drugs at PHC facilities, and introducing a functional referral system to ensure safe and timely care. The PforR will concomitantly enhance the preparedness and readiness of the PHC facilities to respond and adapt to the effects of climate change through understanding vulnerability, readiness, and the local needs for action; development of climate-informed multi-hazard contingency plans; and capacity building on climate and health, among others. These activities will contribute to improved health outcomes in the population and increased transparency, accountability, and climate resilience of the health system. The PforR's Theory of Change summarizes the key health system challenges and the required inputs and activities to support the achievement of the expected outputs and outcomes (Figure 1).

Figure 1. Theory of Change



C. PforR Program Scope

20. **The proposed Program will support a subset of the Government's program in the two targeted divisions (Chattogram and Sylhet) among the eight divisions in Bangladesh**. The total budget over the five-year period of the Government's 5th HPNSP is estimated to be US$9.65 billion. The part of the Government program supported by the PforR totals approximately US$900 million for these five years, which includes an IDA credit of US$379 million and a GFF grant of US$25 million. The proposed PforR will: (a) enhance access and utilization for climate-responsive PHC services (maternal health, newborn and nutrition, child immunization, family planning, and NCDs); (b) strengthen health systems to respond to the evolving needs of the population, by improving midwife availability, increasing the supply of essential NCD medicines, and operationalizing a functional referral system and grievance redress mechanism (GRM); and (c) build climate-resilient health systems. The health system strengthening efforts will benefit the entire country as these will introduce policies and develop systems that have a national impact. The sustainability of the results under the PforR is supported by improved country systems for Program implementation, harmonization of strategic interventions and implementation arrangements, and institutionalization of the key reforms in the health sector. The Program scope is presented in Table 1.

Table 1. Government program and PforR

	GoB program	Program Supported by the PforR	Reasons for Nonalignment
Objective	Expand quality HNP services and strengthen required systems along with governance for improved efficiency and equity.	To improve effective access and utilization of quality health and nutrition services and building climate resilience in select geographical areas.	Aligned
Duration	2024–2029	2024–2029	Aligned
Geographic coverage	All eight divisions of Bangladesh	Two lagging divisions (Sylhet and Chattogram) for service delivery and nationwide for health system strengthening including policy shifts	The selected divisions are included within the broader GoB program to bolster health outcomes within the overarching framework of the GoB's health sector strategy and will build on the investments made by the HSSP (P160846) that targeted the same two divisions.
RAs	RA1–RA3	RA1–RA3	Aligned

RA1: Enhancing access and utilization of health and nutrition services that are climate responsive

21. **This RA will enhance access and utilization of essential health and nutrition services at the PHC level and includes five DLIs.** To ensure an equitable health service delivery scale-up plan that is informed by climate and health vulnerability, an assessment of climate and health vulnerabilities will be conducted in all *upazilas* in Sylhet and Chattogram divisions. This assessment will inform the scale-up of service delivery that prioritizes the poorest and most climate-vulnerable communities, where access to quality essential PHC services is particularly lagging and at risk of future disruption.

22. **Annual increase in the number of deliveries in Upazila Health Complexes (UzHCs) and selected Union Health and Family Welfare Centers (UH&FWCs) (DLI 1).** This DLI will bolster the number of births (normal delivery and Caesarian section) in public health facilities, with goal of reducing maternal and neonatal mortality, particularly considering the dual challenge of lack of access to quality care and the risks of pregnancy complications posed by climate change. The Program prioritizes the most climate-vulnerable districts, adapting service delivery by integrating climate-sensitive planning and data to ensure that the most vulnerable women are reached. UzHCs and UH&FWCs will be equipped with appropriate skilled health professionals (nurses, midwives, and physicians) and logistics and medicines to offer client-friendly and safe maternal and newborn services. Midwives are currently posted at the UzHCs for midwife-led maternity services. In addition, the Directorate General of Family Planning (DGFP) plans to offer 24/7 maternity services in selected UH&FWCs by posting midwives at the union level (see DLI 6). This will strengthen ANC quality including promoting health facility birth. Demand generation for health facility intrapartum care will be fostered through counseling and outreach tailored to the local context utilizing different mechanisms to reach pregnant women in climate-vulnerable communities including community health workers. Counseling will include focus on the importance of access to services and the additional risks to pregnancy from climate-sensitive conditions such as malaria. Women will receive an individualized birth plan, accounting for climate vulnerability, including actions to take during a climate crisis. Satisfied women and families are expected to refer other women to deliver at the health facilities.

23. **Equity enhanced vaccination coverage (DLI 2).** This DLI focuses on two key objectives: ensuring last-mile immunization reaches zero-dose and under-immunized children and communities, particularly among the poorest and most climate-vulnerable, and maintaining continuity of immunization services during climate shocks such as high heat and

flooding. The DLI will track full vaccination coverage for children ages up to 23 months. Activities will include registering births by health assistants; informing and educating parents regarding immunization and outreach sessions; ensuring a consistent supply of vaccines and other logistics, including the cold chain maintenance; and scaling up outreach immunization sessions in satellite clinics and elsewhere especially for lagging and most climate-vulnerable communities. Climate-sensitive health service delivery and planning—including consideration of the most appropriate outreach and transportation modalities according to seasonal climate changes and local climate and health vulnerability—will be an integral part of the approach. Close attention will also be paid to climate-sensitive supply chain, including, for example, prepositioning vaccines for the rainy season, ensuring vaccines and other supplies are protected from climate shocks, and procuring buffer stocks as needed.

24. **Quality Family Planning Services expanded (DLI 3).** This DLI aims to expand quality voluntary family planning services in Sylhet and Chattogram divisions to support women to space or limit unintended pregnancies and support vulnerable communities in adapting to climate change. While increasing overall modern contraceptive use in Sylhet and Chattogram divisions is required, the Program will mainly focus on scaling up access to longer-acting female family planning methods (injectables, implants, and Intrauterine Devices [IUDs]) that have the additional resilience benefits of reducing the impacts of climate-driven disruption of services and displacement and reducing the need to travel regularly to health facilities. Activities include community demand generation, providing of information to women attending postnatal care, identification of 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 of the specific methods by trained service providers, and follow-up including managing any complications or side effects. In cases of insufficient appropriate service providers, alternate approaches such as training additional physicians under the Directorate General of Health Services (DGHS) and leveraging support from nongovernmental organization (NGO) partners such as Marie Stopes will be explored.

25. **Maternal nutrition services are expanded at the community level (DLI 4).** This DLI aims to introduce and scale up the innovative intervention for Bangladesh of MMS for pregnant women, addressing maternal malnutrition and improving health outcomes for pregnant women and newborns. MMS distribution during ANC visits at the PHC level including community clinics will be aligned with the climate vulnerability assessment, prioritizing districts at the most significant risk of food insecurity. Activities will include enabling policy change to adopt MMS provision for pregnant women, developing a rollout plan informed by climate-driven food insecurity, financing the procurement of MMS, procurement and supply chain management, orienting community health care providers, and dispensing MMS during ANC.

26. **Strengthened NCD diagnosis and registration services in primary care (DLI 5).** This DLI aims to strengthen efforts to manage challenges from high-burden and climate-sensitive NCDs, initially focusing on hypertension and type 2 diabetes among adults. Activities will include screening; setting up NCD corners at UzHCs with the required health service providers as part of a team-based approach; ensuring equipment availability; registering diagnosed cases; and providing health education regarding nutrition and physical activity, other climate-informed advice (for example, 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. An uninterrupted supply of essential NCD medicines will be ensured through the linked DLI 8. Screening and demand generation activities will be undertaken in the community clinic and through community health workers and awareness-raising activities and campaigns, targeting the most climate-vulnerable areas.

RA2: Health system strengthening, responsive to the evolving needs of the population

27. **This RA will improve the quality of PHC through foundational health system improvements responsive to the evolving needs of the population and includes four DLIs.** These DLIs will support the necessary policy changes and health

system capacities in Bangladesh, to improve the availability of essential human resources (midwives), ensure an uninterrupted supply of essential drugs for NCDs, develop a functional referral system, and promote continued citizen demand for high-quality services through increased transparency and accountability with strengthened GRMs.

28. **Approve and endorse policy and increase the availability of midwives at union-level facilities (DLI 6).** Although Bangladesh has already introduced midwifery-led maternity services, these are limited to *upazila*-level health facilities in the DGHS. This DLI expands quality maternal and newborn services at the union level by posting at least two midwives at selected UH&FWC. The goal is to incentivize a national policy change to support the creation of midwifery positions at the union level, with midwives also trained in relevant climate and health topics. Expansion will be informed by climate and health vulnerability while scaling up prioritizing the most climate-vulnerable communities. This component of the program is directly complemented by the scaling-up of a functional referral system (links to DLI 7) connecting primary care health facilities to higher-level care, including comprehensive emergency obstetric and neonatal care (CEmONC) for the timely referral of women and newborns with complications.

29. **PHC facilities managing functional and timely referral for maternal and newborn complications (DLI 7).** This DLI focuses on developing a functional and timely referral system for timely access to CEmONC or higher-level care for those women and newborns who need it. The DGHS has already outlined referral guidance for each health system level in its National Health Services Standards, including conditions that require referral and the procedures for ensuring effective communication and coordination between facilities. This DLI will support the operationalization of the referral system guidance by developing standard operating procedures (SOPs), training, and using data and communication exchange between the referring and higher-level facility. Scale-up of the referral system will also be informed by climate and health vulnerability. Training will incorporate climate change and its impacts on human health, including recognizing climate-driven complications that require referrals such as pre-eclampsia at both the referring and receiving facilities.

30. **Improved access to essential NCD drugs in primary care (DLI 8).** This DLI will ensure an uninterrupted supply of essential hypertension and type 2 diabetes medicines at the UzHC while providing the option to distribute these drugs at community clinics for stable patients. The offer of refill provision from the community clinic is expected to enhance long-term adherence, reduce patients' transaction costs, decongest higher-level facilities, and enhance climate resilience by providing a more flexible model closer to people's homes. Reduced transport of patients to the UzHC who can be managed at the community clinics is also expected to have a mitigation benefit. Activities under this DLI will strengthen procurement and supply chain management of essential NCD drugs at the UzHC and community clinic, targeting the most climate-vulnerable areas at the greatest risk of supply chain disruptions. Regular monitoring and forecasting of drug needs and availability will be critical; these data will be overlayed with the data on climate vulnerability to ensure a resilient supply chain.

31. **Strengthening and widening Grievance Redress Mechanism (DLI 9).** This DLI focuses on expanding the GRM system in DGFP facilities while supporting the further strengthening of the existing GRM system under the DGHS. It involves preparing and approving an SOP/Operating Manual, building staff capacity, and integrating the GRM system into the DGFP's management information system (MIS) for reporting grievances, including receiving, responding, and addressing separately for each facility and system rollout.

RA3: Building resilient health systems to prepare and respond to climate change

32. **This RA will strengthen the climate resilience of the primary care system and includes one DLI.**

33. **Strengthened resilience of primary care facilities in Sylhet and Chattogram divisions to address climate change-driven health risks and emergencies (DLI 10).** The DLI focuses on enhancing the preparedness of UzHCs to effectively manage climate-driven health shocks based on a localized assessment of vulnerabilities. Activities will include developing climate change action plans and contingency plans based on the local climate vulnerabilities, capacities, and needs; conducting climate change sensitization activities to ensure awareness and readiness of health care workers; building capacity of health care workers on the links of climate and health; monitoring the maintenance of essential health services including the continuation of the rapid-cycle analytics under the Frequent Assessments and System Tools for Resilience initiative; and strengthening supply chains, among others.

Table 2. Program Financing

Source	Amount (US$, millions)	% of Total
Counterpart Funding	**496**	**55.11**
Borrower/Recipient	496	55.11
Trust Funds	**25**	**2.77**
GFF	25	2.77
International Development Association	**379**	**42.12**
IDA Credit	379	42.12
Total Program Financing	**900**	

34. **The GFF[15] has allocated US$25 million to the PforR.** The GFF grant investments will follow some of the DLIs as the IDA credit investment. The GFF team has been involved at all stages of Program preparations and will also support and provide funding for technical assistance for Program implementation.The Asian Development Bank (ADB) is developing its support for the 5th HPNSP and has indicated close alignment with the World Bank PforR DLIs.

D. Program Development Objective(s) (PDO) and PDO Level Results Indicators

35. **PDO.** To improve access and utilization of quality health and nutrition services and build health system resilience in select geographical areas. Indicators by each element of the PDO are shown in Table 3.

Table 3. Mapping of PDO-Level Results Indicators by Elements of PDO

PDO-Level Results Indicators	Elements of PDO		
	Access and Utilization	Quality	Climate Resilience
1. Institutional deliveries in the UzHC and UH&FWC increased (number) (DLI 1.1)	√	√	
2. Newly registered pregnant women receiving MMS during any antenatal care visits at the Community Clinics in Sylhet and Chattogram divisions, reported for the previous CY (number)[16] (DLI 4.3)	√	√	
3. Primary health care facilities (UzHC) with uninterrupted drug supply of essential NCD drugs (number) (DLI 8.1)	√	√	

[15] The GFF supports low- and lower-middle income countries to accelerate progress on reproductive, maternal, newborn, child and adolescent health and nutrition, and strengthen financing and health systems for UHC.
[16] UzHC and community clinic.

PDO-Level Results Indicators	Elements of PDO		
	Access and Utilization	Quality	Climate Resilience
4. Primary health care facilities (UzHC) develop contingency plans to the satisfaction of the Association based on climate vulnerabilities, capacities, and needs (number) (DLI 10.1)	√		√
5. People receiving quality health, nutrition, and population services (number) (CRI)	√	√	√

E. Disbursement- Linked Indicators and Verification Protocols

36. **The Program focuses on three RAs and will incentivize the achievement of corresponding DLIs.** Selected PDO and intermediate outcome indicators have been strategically included as DLIs. These have been selected based on the extent to which they signal the implementation of critical actions or the realization of key outcomes that need additional incentivization. Table 4 lists the DLIs across the three RAs while Annex 2 provides more details on each DLI (including whether they are time-bound and scalable) and the corresponding verification protocols.

Table 4. DLIs across the RAs

RAs	DLIs
RA1: Enhancing access and utilization of health and nutrition services that are climate responsive	DLI 1 Expansion of maternal health care services DLI 1.1 Institutional deliveries in the UzHC and UH&FWC increased (number)
	DLI 2 Enhancing the immunization coverage and equity DLI 2.1 Districts in Sylhet and Chattogram division maintaining 88% (male and female children) valid vaccine coverage for all antigens by the age of 23 months (percentage)
	DLI 3 Expansion of family planning services DLI 3.1 Long-acting contraceptives provided to married women aged 15-49 years in Sylhet and Chattogram divisions (number)
	DLI 4 Expansion of maternal nutrition services at the community level DLI 4.1 Policy incorporation to the satisfaction of the Association of Maternal Micronutrient Supplements in the government's antenatal care program for improvement of maternal nutrition DLI 4.2 Inclusion of MMS supply-chain to the satisfaction of the Association for the Community Clinics DLI 4.3 Newly registered pregnant women receiving MMS during any antenatal care visits at the Community Clinics in Sylhet and Chattogram divisions, reported for the previous CY (number)
	DLI 5 Strengthening of NCD diagnosis and registration services in primary care level DLI 5.1 Adults diagnosed and registered with hypertension and type 2 diabetes in primary health care facilities in Sylhet and Chattogram divisions (number)
RA2: Health system strengthening, responsive to the evolving needs of the population	DLI 6 Propagate policy for availability of midwives at union level facilities DLI 6.1 Request for post creation sent from MoHFW for midwives at Union Health & Family Welfare Centre (UH&FWC) endorsed by Ministry of Public Administration (MoPA) DLI 6.2 Request for post creation sent from MoHFW for midwives at Union Health & Family Welfare Centre (UH&FWC) endorsed by Ministry of Finance DLI 6.3 Post creation request for midwives at Union Health & Family Welfare Centre (UH&FWC) approved by Cabinet Division DLI 6.4 At least 2 diploma midwives posted in selected UH&FWCs in Sylhet and Chattogram divisions

RAs	DLIs
	DLI 7 Establishing functional and timely referral for facilities at the Upazila level DLI 7.1 System for functional and timely referrals to Comprehensive Emergency Obstetric and Newborn Care (CEmONC) initiated DLI 7.2 Primary health care facilities (UzHC) are ready to provide referral services through staff orientation and training based on national guidelines (number) DLI 7.3 Primary health care facilities (UzHC) performing timely referral based on national guidelines (number)
	DLI 8 Improved access to essential NCD drugs in primary health care level (Upazila) DLI 8.1 Primary health care facilities (UzHC)) with uninterrupted drug supply of essential NCD drugs (number)
	DLI 9 Strengthening grievance redressal system DLI 9.1 Grievance redressal guideline developed for Directorate General of Family Planning (DGFP) facilities reported through Annual GRS performance report in the last two years DLI 9.2 Recorded grievances resolved in Directorate General of Health Services (DGHS) only (percentage)
RA3: Building resilient health systems to prepare and respond to climate change	DLI 10 Strengthening the resilience of the Upazila-level health system to address public health emergencies brought on by climate change DLI 10.1 Primary health care facilities (UzHC) develop contingency plans to the satisfaction of the Association based on climate vulnerabilities, capacities, and needs (number) DLI 10.2 Primary health care facilities (UzHC) have sufficient number of health care workers trained on Climate and Health (number)

37. **The DLI achievements will be reviewed annually and verified by an independent verification agency (IVA) to be engaged by the GoB as per the agreement with the World Bank.** The IVA will be engaged through signing of a memorandum of understanding no later than four months after effectiveness has been declared. The Implementation Monitoring and Evaluation Division (IMED) of the Ministry of Planning will verify the achievement of DLIs. IMED is functionally and financially independent from the MoHFW. It has the mandate and experience in monitoring social sector programs, including the health sector. It is also the IVA for the HSSP (P160846) and the recent education sector PforR Learning Acceleration in Secondary Education Operation (P178487). The MoHFW has agreed to use the existing modality to verify the achievement of DLIs for this Program. The verification process will be periodically reviewed by the existing governance structure of the SWAp, involving both the Government and DPs. The MoHFW will agree with IMED on the arrangements, terms of reference, logistics, other support, and the need for supplemental technical assistance to further enhance IMED's capacity to undertake the verification process on time without any delays.

38. **The DLI achievements will be verified through pre-identified data sources, documents, reports, and other means, in full compliance with the respective verification protocols (Annex 2).** The means of verification will include field-based sample surveys, telephonic and/or online surveys, field-based observation, desk-based triangulation of data/information, and validation of timely release of official government orders/notifications. IVA reports will be the basis for assessing progress toward achieving the DLI targets and for the disbursement authorization by the World Bank.

III. PROGRAM IMPLEMENTATION

A. Institutional and Implementation Arrangements

39. **The PforR will use government systems for Program implementation, oversight, FM, procurement, social and environmental safeguards, monitoring and evaluation, and reporting arrangements.** 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 implementing the sector program, including achieving the results to be supported by the proposed PforR. 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 developing and implementing the 38 operational plans, including budgets that constitute the Program Implementation Plan.

40. **The existing SWAp 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 DP Consortium. The HNP DP 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 DPs, review implementation progress of the sector program in various technical areas.

41. **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 be the primary points of contact for monitoring and communicating with the World Bank on routine project-related matters. They 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 IVA. The Planning Wing of both the divisions will be equipped with adequately skilled professionals and other necessary capacity to undertake these tasks. A DLI Monitoring Committee will monitor progress toward achieving the DLIs. It will be coordinated by the Planning Wing of the HSD and the ME&FWD, including other relevant officials from the two divisions of the MoHFW, pooled funding DPs, and other parts of the Government.

B. Results Monitoring and Evaluation

42. **The Program will rely on government administrative reporting and information systems, for monitoring the DLIs.** Some of the DLIs are actions and process oriented which are the easiest to measure and verify, relying on administrative reports. DLIs reflecting outputs are related to service delivery capacity and supply, requiring data to be reported at the facility level. Measurement and verification of outcome oriented DLIs, measuring numbers of services delivered and utilized, similarly require data reported at the facility level through the Government's health MISs. The MoHFW will send the summary of achievements to the IVA for verification, which will then be verified by the IVA using the agreed verification protocols. Once done, the MoHFW will send the verified results to the World Bank for disbursement with supporting evidence. The communication process between the World Bank and the MoHFW with regard to DLI achievements and their allocations is explained under the disbursement section below.

43. **Bangladesh has a well-institutionalized data collection and reporting system,** including routine data reporting by health facilities through the District Health Information System (DHIS2), specific data collection for health system reform monitoring, periodic Bangladesh Demographic Health Surveys (BDHSs), Multiple Indicator Cluster Surveys (MICSs), and regular national Household Income and Expenditure Surveys (HIESs). Although the country already reports on key indicators of health system performance, the PforR lending instrument is new for the MoHFW and will require good coordination between the directorates of HSD and ME&FWD for data collection and reporting. For the PforR implementation, this coordination must be strengthened to use existing data collection systems.

C. Disbursement Arrangements

44. **Disbursement will be made to the MoHFW based on the achievement of the DLIs**. Disbursements against DLIs will be contingent upon the GoB furnishing evidence satisfactory to the World Bank that it has achieved the respective DLI

targets, verified by the IVA. Applications of withdrawals from the World Bank's financing will be sent to IDA any time after the World Bank has notified the GoB in writing that it has accepted evidence of achievement of the DLIs. The withdrawal amount against the DLIs achieved will not exceed the amount of the financing confirmed by the World Bank for the specific DLIs. All withdrawals from the credit accounts will be made into the treasury account in Bangladesh taka maintained at the Bangladesh Bank. The PforR will provide an advance of up to 25 percent under the PforR. The advance will be adjusted against disbursements due when the DLIs are achieved or in the later years of the Program. If DLIs are not achieved, refund of the advance is required in accordance with the provisions of the Financing Agreement (FA) and Grant Agreement. At the end of the Program period, PforR expenditures will be reconciled according to the PforR eligible codes. For Program expenditure reconciliation, the eligible economic codes under the Health, Population and Nutrition, Sector Development Program Budget and Accounting Classification System are 3252109, 3252105, 3252102, 3231301, 3255101-105, and 3258101-144. If any amount of Program expenditures not financed by other financiers is less than the size of the PforR funding, which is equivalent to US$404 million, it will be refunded to the World Bank.

45. Details of the agreed disbursement rules for each DLI are provided in the respective verification protocols (Annex 2). Some DLIs are scalable, with funds being disbursed in proportion to the achievement of the DLI as provided in the FA. Similarly, if the achievement outperforms the targets, the corresponding World Bank financing against the given DLIs may be disbursed before the respective deadline of each DLI.

46. Financing of about US$10 million of the IDA Credit will be available to finance payments made for eligible expenditures during the period between October 19, 2023 (Project Concept Note date) and the date of the signed FA. It will be disbursed against a prior result achievement (DLI 6.1) that is necessary for later Program implementation. An advance of 25 percent of the IDA credits and from the GFF grant will also be provided.

D. Capacity Building

47. **Capacity-building support will be critical for achieving the transformational results envisaged under the PforR.** Continuous hands-on engagement, including need-based implementation support, along with just-in-time analytical support will be mobilized by the World Bank and the GFF for the RAs. The Program will ensure synergy and coordination on capacity building on the specific technical domains requiring support. To improve the MoHFW and districts' management capacity, technical assistance will be provided by the World Bank and the GFF through mid-level management training courses including data use for decision-making and other customized specialized technical courses to enhance the fiduciary capacities of relevant staff and officials at all levels.

48. **Other DPs engaging in the health sector program will provide technical assistance.** This will include global and regional partners including United Nations (UN) agencies; ADB; bilateral agencies such as the United States Agency for International Development, Japan International Cooperation Agency, Foreign, Commonwealth and Development Office, Global Affairs Canada, and Swedish International Development Cooperation Agency; and international entities such as Gavi, the Vaccine Alliance; Resolve to Save Lives; and the Bill & Melinda Gates Foundation, among others. Centers of excellence within Bangladesh will also be priority partners to support this program, including professional NCD organizations (for example, the Diabetic Association and the National Heart Foundation) and relevant reproductive, maternal, neonatal, child, and adolescent health and climate change organizations with expertise in health system strengthening to enable resilience to climate change. This technical support is expected to contribute to the effective implementation of the 5th HPNSP.

IV. ASSESSMENT SUMMARY

A. Paris Alignment

49. **The proposed Program is fully aligned with the Paris Agreement on Climate Change's adaptation goal and risk reduction measures.** The major climate hazards with potential to disrupt and cause damage to the proposed activities to be conducted to meet the Program's DLIs include storms, cyclones, floods, extreme heat, and landslides. However, adaptation measures will be incorporated per activity. Under DLIs 1, 2, 3, 4, 5, 7, and 8, the Program will finance health service delivery. DLIs under RAs also contribute to adaptation. DLI 10 includes robust measures to increase the resilience of the health system to climate change, which will also embed resilience into activities conducted to meet the Program's DLIs that finance health service delivery. Climate adaptation measures will include training health workers on climate change emergency preparedness and response and climate-health links and the development of climate emergency preparedness and response plans. Under DLIs 1, 2, 5, and 8, the Program will support the procurement of medicines, vaccines, logistics, equipment, and buffer stocks to ensure improved equitable access to services and essential medicines particularly during climate shocks. To reduce flood, storm, and extreme heat damage risk to medical supplies and buffer stocks, climate-controlled storage such as flood-proof and proper ventilated storage will be used. Weather forecast data and vulnerability maps will be used to guide the planning, transportation, distribution, and delivery of medical supplies and logistics to avoid severe floods, strong winds, and extreme heat periods, particularly in the most climate-vulnerable areas. All the proposed Program activities are considered Universally Aligned with the Paris Agreement's Mitigation Goals and are therefore consistent with low-GHG development pathways.

B. Technical (including Program Economic Evaluation)

50. **The PforR will support high-impact, highly cost-effective, and pro-poor health and nutrition services.** The Program is focused on two divisions that are among the most climate vulnerable and that are also lagging in key coverage and outcome indicators for women and children. It will expand equitable access to essential maternal and neonatal health, nutrition, family planning, and NCD services, which are estimated to be highly cost-effective, and will prioritize the poor and vulnerable groups. Program investments to improve public health systems quality are also pro-poor and can reduce unnecessary procedures and out-of-pocket expenditures on medications. Enhancing the health of adolescents could bring tenfold economic and social benefits. Finally, given the climate crisis, investments in strengthening climate resilience are also timely and critically important as climate change is projected to cause at least 11,000 additional deaths by 2030 and 78,000 additional deaths by 2050 from only five health risks;[17] this translates to an additional annual economic cost of almost US$3 billion from these five health risks alone.

Program Expenditure Framework (PEF)

51. **The total budget over the five-year period of the Government's 5th HPNSP is estimated to be US$9.65 billion**. The part of the Government program supported by the PforR is approximately US$900 million for five years (FY24–29). The expenditure framework of the PforR Program (P) for FY24–29 is estimated at US$379 million along with the GFF grant financing of US$25 million. This estimate includes only development expenditures. The GoB will support the expenditure framework through the annual development budget executed by the MoHFW which includes HSD and ME&FWD. The

[17] The five health risks are malnutrition, heat, malaria, dengue, and diarrhea. Estimates are from a World Bank modeling analysis using the Climate and Economic Valuation Tool.

PforR is clustered around three RAs, as described earlier. It will span the selected 8 out of 38 operational plans of the Government.

52. **The PforR excludes capital expenditure such as civil works, new constructions, high-valued medical equipment procurement, land acquisitions, and some recurrent line items such as salary allowances, administrative costs, fuel cost, capital grants, and taxes, which the Government will fund.** The economic codes to be considered in the PforR Program include vaccine, medicines, medical and surgical supplies, IUD and implant, domestic/local training, printing and stationery, and repair and maintenance. Toward the achievement of the DLIs, the Government will support investments, administrative/operating costs, high-value equipment, land acquisitions (if any), salaries and allowances, fuel costs, taxes, and so on while the PforR will cover vaccines, medicines, medical and surgical supplies, IUD/hormonal contraceptive implants, trainings, printing and stationery, and repair and maintenance[18]. Economic codes mapped with the RAs and allocations are given in Table 5:

Table 5. Selected Economic Classification, RAs, and Allocated Budget for 5 Years

Economic Code	Economic Classification	RA Mapping	'p'	'P'	
			Government program Boundary Supported by the PforR (US$, millions)	IDA (US$, millions)	GFF (US$, millions)
3252109	Vaccine	RA1, RA2	250	113	1.28
3252109	Medicine	RA1, RA2	280	119	8.62
3252105	Medical and Surgical Supplies	RA1, RA2	218	80	12.00
3252102	IUD Implant	RA1, RA2	3	1	0.10
	Injectables	RA1, RA2	3	2	0.20
3231301	Domestic/Local Training	RA1, RA2, RA3	96	50	1.50
3255101-5	Printing and stationery	RA1, RA2, RA3	22	3	1.30
3258101-44	Repair and maintenance	RA1, RA2, RA3	28	11	
	Total		**900**	**379**	**25.00**

53. The MoHFW budget has been growing on average 10 percent in the past five years, and hence, the risks to the Government program arising from budgetary constraints are low.

Economic Evaluation

54. Despite consistent GDP growth averaging 5.6 percent over the past decade, health spending remains low, constituting less than 1 percent of GDP. This contrasts sharply with similar countries and must be addressed for the nation to achieve a developed country status by 2041. A cost-benefit analysis of the proposed Program, based on its costs and projected economic benefits, demonstrates its potential. With an estimated cost of US$900 million over five years, the Program is forecasted to yield significant benefits, including a net present value of US$316 million and an internal rate of

[18] Examples include repair and maintenance of motor vehicles (i.e. ambulances); furniture and fixtures; computers and other equipment; medical and surgical equipment; and software and database maintenance.

return (IRR) of 9 percent over 20 years (at 5 percent discount rate), aligning with assumptions derived from the PforR theory of change and existing literature on improved health outcomes.

C. Fiduciary

55. An integrated fiduciary system assessment (IFSA) (procurement, governance, and FM) concluded that the Program system, completed by the mitigation measures, will provide adequate support for Program implementation. The Program reflects adequate capacity for FM with limitations in procurement. However, mitigation measures are in place to implement the fiduciary arrangements for the Program.

56. **Financial management.** For FM functions, the PforR will be aligned with the country system. The IFSA considered the lessons learned from the previous assessments, implementation of HSSP (an IPF DLI), and consultations with various stakeholders of the HSD and ME&FWD. It has identified potential areas of improvement in the overall fiduciary systems and suggested relevant mitigation measures in the Program Action Plan (PAP) (Annex 6). The IFSA gauged the capacity of the implementing agency in terms of budgeting, accounting, internal control, fund flow, reporting, and auditing mechanisms. The FM risk is assessed as Substantial. The Program activities will be reflected in the GoB's budget, thus aligning with the Government's budget cycle. The Program audit responsibility will lie with the Office of the Comptroller and Auditor General (OCAG) as per the audit rules of the GoB. The audited financial statements of the Program for each FY will be submitted to the World Bank within nine months of the close of the financial year. There is no overdue audit report under the MoHFW.

57. **Procurement.** Bangladesh has been making continued efforts for over a decade to bring systemic changes to its public procurement system**.** A robust public procurement system has been established including procurement law, secondary legislation (rules), and associated standard bidding documents. A comprehensive electronic government procurement (e-GP) system brought the procurement process online. Despite a robust procurement system and legal framework, there are significant procurement weaknesses in the health sector.

58. **The health sector procures pharmaceuticals, medical equipment, and consumables through Central Medical Storage Depot (CMSD) and the Line Directors of the MoHFW.** The IFSA identified the following risks in the MoHFW: (a) inadequate use of e-GP; (b) inadequate procurement and contract management capacity; (c) CMSD not taking the role of procuring entity to manage all health sector procurements and thereby fragmented procurement function; (d) inadequate digitization of storage and distribution of CMSD-procured goods; (e) inadequate procurement oversight (procurement post review); (f) inadequate effective and efficient complaint-handling system in the MoHFW as per the provisions of public procurement law and rules; and (g) the lack of delegation of financial power to field units. The identified procurement risks to the program procurement implementation will be mitigated through PAPs during the program implementation.

59. With concurrent implementation of risk mitigation measures during implementation, the procurement system is assessed to be adequate to the extent to which the planning, bidding, evaluation, contract award, and administration arrangements and practices provide a reasonable assurance that the Program will achieve the intended results through its procurement processes and procedures. The Program procurement risk is assessed as 'High' with the possibility of upgrading to 'Substantial' during implementation, with implementation of the mitigation measures.

60. **Anti-corruption.** The Program recognizes corruption vulnerabilities. More specifically, risks to this Program include supply chain distortions and distribution challenges for medicines and supplies, access to micronutrient supplies, absence of robust monitoring of nonfinancial assets mechanisms, and weak capacity for grievance redressal. These risks

are exacerbated by weak institutional and legal enforcement mechanisms. The Program would need to adhere to the World Bank's Anti-Corruption Guidelines (ACGs) for PforR operations dated February 1, 2012, and revised on July 10, 2015. Program-specific mitigation measures include ensuring timely reporting on corruption allegations, generating quarterly inventory and assets reports, and generating and publishing regular verification reports on the supply and receipt of medical and surgical supplies, including micronutrient supplies. Additionally, measures such as having designated focal points for monitoring corruption, strengthening internal audits, and enhancing GRMs will be applied. Details are provided in the assessment and PAP. The IFSA found that existing country systems, including the legal and institutional arrangements to counter fraud and corruption, are sufficient for the Program. Implementing agencies have sufficient sanctioned positions for the procurement and budget and accounting staff to manage the existing workload.

D. Environmental and Social

61. **An Environmental and Social System Assessment (ESSA)[19] was conducted to assess Environmental and Social risks associated with the PforR; analyze the borrowers' legal framework, systems, policy procedure, and experience; and assess whether these are adequate to address the environmental and social risks and impacts.** A screening of the activities was made through the ESSA. There will be no civil work and associated risks (labor influx, civil work-related occupational health and safety and community health and safety issues), no impact on biodiversity and cultural heritages, and no land acquisition and physical and economic displacement in the PforR. The main environmental concern is focused on medical waste generation and its treatment. Several laws and regulations address medical waste management (MWM) issues; however, the implementation is inadequate. Medical facilities at the *upazila* and union levels lack proper infrastructure, trained manpower, and a system to handle medical waste according to good practice. The social concerns relate to the exclusion of the disadvantaged and vulnerable (including small ethnic communities) from consultation and access to services. The Program will focus on Chattogram and Sylhet divisions, where some areas are inaccessible due to the geographic profile. Suitable road networks and digital and mobile penetration are also lagging compared to most other areas of the country. Further, service seekers, in difficult-to-monitor areas may also be subject to harassment and sexual exploitation and abuse/sexual harassment (SEA/SH) concerns.

62. **The MoHFW has implemented several World Bank-financed operations and has experience in health service delivery.** Its experience is also bolstered by policies, procedures, laws, and acts. The implementation of these policies has, however, been sometimes inadequate due to a lack of manpower, funds, infrastructure, equipment, and systems. The ESSA provided several recommendations in this regard (detailed in Annex 5) to bolster good practices and enhance capacity to address environmental and social issues and concerns and improve monitoring in the field. The overall environmental and social risk has been rated as Moderate. The World Bank environmental and social team will provide capacity building, guidance, and support and will monitor the implementation of the action plan/ESSA recommendations for proper environmental and social management through the PforR.

63. **Grievance redress.** Communities and individuals who believe that they are adversely affected as a result of a Bank supported PforR operation, as defined by the applicable policy and procedures, may submit complaints to the existing program grievance mechanism or the Bank's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed to address pertinent concerns. Project affected communities and individuals may submit their complaint to the Bank's independent Accountability Mechanism (AM). The AM houses the Inspection Panel, which determines whether harm occurred, or could occur, as a result of Bank non-compliance with its policies and procedures,

[19] ESSA disclosed on May 16, 2024, https://documents.worldbank.org/en/publication/documentsreports/documentdetail/099051624200590518/p18028317c84e10b1b9901c1f9d8dba59e

and the Dispute Resolution Service, which provides communities and borrowers with the opportunity to address complaints through dispute resolution. Complaints may be submitted at any time after concerns have been brought directly to the Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the Bank's Grievance Redress Service (GRS), visit https://www.worldbank.org/GRS. For information on how to submit complaints to the Bank's Accountability Mechanism, please visit https://accountability.worldbank.org.

64. **Gender.** The program is taking a multipronged approach in tackling challenges on maternal and newborn health and reproductive services in Bangladesh and will address gender and inclusion gaps related to: (a) institutional deliveries; (b) the use of modern contraceptives among women; and (c) maternal nutrition. First, although the MMR in Bangladesh declined by 38 percent, from 441 deaths to 156 deaths per 100,000 live births from 2000 to 2022, according to Bangladesh Sample Vital Statistics 2022, the rate of decline is slowing largely due to poor rural access to skilled birth attendants and lack of safe delivery services:[20] 70 percent of urban women received skilled birth attendance during delivery, compared to 36 percent of rural women.[21] Second, married adolescents have a much lower contraceptive prevalence rate (CPR) than people of other ages, which is a critical concern for Bangladesh, given its high levels of child marriage.[22] Chattogram (49 percent) and Sylhet (41.3 percent) divisions have the lowest modern CPR compared to the rest of the divisions, an average of 57 percent.[23] Third, a study found that the prevalence of anemia among pregnant women in Bangladesh attending ANC is high at 62.5 percent, emphasizing the need for routine ANC and iron supplementation for pregnant women.[24] Conservative gender norms and girls' insufficient access to health information and services contribute to limited awareness about family planning, the female body, and reproductive rights.[25] RA1 will address the identified gaps with targeted approaches for vulnerable women, such as rural women and adolescent mothers. The impacts will be captured by DLI 1, DLI 3, and DLI 4.

65. **Citizen's engagement.** The Program will support both divisions of the MoHFW to strengthen the grievance redressal system to enhance responsiveness and transparency to the public. The MoHFW uses web-based, text message-based, and phone-based platforms for citizen engagement. DLI 9 focuses on further enhancement of the system to improve handling of complaints, regarding both time and process, according to clear guidelines. There is a citizen charter of the MoHFW available on its website, which identifies the services to be provided by the MoHFW along with contact details of responsible officials. There is also a citizen charter for facilities that is usually on display at the service delivery point. DLI 9 focuses on strengthening GRS for both DGHS and DGFP.

V. RISK

66. **The overall Program risk is Moderate.** This is mainly because all risk categories are assessed to be moderate except political and governance, macroeconomic and fiduciary risks.

[20] Bangladesh Health Facility Survey 2017.
[21] BDHS 2017-18; BMC Pregnancy and Childbirth Journal 2021. In urban areas, the percentage fell from 83 percent in 2018 to 49.3 percent in 2021; BBS 2017.
[22] Despite its decreasing incidence of child marriage, Bangladesh has the highest national prevalence of child marriage in South Asia and is the eighth highest in the world (Bangladesh Country Gender Assessment 2021, World Bank).
[23] Bangladesh DHS 2022.
[24] Azhar B. Sabina, M. S. Islam, and M. R. Karim. 2021. "Prevalence of Anemia and Associated Risk Factors among Pregnant Women Attending Antenatal Care in Bangladesh: A Cross-Sectional Study." *Primary Health Care Research and Development*.
[25] Bangladesh Country Gender Assessment 2021, World Bank.

67. **Political and governance risk is substantial.** Safety and security concerns persist and are likely to remain until the police force is fully operational, despite the priority the interim government is placing on law and order. The interim government is implementing critical reforms prior to holding elections. Hence the timing of the next election is uncertain, and disagreements between political parties and the interim government over the election date could heighten political tensions. These risks will be mitigated during implementation through continuous engagement with all relevant government and non-government entities, and dialogue with other stakeholders.

68. **Macroeconomic risk is substantial.** Downside risks have increased, related to uncertainties in the political process and the security situation which impact the recovery of economic activities. The financial sector remains vulnerable with deviations from international regulatory and supervisory standards, and weak corporate governance. Despite recent improvements, the balance of payments remained in deficit and foreign exchange reserves remained under pressure. The macroeconomic risks are partially mitigated by the GoB's reform program, supported by the International Monetary Fund (IMF) arrangements, as well as ongoing World Bank and other DPs policy lending.

69. **Fiduciary risks are Substantial,** reflecting the need for improving the fiduciary management in the MoHFW. These risks are well recognized as discussed in the sectoral context and FM and procurement sections through various preceding operations. The FM risks mainly include challenges in budget planning and execution, coverage and capacity of internal audit, and suboptimal asset management. The Procurement risks are high, mainly due to inadequate use of e-GP, contract management capacity and lack of procurement oversight. These fiduciary risks will be mitigated through various measures proposed in the PAP, including the following: (i) use of e-procurement system by the line directors; (ii) post procurement review; and (iii) comprehensive capacity building programs for financial management and procurement.

ANNEX 1. RESULTS FRAMEWORK MATRIX

Program Development Objective(s)

To improve access and utilization of quality health and nutrition services and build health system resilience in select geographical areas.

PDO Indicators by Outcomes

Baseline	Period 1	Period 2	Period 3	Period 4	Closing Period
Access and Utilization					
Institutional deliveries in the primary health care facilities (UzHC and UH&FWC) increased (Number) [DLI]					
Jun/2024	Jun/2025	Jun/2026	Jun/2027	Jun/2028	Jun/2029
155,621	158,736	161,848	164,960	168,073	171,186
Newly registered pregnant women receiving MMS during any antenatal care visits at the Community Clinics in Sylhet and Chattogram divisions, reported for the previous CY (Number) [DLI]					
Jun/2024	Jun/2025	Jun/2026	Jun/2027	Jun/2028	Jun/2029
0	0	0	105,000	147,000	178,000
People receiving quality health, nutrition, and population services (Number of people)					
Jun/2024					Jun/2029
1,353,832					5,100,000
➢People receiving quality health, nutrition, and population services – Youth (Number of people)					
					Jun/2029
					2,100,000
➢People receiving quality health, nutrition, and population services – Female (Number of people)					
Jun/2024					Jun/2029
924,098					3,000,000
Quality					
Primary Health Care Facilities (UzHC) with uninterrupted drug supply of essential NCD drugs (Number) [DLI]					
Jun/2024					Jun/2029
0					100
Resilience					

Primary Health Care facilities (UzHC) develop contingency plans to the satisfaction of the association based on climate vulnerabilities, capacities and needs (Number) [DLI]					
Jun/2024					Jun/2029
0					30

Intermediate Indicators by Results Areas

Baseline	Period 1	Period 2	Period 3	Period 4	Closing Period
Enhancing access and utilization of health and nutrition services that are climate responsive					
Districts in Sylhet and Chattogram division maintaining 88% (male and female children) valid vaccine coverage for all antigens by the age of 23 months (Number) [DLI]					
Jun/2024	Jun/2025	Jun/2026	Jun/2027	Jun/2028	Jun/2029
7 districts	9 districts	10 districts	12 districts	13 districts	15 districts
Long-acting contraceptives provided to married women aged 15-49 years in Sylhet and Chattogram division (Number) [DLI]					
Jun/2024	Jun/2025	Jun/2026	Jun/2027	Jun/2028	Jun/2029
2,634,127	2,684,180	2,739,492	2,792,175	2,844,858	2,897,540
Policy incorporation to the satisfaction of the Association of Maternal Micronutrient Supplements in the Government's antenatal care program for improvement of maternal nutrition (Text) [DLI]					
Jun/2024					Jun/2029
No					Yes
Inclusion of MMS supply-chain to the satisfaction of the Association for the Community Clinics (Text) [DLI]					
Jun/2024					Jun/2029
No					MMS to be included in the supply chain for the community clinic
Adults diagnosed and registered with hypertension and type 2 diabetes in primary health care facilities in Sylhet and Chattogram divisions (Number) [DLI]					
Jun/2024					Jun/2029
284,441					400,000
Health system strengthening, responsive to the evolving needs of the population					
Request for post creation sent from MoHFW for midwives at Union Health and Family Welfare Centers (UH&FWC) endorsed by Ministry of Public Administration (MoPA) (Text) [DLI]					
Jun/2024					Jun/2029
Not yet created					Post creation request for midwives at UH&FWC to be endorsed by MoPA
Request for post creation sent from MoHFW for midwives at Union Health and Family Welfare Centers (UH&FWC) endorsed by Ministry of Finance (MoF) (Text) [DLI]					
Jun/2024					Jun/2029

No					Post creation request for midwives at UH&FWC to be endorsed by MoF
Post creation request for midwives at Union Health and Family Welfare Centers (UH&FWC) approved by the Cabinet Division (Text) DLI					
Jun/2024					Jun/2029
No					Post creation request for midwives at UH&FWC approved by Cabinet Division
At least 2 diploma midwives posted in selected UH&FWCs in Sylhet and Chattogram divisions (Number) DLI					
Jun/2024					Jun/2029
0					100
System for functional and timely referrals to Comprehensive Emergency Obstetric and Newborn Care (CEmONC) initiated (Text) DLI					
Jun/2024					Jun/2029
No					Yes
Primary health care facilities (UzHC) are ready to provide referral services through staff orientation and training based on national guidelines (Number) DLI					
Jun/2024					Jun/2029
0					80
Primary health care facilities (UzHC) performing timely referral based on national guidelines (Number) DLI					
Jun/2024					Jun/2029
0					30
Grievance redressal guideline developed for Directorate General of Family Planning (DGFP) facilities reported through Annual GRS performance report in last two years (Text) DLI					
Jun/2024	Jun/2025	Jun/2026	Jun/2027	Jun/2028	Jun/2029
No	Yes	Not Applicable	Not Applicable	1 annual report	1 annual report
Recorded grievances resolved in Directorate General of Health Services (DGHS) only (Percentage) DLI					
Jun/2024	Jun/2025	Jun/2026	Jun/2027	Jun/2028	Jun/2029
3	5	7	10	15	15
Building resilient health systems to prepare and respond to climate change					
Primary health care facilities (UzHC) have sufficient number of health care workers trained on climate and health (Number) DLI					
Jun/2024	Jun/2025	Jun/2026	Jun/2027	Jun/2028	Jun/2029
0	0	0	10	10	10

Disbursement Linked Indicators (DLI)

Period	Period Definition
Prior Results	On or after October 19, 2023 and before the expected financing agreement signing date
Period 1	FY 25
Period 2	FY 26
Period 3	FY 27
Period 4	FY 28
Period 5	FY 29

Baseline	Prior Results	Period 1	Period 2	Period 3	Period 4	Period 5
1:Institutional deliveries in the primary health care facilities (UzHC and UH&FWC) increased (Number)						
155,621						Up to 10% increase from baseline
0.00	0.00	0.00	0.00	0.00	0.00	40,000,000.00
DLI allocation		40,000,000.00		As a % of Total DLI Allocation		10.55%
2:Districts in Sylhet and Chattogram division maintaining 88% (male and female children) valid vaccine coverage for all antigens by the age of 23 months (Number)						
7 districts		9 districts	10 districts	12 districts	13 districts	15 districts
0.00	0.00	5,400,000.00	6,000,000.00	7,200,000.00	7,800,000.00	9,000,000.00
DLI allocation		35,400,000.00		As a % of Total DLI Allocation		9.34%
3:Long-acting contraceptives provided to married women aged 15-49 years in Sylhet and Chattogram division (Number)						
2,634,127						10% increase from baseline
0.00	0.00	0.00	0.00	0.00	0.00	25,000,000.00
DLI allocation		25,000,000.00		As a % of Total DLI Allocation		6.6%
4:Policy incorporation to the satisfaction of the Association of Maternal Micronutrient Supplements in the Government's antenatal care program for improvement of maternal nutrition (Text)						
No		Yes				
0.00	0.00	9,250,000.00	0.00	0.00	0.00	0.00
DLI allocation		9,250,000.00		As a % of Total DLI Allocation		2.44%
5:Inclusion of MMS supply-chain to the satisfaction of the Association for the Community Clinics (Text)						
No			Yes			
0.00	0.00	0.00	10,250,000.00	0.00	0.00	0.00

DLI allocation		10,250,000.00		As a % of Total DLI Allocation		2.7%
6:Newly registered pregnant women receiving MMS during any antenatal care visits at the Community Clinics in Sylhet and Chattogram divisions, reported for the previous CY (Number)						
0				105,000	147,000	178,000
0.00	0.00	0.00	0.00	7,350,000.00	10,290,000.00	12,460,000.00
DLI allocation		30,100,000.00		As a % of Total DLI Allocation		7.94%
7:Adults diagnosed and registered with hypertension and type 2 diabetes in primary health care facilities in Sylhet and Chattogram divisions (Number)						
284,441						Hypertension - 250000; Type 2 Diabetes - 150000
0.00	0.00	0.00	0.00	0.00	0.00	40,000,000.00
DLI allocation		40,000,000.00		As a % of Total DLI Allocation		10.55%
8:Request for post creation sent from MoHFW for midwives at Union Health and Family Welfare Centers (UH&FWC) endorsed by Ministry of Public Administration (MoPA) (Text)						
Not yet created	Yes					
0.00	10,000,000.00	0.00	0.00	0.00	0.00	0.00
DLI allocation		10,000,000.00		As a % of Total DLI Allocation		2.64%
9:Request for post creation sent from MoHFW for midwives at Union Health and Family Welfare Centers (UH&FWC) endorsed by Ministry of Finance (MoF) (Text)						
No		Yes				
0.00	0.00	9,500,000.00	0.00	0.00	0.00	0.00
DLI allocation		9,500,000.00		As a % of Total DLI Allocation		2.51%
10:Post creation request for midwives at Union Health and Family Welfare Centers (UH&FWC) approved by the Cabinet Division (Text)						
No			Yes			
0.00	0.00	0.00	9,500,000.00	0.00	0.00	0.00
DLI allocation		9,500,000.00		As a % of Total DLI Allocation		2.51%
11:At least 2 diploma midwives posted in selected UH&FWCs in Sylhet and Chattogram divisions (Number)						
0						100 UzHC
0.00	0.00	0.00	0.00	0.00	0.00	30,000,000.00
DLI allocation		30,000,000.00		As a % of Total DLI Allocation		7.92%
12:System for functional and timely referrals to Comprehensive Emergency Obstetric and Newborn Care (CEmONC) initiated (Text)						
No		Yes				
0.00	0.00	4,000,000.00	0.00	0.00	0.00	0.00
DLI allocation		4,000,000.00		As a % of Total DLI Allocation		1.06%
13:Primary health care facilities (UzHC) are ready to provide referral services through staff orientation and training based on national guidelines (Number)						

0						80 UzHC
0.00	0.00	0.00	0.00	0.00	0.00	16,000,000.00
DLI allocation		16,000,000.00		As a % of Total DLI Allocation		4.22%
14:Primary health care facilities (UzHC) performing timely referral based on national guidelines (Number)						
0						30 UzHC
0.00	0.00	0.00	0.00	0.00	0.00	6,000,000.00
DLI allocation		6,000,000.00		As a % of Total DLI Allocation		1.58%
15:Primary Health Care Facilities (UzHC) with uninterrupted drug supply of essential NCD drugs (Number)						
0						100 UzHC
0.00	0.00	0.00	0.00	0.00	0.00	25,000,000.00
DLI allocation		25,000,000.00		As a % of Total DLI Allocation		6.6%
16:Grievance redressal guideline developed for Directorate General of Family Planning (DGFP) facilities reported through Annual GRS performance report in last two years (Text)						
No		Yes			1 annual report	1 annual report
0.00	0.00	11,000,000.00	0.00	0.00	2,375,000.00	2,375,000.00
DLI allocation		15,750,000.00		As a % of Total DLI Allocation		4.16%
17:Recorded grievances resolved in Directorate General of Health Services (DGHS) only (Percentage)						
3		5%	7%	10%	15%	
0.00	0.00	1,250,000.00	1,750,000.00	2,500,000.00	3,750,000.00	0.00
DLI allocation		9,250,000.00		As a % of Total DLI Allocation		2.44%
18:Primary Health Care facilities (UzHC) develop contingency plans to the satisfaction of the association based on climate vulnerabilities, capacities and needs (Number)						
0						30 UzHC
0.00	0.00	0.00	0.00	0.00	0.00	24,000,000.00
DLI allocation		24,000,000.00		As a % of Total DLI Allocation		6.33%
19:Primary health care facilities (UzHC) have sufficient number of health care workers trained on climate and health (Number)						
0						30 UzHC
0.00	0.00	0.00	0.00	0.00	0.00	30,000,000.00
DLI allocation		30,000,000.00		As a % of Total DLI Allocation		7.92%

Monitoring & Evaluation Plan: PDO Indicators by PDO Outcomes

To improve access and utilization of quality health and nutrition services and build health system resilience in select geographical areas (PDO)	
Institutional deliveries in the UzHC and UH&FWC increased (number) (DLI 1.1)	
Description	Maternal health care services expanded by increasing institutional deliveries in UzHCs and selected UH&FWCs in Sylhet and Chattogram divisions which have 4 and 11 districts, respectively. Baseline number of institutional deliveries in UzHCs and UH&FWCs in Sylhet and Chattogram divisions is 155,621 in 2023 Calendar Year (CY).
Frequency	Annual
Data source	DHIS2 of the DGHS and MIS of the DGFP
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	MoHFW
Newly registered pregnant women receiving MMS during any antenatal care visits at the Community Clinics in Sylhet and Chattogram divisions, reported for the previous CY (number)[26] (DLI 4.3)	
Description	Maternal nutrition service is the distribution of at least 60 MMS for newly registered pregnant women ages 15–49 years at least once during any ANC service at the community clinics.
Frequency	Annual
Data source	MIS of the DGHS (DHIS2)
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	MoHFW
People receiving quality health, nutrition, and population services (number) (CRI)	
Description	This indicator represents the corporate indicator of the World Bank, where 5,100,000 people (including children, adolescent and young women, pregnant mothers) will receive quality maternal healthcare (institutional delivery), nutrition services (ANC package that includes MMS) and population (vaccination) services through the project period (2024-2029).

[26] UzHC and community clinic.

Frequency	Annual
Data source	DHIS2 of the DGHS and MIS of the DGFP
Methodology for Data Collection	MoHFW Records
Responsibility for Data Collection	MoHFW
Primary health care facilities (UzHC) with uninterrupted drug supply of essential NCD drugs (number) (DLI 8.1)	
Description	Currently regular supply of essential NCD drugs at the PHC facilities (UzHCs) is lacking, and stock-out of essential NCD drugs is high. This DLI is to support the establishment of a continuous supply of NCD drugs at public PHC-level facilities such as UzHCs to overcome the current high OOP expenses for clients. Types of NCD to be covered are diabetes type 2 and hypertension. Drugs to be included: metformin, amlodipine, losartan, chlorothiazide, and gliclazide.
Frequency	Annual
Data source	DHIS2 and logistics management system
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	DGHS, MoHFW
Primary health care facilities (UzHC) develop contingency plans to the satisfaction of the Association based on climate vulnerabilities, capacities, and needs (DLI 10.1)	
Description	The target for DLI 10.1 is to develop the contingency plans based on local climate vulnerabilities, capacities, and needs in 30 UzHCs in Sylhet and Chattogram divisions from FY 2025. Contingency plans should include as a minimum consideration of *upazila* climate and health vulnerability and local procedures for maintenance of essential services during climate-related health emergencies. This is a scalable DLI.
Frequency	Annual
Data source	MIS of DGFP
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	MoHFW

Monitoring & Evaluation Plan: Intermediate Results Indicators by Results Areas

Enhancing access and utilization of health and nutrition services that are climate responsive (RA1)	
Districts in Sylhet and Chattogram division maintaining 88% (male and female children) valid vaccine coverage for all antigens by the age of 23 months (percentage) (DLI 2.1)	
Description	Valid vaccination coverage means vaccines received by following the Expanded Programme of Immunization (EPI) recommended age and dose interval for each antigen. Valid vaccination coverage by the age of 23 months (male and female children) means childhood vaccines have been received following the 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 vaccination coverage for male and female children. At baseline, seven districts in Sylhet and Chattogram divisions have achieved 88% valid vaccine coverage for all recommended antigens among children by the age of 23 months.
Frequency	Annual
Data source	Coverage Evaluation Survey (CES) commissioned by the DGHS EPI and conducted by a contracted independent research firm with support from World Health Organization (WHO) and United Nations Children Fund (UNICEF). In the years CES is not available, MICS may be used.
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	MoHFW
Long-acting contraceptives provided to married women aged 15-49 years in Sylhet and Chattogram divisions (number) (DLI 3.1)	
Description	Increase the CPR for longer-acting methods of injectable, implant, and IUD. The CY 2023 baseline for Sylhet is 636,756 (injectable: 602,973, implant: 26,649, and IUD: 7,134) and for Chattogram is 1,997,371 (injectable: 1,870,753, implant: 83,770, and IUD: 42,848) users. The target is to increase the total use of longer-acting methods at 10% from the baseline in each of Sylhet and Chattogram divisions by 5 years.
Frequency	Annual
Data source	MIS of DGFP
Methodology for	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table

Data Collection	
Responsibility for Data Collection	MoHFW
Policy incorporation to the satisfaction of the Association of Maternal Micronutrient Supplements in the government's antenatal care program for improvement of maternal nutrition (DLI 4.1)	
Description	This DLI aims to introduce and scale up the innovative intervention for Bangladesh of MMS for pregnant women, addressing maternal malnutrition and improving health outcomes for pregnant women and newborns. Currently there is no policy available to implement the MMS in the country. Activities will include enabling policy change to adopt MMS provision for pregnant women.
Frequency	Once in Project Lifetime
Data source	DHIS2
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	MoHFW
Inclusion of MMS supply-chain to the satisfaction of the Association for the Community Clinics (DLI 4.2)	
Description	MMS distribution during ANC visits at the PHC level including community clinics will be aligned with the climate vulnerability assessment, prioritizing districts that are at the greatest risk of food insecurity. Activities will include financing the procurement of MMS, procurement and supply chain management, orienting community health care providers, and dispensing MMS during ANC.
Frequency	Once in Project Lifetime
Data source	DHIS2
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	MoHFW
Adults diagnosed and registered with hypertension and type 2 diabetes in primary health care facilities in Sylhet and Chattogram divisions (Number) (DLI 5.1)	
Description	Adults diagnosed and registered for hypertension and diabetes type 2 in UzHCs, disaggregated by condition (hypertension and type 2 diabetes), tracked separately for each condition.

Frequency	Annual
Data source	DHIS2
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	MoHFW
Health system strengthening, responsive to the evolving needs of the population (RA2)	
Request for post creation sent from MoHFW for midwives at Union Health & Family Welfare Centre (UH&FWC) endorsed by Ministry of Public Administration (MoPA) (DLI 6.1)	
Description	The DGFP UH&FWC currently have no positions for midwives in the organogram. The DGFP has requested appropriate government authorities to create the posts, recruit, and retain two midwifery posts in the upgraded UH&FWCs. All midwives will complete 3 years diploma course and be registered by the Bangladesh Nursing and Midwifery Council.
Frequency	Once in Project Lifetime
Data source	MIS of the DGFP
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	MoHFW
Request for post creation sent from MoHFW for midwives at Union Health & Family Welfare Centre (UH&FWC) endorsed by Ministry of Finance (DLI 6.2)	
Description	After the endorsement from MOPA (DLI 6.1), request for post creation will sent from MoHFW for midwives at Union Health & Family Welfare Centre (UH&FWC)for the endorsement from the Ministry of Finance.
Frequency	Once in Project Lifetime
Data source	MIS of the DGFP
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	MoHFW
Post creation request for midwives at Union Health & Family Welfare Centre (UH&FWC) approved by Cabinet Division (DLI 6.3)	

Description	After the achievment of the DLI 6.2, post creation request for midwives at Union Health & Family Welfare Centre (UH&FWC) will sent to the Cabinet Division for approval.
Frequency	Once in Project Lifetime
Data source	MIS of the DGFP
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	MoHFW
At least 2 diploma midwives posted in selected UH&FWCs in Sylhet and Chattogram divisions (DLI 6.4)	
Description	The target of DLI 6.4 is to post and retain at least 2 midwives in 100 UH&FWCs, within FY 2029 in Sylhet and Chattogram divisions. At the end of each CY, data on midwives posted for the previous CY will be collected from the DGFP in Sylhet and Chattogram divisions.
Frequency	Within FY 2029
Data source	MIS of the DGFP
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	MoHFW
System for functional and timely referrals to Comprehensive Emergency Obstetric and Newborn Care (CEmONC) initiated (DLI 7.1)	
Description	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 systems include SOP, training, and information technology (IT) systems in place for women and newborns with complications to health facilities providing CEmONC (including cesarean section and blood transfusion) and services for small and sick newborns. Functional referral to CEmONC will be performed based on national policy guidance. Timely means that patients are managed and transferred as quickly as possible.
Frequency	Once in Project Lifetime
Data source	DHIS2 of the DGHS (for UzHC and district/general hospitals)
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for	MoHFW

Data Collection	
Primary health care facilities (UzHC) are ready to provide referral services through staff orientation and training based on national guidelines (number) (DLI 7.2)	
Description	DLI 7.2 is a scalable target on the number of UzHCs whose staff are oriented and trained on functional and timely referral based on national guidelines, and 80 UzHCs are ready to provide these referral services between FY 2025 and FY 2029.
Frequency	Annual
Data source	DHIS2 of the DGHS
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	MoHFW
Primary health care facilities (UzHC) performing timely referral based on national guidelines (number) (DLI 7.3)	
Description	The DLI 7.3 is a scalable target on the number of UzHCs performing timely referral based on national guidelines, and 30 UzHCs are performing from FY 2026 to FY 2029. At the end the CY, data will be collected from DGHS MIS (DHIS2) in Sylhet and Chattogram divisions. The full amount will be disbursed on the CY target achievements. In the case of less achievement, the disbursement will be proportional.
Frequency	Annual
Data source	DHIS2 of the DGHS
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	MoHFW
Grievance redressal guideline developed for Directorate General of Family Planning (DGFP) facilities reported through Annual GRS performance report in the last two years (DLI 9.1)	
Description	For FY 2025, the target under DLI 9.1 is to develop and approve Grievance Redress Guidelines by the DGFP. The GRS guidelines will be developed and approved and staff orientation completed by the DGFP. In parallel, the additional targets under DLI 9.1 include the annual reporting of GRS performance for the previous CY published by the DGFP in FY 2028 and FY 2029. For DLI 9, disbursements will be made once the grievance redressal guideline is developed and then separately for each annual GRS performance report.

Frequency	Annual
Data source	MIS of DGFP
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	MoHFW
Recorded grievances resolved in Directorate General of Health Services (DGHS) only (percentage) (DLI 9.2)	
Description	Under DLI 9.2, the target for FY 2025 to resolve valid recorded complaints received in GRS is 5 percent, in FY 2026 is 7 percent, in FY 2027 is 10 percent, and in FY 2028 is 15 percent of valid complaints by the MIS unit of the DGHS through DLI 9.2. This is a scalable DLI, and the amount will be disbursed on the basis of each 1 percent resolve. The full amount will be disbursed on the CY target achievements. In the case of less achievement, the disbursement will be proportional.
Frequency	Annual
Data source	MIS of DGFP
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	MoHFW
Building resilient health systems to prepare and respond to climate change (RA3)	
Primary health care facilities (UzHC) have sufficient number of health care workers trained on Climate and Health (number) (DLI 10.2)	
Description	This DLI focuses on enhancing the preparedness of UzHCs to be prepared for and effectively manage climate-driven health risks and emergencies. From FY 2027, the target for DLI 10.2 is to have sufficient number (at least 4) of health professionals (doctors, nurses, and midwives) trained in climate and health in 30 UzHCs. This is also a scalable DLI.
Frequency	Annual
Data source	DHIS2
Methodology for Data Collection	MoHFW Records and described in detail in Annex 2 - Verification Protocol Table
Responsibility for Data Collection	DGHS, MoHFW

ANNEX 2. DISBURSEMENT-LINKED INDICATORS, DISBURSEMENT-LINKED RESULTS, DISBURSEMENT ARRANGEMENTS, AND VERIFICATION PROTOCOLS

DLI/Disbursement-Linked Result (DLR) Matrix

	Disbursement-Linked Indicators, Disbursement-Linked Results, Targets and Allocated Amounts Applicable to the Program				
DLI Period	***FY 2025***	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***
DLI 1 Expansion of maternal health care services **DLI 1.1 Institutional deliveries in the UzHC and UH&FWC increased (number) (2)** ***Baseline:*** **155,621** deliveries					
Target(s) (DLRs)	10% increase from baseline of 155,621				
Allocated Amount	US$40 million (US$4 million per 1% increase from FY 2024 baseline)				
DLI 2 Enhancing the immunization coverage and equity **DLI 2.1 Districts in Sylhet and Chattogram division maintaining 88% (male and female children) valid vaccine coverage for all antigens by the age of 23 months (percentage) (2)** ***Baseline: 7 Districts***					
Target(s) (DLRs)	9 districts	10 districts	12 districts	13 districts	15 districts
Allocated Amount	US$35.4 million (US$0.60 million per district)				
DLI 3 Expansion of family planning services **DLI 3.1 Long-acting contraceptives provided to married women aged 15-49 years in Sylhet and Chattogram divisions (number) (2)** ***Baseline:*** Users of long-acting contraceptive methods are approximately 2,634,127 (636,756 in Sylhet and 1,997,371 in Chattogram).					
Target(s) (DLRs)	10% increase from baseline of 2,634,127				
Allocated Amount	US$25 million (US$2.5 million per 1% increase from FY 2024 baseline)				
DLI 4 Expansion of maternal nutrition services at the community level					

DLI 4.1: Policy incorporation to the satisfaction of the Association of Maternal Micronutrient Supplements in the government's antenatal care program for improvement of maternal nutrition (1) ***Baseline:*** No policy				
Target (DLR)	Yes			
Allocated Amount	US$9.25 million			
DLI 4.2: Inclusion of MMS supply-chain to the satisfaction of the Association for the Community Clinics (1) ***Baseline:*** No policy				
Target (DLR)	Yes			
Allocated Amount	US$10.25 million			
DLI 4.3: Newly registered pregnant women receiving MMS during any antenatal care visits at the Community Clinics in Sylhet and Chattogram divisions, reported for the previous calendar year. (number) (2) ***Baseline:*** No baseline as this DLI is introducing MMS to the country for the first time				
Target(s) (DLRs)		105,000	147,000	178,000
Allocated Amount	US$30.1 million (US$70 per woman received MMS)			
DLI 5 Strengthening of NCD diagnosis and registration services in primary care level **DLI 5.1 Adults diagnosed and registered with hypertension and type 2 diabetes in primary health care facilities in Sylhet and Chattogram divisions (number) (2)** ***Baseline:*** Adults registered (2023) **Hypertension:** 153,369; **Diabetes type 2**: 110,711				
Target(s) (DLRs)	Hypertension - 250,000; Type 2 Diabetes - 150,000			
Allocated Amount	US$40 million (US$100 per adult)			
DLI 6 Propagate policy for availability of midwives at union level facilities **DLI 6.1: Request for post creation sent from MoHFW for midwives at Union Health & Family Welfare Centre (UH&FWC) endorsed by Ministry of Public Administration (MoPA) (3)**				

Baseline: 0 ***Prior Result:*** Yes ***Allocated Amount for Prior Result:*** US$10 million	
Target(s) (DLR)	Yes
Allocated Amount	US$10 million
DLI 6.2: Request for post creation sent from MoHFW for midwives at Union Health & Family Welfare Centre (UH&FWC) endorsed by Ministry of Finance (1) ***Baseline:*** Midwife posts currently not in policy for UH&FWC	
Target(s) (DLR)	Yes
Allocated Amount	US$9.5 million
DLI 6.3: **Post creation request for midwives at Union Health & Family Welfare Centre (UH&FWC) approved by the Cabinet division (1)** ***Baseline:*** No baseline	
Target(s) (DLR)	Yes
Allocated Amount	US$9.5 million
DLI 6.4: **At least 2 diploma midwives posted in selected UH&FWCs in Sylhet and Chattogram divisions (2)** ***Baseline:*** No midwives at UH&FWC	
Target(s) (DLR)	100 UH&FWCs
Allocated Amount	US$30 million (US$300,000 per UH&FWC)
DLI 7 Establishing functional and timely referral for facilities at the Upazila level **DLI 7.1: System for functional and timely referrals to Comprehensive Emergency Obstetric and Newborn Care (CEmONC) initiated (1)** ***Baseline:*** No functional referral system presently available	
Target(s) (DLR)	Yes
Allocated Amount	US$4 million

DLI 7.2: Primary health care facilities (UzHC) are ready to provide referral services through staff orientation and training based on national guidelines (number) (2) ***Baseline:*** No functional referral system presently available				
Target(s) (DLRs)	80 UzHCs			
Allocated Amount	US$16 million (US$200,000 per UzHC)			
DLI 7.3: Primary health care facilities (UzHC) performing timely referral based on national guidelines (number) (2) ***Baseline:*** No functional referral system presently available				
Target(s) (DLRs)		30 UzHCs		
Allocated Amount	US$6 million (US$200,000 per UzHC)			
DLI 8 Improved access to essential NCD drugs in primary health care level (Upazila) **DLI 8.1 Primary health care facilities (UzHC)) with uninterrupted drug supply of essential NCD drugs (number) (2)** ***Baseline:*** TBD				
Target(s) (DLRs)	100 UzHC			
Allocated Amount	US$25 million (US$0.25 million per UzHC)			
DLI 9 Strengthening grievance redressal system **DLI 9.1: Grievance redressal guideline developed for Directorate General of Family Planning (DGFP) facilities reported through Annual GRS performance report in the last two years (1)** ***Baseline:*** 0%				
Target(s) (DLR)	Yes		1 annual report	1 annual report
Allocated Amount	US$11 million		US$2.397 million	US$2.397 million
DLI 9.2 Recorded grievances resolved in Directorate General of Health Services (DGHS) only (percentage) (2) ***Baseline:*** 3% of valid complaints resolved in DGHS facilities				

Target(s) (DLR)	5%	7%	10%	15%
Allocated Amount	US$9.25 million (US$0.25 per 1% of complaints resolved)			
DLI 10. Strengthening the resilience of the Upazila-level health system to address public health emergencies brought on by climate change **DLI 10.1: Primary health care facilities (UzHC) develop contingency plans to the satisfaction of the Association based on climate vulnerabilities, capacities, and needs (number) (2)** ***Baseline:*** 0%				
Target(s) (DLRs)	30 UzHCs			
Allocated Amount	US$24 million (US$800,000 per UzHC)			
DLI 10.2: Primary health care facilities (UzHC) have sufficient number of health care workers trained on Climate and Health (number) (2) **Baseline:** 0				
Target(s) (DLRs)			30 UzHCs	
Allocated Amount	US$30 million (US$1 million per UzHC)			

Note:

1. This DLI is non-scalable and shall be achieved only once. This time frame for achievement of this DLI is indicative and can be anytime during the implementation period but no later than the Closing Date.
2. This DLI is scalable and may be achieved once annually in any FY during the implementation period but not later than the Closing Date.
3. This DLI is a prior result and shall be achieved only once.

DLI Matrix - GFF Grant Financing

	Disbursement-Linked Indicators, Disbursement Linked Results, Targets and Allocated Amounts from GFF Applicable to the Program				
DLI Period	***FY 2025***	***FY 2026***	***FY 2027***	***FY 2028***	***FY 2029***
Category (1) **DLI 1 Expansion of maternal health care services** **DLI 1.1 Institutional deliveries in the UzHC and UH&FWC increased (number) (2)** ***Baseline:*** **155,621** deliveries					
Target(s) (DLRs)	10% increase from baseline of 155,621				
Allocated Amount	US$4 million (US$400,000 million per 1% increase from FY 2024 baseline)				
Category (2) **DLI 2 Enhancing the immunization coverage and equity** **DLI 2.1 Districts in Sylhet and Chattogram division maintaining 88% (male and female children) valid vaccine coverage for all antigens by the age of 23 months (percentage) (2)** ***Baseline:*** **7** Districts					
Target(s) (DLRs)	9 districts	10 districts	12 districts	13 districts	15 districts
Allocated Amount	US$1.298 million (US$22,000 per district beyond the baseline)				
Category (3) **DLI 3 Expansion of family planning services** **DLI 3.1 Long-acting contraceptives provided to married women aged 15-49 years in Sylhet and Chattogram divisions (number) (2)** ***Baseline:*** Users of long-acting contraceptive methods are approximately 2,634,127 (636,756 in Sylhet and 1,997,371 in Chattogram)					
Target(s) (DLRs)	10% increase from baseline				
Allocated Amount	US$4 million (US$400,000 million per 1% increase from FY 2024 baseline)				
Category (4)					

DLI 4 Expansion of maternal nutrition services at the community level **DLI 4.1: Policy incorporation to the satisfaction of the Bank of Maternal Micronutrient Supplements in the government's antenatal care program for improvement of maternal nutrition (1)** ***Baseline:*** No policy				
Target(s) (DLR)	Yes			
Allocated Amount	US$1 million			
DLI 4.2 Inclusion of MMS supply-chain to the satisfaction of the Bank for the Community Clinics (1)				
Target(s) (DLR)	Yes			
Allocated Amounts	US$1 million			
DLI 4.3 Newly registered pregnant women receiving MMS during any antenatal care visits at the Community Clinics in Sylhet and Chattogram divisions, reported for the previous calendar year (number) (2)				
Target(s) (DLRs)		105,000	147,000	178,000
Allocated Amount	US$1.72 million (US$4 per MMS delivery)			
Category (5) **DLI 6. Propagate policy for availability of midwives at union level facilities** **DLI 6.2: Request for post creation sent from MoHFW for midwives at Union Health & Family Welfare Centre (UH&FWC) endorsed by Ministry of Finance (1)** ***Baseline:*** Midwife posts currently not in policy for UH&FWC				
Target(s) (DLR)	Yes			
Allocated Amount	US$750,000			
DLI 6.3: **Post creation request for midwives at Union Health & Family Welfare Centre (UH&FWC) approved by the Cabinet division (1)** ***Baseline:*** No baseline				
Target(s) (DLR)	Yes			
Allocated Amount	US$750,000			

DLI 6.4: **At least 2 diploma midwives posted in selected UH&FWCs in Sylhet and Chattogram divisions (2)** ***Baseline:*** No midwives at UH&FWC		
Target(s) (DLRs)	100 UH&FWCs	
Allocated Amounts	US$3 million (US$30,000 per UH&FWC)	
Category (6) **DLI 7 Establishing functional and timely referral for facilities at the Upazila level** **DLI 7.1: System for functional and timely referrals to Comprehensive Emergency Obstetric and Newborn Care (CEmONC) initiated (1)** ***Baseline:*** No functional referral system presently available		
Target(s) (DLR)	Yes	
Allocated Amount	US$0.502 million	
DLI 7.2: Primary health care facilities (UzHC) are ready to provide referral services through staff orientation and training based on national guidelines (number) (2) ***Baseline:*** No functional referral system presently available		
Target(s) (DLRs)	Up to 80 UzHCs	
Allocated Amount	US$1.5 million (US$18,750 per UzHC)	
DLI 7.3: Primary health care facilities (UzHC) performing timely referral based on national guidelines (number) (2) ***Baseline:*** No functional referral system presently available		
Target(s) (DLRs)		30 UzHCs
Allocated Amount		US$1.5 million (US$50,000 per UzHC)
Category (7) **DLI 9 Strengthening grievance redressal system** **DLI 9.1: Grievance redressal guideline developed for Directorate General of Family Planning (DGFP) facilities reported through Annual GRS performance report in the last two years (1)** ***Baseline:*** 0%		

Target(s) (DLRs)	Yes			1 annual report	1 annual report
Allocated Amount	US$0.5 million			US$0.5 million	US$0.5 million
DLI 9.2 Recorded grievances resolved in Directorate General of Health Services (DGHS) only (percentage) (2) ***Baseline:*** 3% of valid complaints resolved in DGHS facilities					
Target(s) (DLRs)	5%	7%	10%	15%	
Allocated Amount	US$1.480 million (US$40,000 per 1% resolved)				
Category (8) **DLI 10. Strengthening the resilience of the Upazila-level health system to address public health emergencies brought on by climate change** **DLI 10.1: Primary health care facilities (UzHC) develop contingency plans to the satisfaction of the Bank based on climate vulnerabilities, capacities, and needs (number) (2)** ***Baseline:*** **0%**					
Target(s) (DLRs)	30 UzHCs				
Allocated Amount	US$1 million (US$33,333.33 per UzHC)				

Notes:

1. This DLI is non-scalable and shall be achieved only once. This time frame for the achievement of this DLI is indicative and can be anytime during the implementation period but no later than the Closing Date.
2. This DLI is scalable and may be achieved once annually in any FY during the implementation period but not later than the Closing Date.

Verification Protocol Table: Disbursement Linked Indicators

DLI 1 **DLI 1.1**	**DLI 1 Expansion of maternal health care services** **DLI 1.1 Institutional deliveries in the UzHC and UH&FWC increased (number)**
Description	Maternal health care services expanded by increasing institutional deliveries in UzHCs and selected UH&FWCs in Sylhet and Chattogram divisions which have 4 and 11 districts, respectively. Baseline number of institutional deliveries in UzHCs and UH&FWCs in Sylhet and Chattogram divisions is 155,621 in 2023 Calendar Year (CY).
Data source/ Agency	MIS of the DGHS through DHIS2 and DGFP through its MIS.
Verification Entity	Identified IVA
Procedure	DLI periods are FY 2025, FY 2026, FY 2027, FY 2028, and FY 2029. At the end of each financial year, institutional delivery data for the previous CY will be collected from each district of the UzHC and UH&FWC for the districts of Sylhet and Chattogram divisions. This is a scalable DLI with a target of 10% increase from the baseline in 15 districts over 5 years. 100% disbursement will be done once this is achieved in all the 15 districts.
DLI 2 **DLI 2.1**	**DLI 2 Enhancing the immunization coverage and equity** **DLI 2.1 Districts in Sylhet and Chattogram division maintaining 88% (male and female children) valid vaccine coverage for all antigens by the age of 23 months (percentage)**
Description	Valid vaccination coverage means vaccines received by following the Expanded Programme of Immunization (EPI) recommended age and dose interval for each antigen. Valid vaccination coverage by the age of 23 months (male and female children) means childhood vaccines have been received following the 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 vaccination coverage for male and female children. At baseline, seven districts in Sylhet and Chattogram divisions have achieved 88% valid vaccine coverage for all recommended antigens among children by the age of 23 months.
Data source/ Agency	Coverage Evaluation Survey (CES) commissioned by the DGHS EPI and conducted by a contracted independent research firm with support from WHO and UNICEF. In the years CES is not available, MICS may be used.
Verification Entity	IVA

Procedure	DLI periods are FY 2025 through FY 2029. After each FY, sex-disaggregated data will be estimated by CES for the preceding CY for Sylhet and Chattogram divisions for vaccination coverage of children by the age of 23 months. This is a stepwise DLI with annualized target for each year (number of districts), with full disbursement on all 15 districts achieving and maintaining at least 88% valid vaccination coverage for both girls and boys by the end of the project period (FY 2029).
DLI 3 **DLI 3.1**	**DLI 3 Expansion of family planning services** **DLI 3.1 Long-acting contraceptives provided to married women aged 15-49 years in Sylhet and Chattogram divisions (number)**
Description	Increase the CPR for longer-acting methods of injectable, implant, and IUD. The CY 2023 baseline for Sylhet is 636,756 (injectable: 602,973, implant: 26,649, and IUD: 7,134) and for Chattogram is 1,997,371 (injectable: 1,870,753, implant: 83,770, and IUD: 42,848) users. The target is to increase the total use of longer-acting methods at 10% from the baseline in each of Sylhet and Chattogram divisions by 5 years.
Data source/ Agency	MIS of the DGFP
Verification Entity	IVA
Procedure	DLI periods are FY 2025, FY 2026, FY 2027, FY 2028, and FY 2029. After each FY, data will be collected for the preceding CY for Sylhet and Chattogram divisions for each of the longer-acting methods—injectable, implant, and IUD. This is a scalable DLI. The full amount will be disbursed on the CY achievement of 10% for each division. In the case of less achievement, the disbursement will be proportional.
DLI 4 **DLI 4.1** **DLI 4.2** **DLI 4.3**	**DLI 4 Expansion of maternal nutrition services at the community level** **DLI 4.1: Policy incorporation to the satisfaction of the Association of Maternal Micronutrient Supplements in the government's antenatal care program for improvement of maternal nutrition** **DLI 4.2 Inclusion of MMS supply-chain to the satisfaction of the Association for the Community Clinics** **DLI 4.3 Newly registered pregnant women receiving MMS during any antenatal care visits at the Community Clinics in Sylhet and Chattogram divisions, reported for the previous CY (number)**
Description	Maternal nutrition service is the distribution of at least 60 MMS for newly registered pregnant women ages 15–49 years at least once during any ANC service at the community clinics.
Data source/ Agency	MIS of the DGHS (DHIS2)
Verification Entity	IVA

Procedure	DLI periods are FY 2025, FY 2026, FY 2027, FY 2028, and FY 2029. Under DLI 4.1, the objective is to incorporate MMS into the standard ANC package delivered through community clinics. This integration is necessary as MMS is not currently part of the Government program, necessitating the establishment of the required supply chain infrastructure. Under DLI 4.2 the aim is to finalize the inclusion of MMS in the community clinic supply chain for the following years. In the subsequent years, from CY 2027, the target is to administer at least 60 MMS doses to 105,000 newly registered pregnant women at least once during any ANC visit in the previous calendar year through DLI 4.3. Subsequently, in CY 2028 and CY 2029, the aim is to administer the same to 147,000 and 178,000 newly registered pregnant women, respectively, during the preceding year. After each FY, data will be collected for the preceding CY for Sylhet and Chattogram divisions from DHIS2 for MMS distributed during ANC.
DLI 5 **DLI 5.1**	**DLI 5 Strengthening of NCD diagnosis and registration services in primary care level** **DLI 5.1 Adults diagnosed and registered with hypertension and type 2 diabetes in primary health care facilities in Sylhet and Chattogram divisions (number)**
Description	Adults diagnosed and registered for hypertension and diabetes type 2 in UzHCs, disaggregated by condition (hypertension and type 2 diabetes), tracked separately for each condition.
Data source/ Agency	MIS of the DGHS (DHIS2)
Verification Entity	IVA
Procedure	The DLI reporting will refer to the preceding calendar year (CY 2025, CY 2026, CY 2027, CY 2028, and CY 2029). At the end of each CY, data on NCD diagnoses (hypertension and type 2 diabetes) for the previous CY will be collected from DHIS2 separately for each condition from each UzHC in Sylhet and Chattogram divisions. This is a scalable DLI with a target up to 250,000 for hypertension and 150,000 for diabetes over 5 years. 100% disbursement will be done once this is achieved. In the case of less achievement, the disbursement will be proportional.
DLI 6 **DLI 6.1** **DLI 6.2** **DLI 6.3** **DLI 6.4**	**DLI 6 Propagate policy for availability of midwives at union level facilities** **DLI 6.1: Request for post creation sent from MoHFW for midwives at Union Health & Family Welfare Centre (UH&FWC) endorsed by Ministry of Public Administration (MoPA)** **DLI 6.2: Request for post creation sent from MoHFW for midwives at Union Health & Family Welfare Centre (UH&FWC) endorsed by Ministry of Finance** **DLI 6.3: Post creation request for midwives at Union Health & Family Welfare Centre (UH&FWC) approved by Cabinet Division** **DLI 6.4 At least 2 diploma midwives posted in selected UH&FWCs in Sylhet and Chattogram divisions**

Description	The DGFP UH&FWC currently have no positions for midwives in the organogram. The DGFP has requested appropriate government authorities to create the posts, recruit, and retain two midwifery posts in the upgraded UH&FWCs. All midwives will complete 3 years diploma course and be registered by the Bangladesh Nursing and Midwifery Council.
Data source/ Agency	MIS of DGFP
Verification Entity	IVA
Procedure	DLI periods are FY 2025, FY 2026, FY 2027, FY 2028, and FY 2029. Between FY 2024 (after Project Concept Note) and FY 2025. The DGFP's proposal of creation of 2 midwives posts at each selected UH&FWC is endorsed by MoPA (DLI 6.1). It will be a prior result. Once achieved and verified, disbursements can be made after effectiveness based on the allocation made. The subsequent target is to get endorsement from the MoF (DLI 6.2) and approval from the Cabinet Division (DLI 6.3). The target of DLI 6.4 is to post and retain at least 2 midwives in 100 UH&FWCs, within FY 2029 in Sylhet and Chattogram divisions. At the end of each CY, data on midwives posted for the previous CY will be collected from the DGFP in Sylhet and Chattogram divisions This is a scalable DLI. The full amount will be disbursed on the CY target achievement. In the case of less achievement, the disbursement will be proportional.
DLI 7 **DLI 7.1** **DLI 7.2** **DLI 7.3**	**DLI 7 Establishing functional and timely referral for facilities at the Upazila level** **DLI 7.1: System for functional and timely referrals to Comprehensive Emergency Obstetric and Newborn Care (CEmONC) initiated** **DLI 7.2 Primary health care facilities (UzHC) are ready to provide referral services through staff orientation and training based on national guidelines (number)** **DLI 7.3 Primary health care facilities (UzHC) performing timely referral based on national guidelines (number)**
Description	In rural Bangladesh, public sector primary care facilities involved in institutional delivery (UzHC) need to be linked with facilities providing 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 systems include SOP, training, and IT systems in place for women and newborns with complications to health facilities providing CEmONC (including cesarean section and blood transfusion) and services for small and sick newborns. Functional referral to CEmONC will be performed based on national policy guidance. Timely means that patients are managed and transferred as quickly as possible.
Data source/ Agency	DGHS MIS (DHIS2) (for UzHC and district/general hospitals)
Verification Entity	IVA

Procedure	DLI periods are FY 2025, FY 2026, FY 2027, FY 2028, and FY 2029. Under DLI 7.1, the target is to develop a detailed manual on functional referral systems (SOPs, readiness criteria training, and IT), including roles and responsibilities and reporting systems of the different facilities (UzHC and district/general hospitals) are delineated. DLI 7.2 is a scalable target on the number of UzHCs whose staff are oriented and trained on functional and timely referral based on national guidelines, and 80 UzHCs are ready to provide these referral services between FY 2025 and FY 2029. At the end of the CY, data will be collected from DGHS MIS (DHIS2) in Sylhet and Chattogram divisions. The DLI 7.3 is a scalable target on the number of UzHCs performing timely referral based on national guidelines, and 30 UzHCs are performing from FY 2026 to FY 2029. At the end the CY, data will be collected from DGHS MIS (DHIS2) in Sylhet and Chattogram divisions. The full amount will be disbursed on the CY target achievements. In the case of less achievement, the disbursement will be proportional.
DLI 8 **DLI 8.1**	**DLI 8 Improved access to essential NCD drugs in primary health care level (Upazila)** **DLI 8.1 Primary health care facilities (UzHC) with uninterrupted drug supply of essential NCD drugs (number)**
Description	Currently regular supply of essential NCD drugs at the PHC facilities (UzHCs) is lacking, and stock-out of essential NCD drugs is high. This DLI is to support the establishment of a continuous supply of NCD drugs at public PHC-level facilities such as UzHCs to overcome the current high OOP expenses for clients. Types of NCD to be covered are diabetes type 2 and hypertension. Drugs to be included: metformin, amlodipine, losartan, chlorothiazide, and gliclazide.
Data source/ Agency	DGHS (DHIS2) and logistics management system
Procedure	DLI periods are FY 2025, FY 2026, FY 2027, FY 2028, and FY 2029. For DLI 8, the target is 100 UzHCs in Sylhet and Chattogram where there is no stock-out of essential NCD medicines—at least 1 medicine for type 2 diabetes (metformin and gliclazide) and at least 1 medicine for hypertension (amlodipine, losartan, and chlorothiazide) in the last six months of the previous CY. At the end each CY, data will be collected from DGHS (DHIS2) and logistics management system in Sylhet and Chattogram divisions. This is a scalable DLI.
DLI 9 **DLI 9.1** **DLI 9.2**	**DLI 9 Strengthening grievance redressal system** **DLI 9.1: Grievance redressal guideline developed for Directorate General of Family Planning (DGFP) facilities reported through Annual GRS performance report in the last two years** **DLI 9.2 Recorded grievances resolved in Directorate General of Health Services (DGHS) only (percentage)**

Description	GRS includes receiving, responding to, and addressing grievances from beneficiaries. This DLI reflects further development of the MoHFW's GRS for both the DGHS and DGFP so that grievance can be tracked, its corresponding response(s), and time taken for the response(s). For the 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 (DLI 9.1). For DGHS, it will further strengthen the GRS running under the MIS of DGHS (DLI 9.2). The results will include percentage of valid complaints resolved by the DGHS among valid complaints received in the system throughout the project period. The term resolved means 'feedback is resolved while investigating', and this excludes the number of valid complaints that were forwarded or closed.
Data source/ Agency	DGFP MIS and DGHS MIS (DHIS2)
Verification Entity	IVA
Procedure	DLI periods are FY 2025, FY 2026, FY 2027, FY 2028, and FY 2029. For FY 2025, the target under DLI 9.1 is to develop and approve Grievance Redress Guidelines by the DGFP. The GRS guidelines will be developed and approved and staff orientation completed by the DGFP. In parallel, the additional targets under DLI 9.1 include the annual reporting of GRS performance for the previous CY published by the DGFP in FY 2028 and FY 2029. For DLI 9, disbursements will be made once the grievance redressal guideline is developed and then separately for each annual GRS performance report. Under DLI 9.2, the target for FY 2025 to resolve valid recorded complaints received in GRS is 5 percent, in FY 2026 is 7 percent, in FY 2027 is 10 percent, and in FY 2028 is 15 percent of valid complaints by the MIS unit of the DGHS through DLI 9.2. This is a scalable DLI, and the amount will be disbursed on the basis of each 1 percent resolve. The full amount will be disbursed on the CY target achievements. In the case of less achievement, the disbursement will be proportional.
DLI 10 **DLI 10.1** **DLI 10.2**	**DLI 10 Strengthening the resilience of the Upazila-level health system to address public health emergencies brought on by climate change** **DLI 10.1 Primary health care facilities (UzHC) develop contingency plans to the satisfaction of the Association based on climate vulnerabilities, capacities, and needs (number)** **DLI 10.2 Primary health care facilities (UzHC) have sufficient number of health care workers trained on Climate and Health (number)**

Description	This DLI focuses on enhancing the preparedness of UzHCs to be prepared for and effectively manage climate-driven health risks and emergencies. The activities to achieve in this DLI will include developing health facility (UzHC) contingency plans based on local climate 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 UzHCs who have been trained on how to detect and respond to climate-driven health risks identified during the assessment which includes at least dengue, malaria, heat, and salinity.
Data source/ Agency	DGHS (DHIS2)
Verification Entity	IVA
Procedure	DLI periods are FY 2025, FY 2026, FY 2027, FY 2028, and FY 2029. The target for DLI 10.1 is to develop the contingency plans based on local climate vulnerabilities, capacities, and needs in 30 UzHCs in Sylhet and Chattogram divisions from FY 2025. Contingency plans should include as a minimum consideration of *upazila* climate and health vulnerability and local procedures for maintenance of essential services during climate-related health emergencies. This is a scalable DLI. The full amount will be disbursed on the CY target achievements. In the case of less achievement, the disbursement will be proportional. For FY 2027, the target for DLI 10.2 is to have sufficient number (at least 4) of health professionals (doctors, nurses, and midwives) trained in climate and health in 30 UzHCs. This is also a scalable DLI.

ANNEX 3. SUMMARY TECHNICAL ASSESSMENT

A. Strategic Relevance of the Program

1. **Achieving the PDO (To improve access and utilization of quality health and nutrition services and build health system resilience in select geographical areas) will require a wide range of interventions and policy shifts.** The Program's interventions under each RA are based on an analysis of the local context, health indicators, the gaps in the state's health service delivery system, and international and national best practices.

2. **Several indicators point to the unfinished agenda for women and children.** While some districts of the two divisions (Sylhet and Chattogram) perform well for indicators related to first antenatal visits and immunization, a substantial proportion of women do not return for subsequent antenatal visits and still deliver at home. The national institutional delivery rate overall is 65 percent and substantially lower among the poorest quintile at 42 percent. In the Program areas, institutional delivery is lower: Chattogram (61 percent) and Sylhet (52 percent). Maternal malnutrition remains a major issue, with a high prevalence of anemia contributing to the large burden of low birth weight and small for gestational age newborns. At the same time, a growing burden of NCDs exacerbates adult morbidity and OOP expenditures. All these trends highlight gaps in health system quality and the organization of services.

3. **The divisions of Sylhet and Chattogram are highly prone to climate change health effects,** including extreme heat stress, waterborne and foodborne diseases, allergies, mental and cardiopulmonary diseases, and so on. Climate change also puts additional strain on the health system and amplifies risks and poor outcomes across multiple other disease conditions. Thus, climate change acts as a risk multiplier to the multiple factors contributing to the lagging district indicators in the divisions of Sylhet and Chattogram: geographical access issues and inadequate quality of maternal, newborn, and NCD health services at the PHC level**.**

4. **Further investments in providing more inputs are necessary but not sufficient.** Several health system bottlenecks directly affect the quality of care for women, newborns, and clients affected by NCDs, which require reorganization and policy shifts. Currently, at the PHC level, midwives are not deployed to conduct births at the union-level health facilities; referral networks are weak for women and newborns who experience complications; and essential NCD medicines are not being dispensed at public PHC community clinics, necessitating OOP spending on drugs. The activities under the three RAs will help address these deficiencies.

B. Technical Soundness by RAs

RA1 Enhancing access and utilization of health and nutrition services that are climate responsive

5. The Program will support the GoB's plan to expand quality health and nutrition services to address the unfinished agenda of maternal, child health, and nutrition and emerging challenges of NCDs through strengthening maternal, immunization, family planning, nutrition, and NCD services. RA1 is critical because, despite Bangladesh's remarkable progress in health outcomes in recent decades, the country is still off-track to meeting the health SDGs, including maternal and neonatal mortality.[27]

- **Maternal deaths in Bangladesh show a large equity gap, more likely to occur in women who are poor, with no education, and those living in rural areas.** High-quality care before, during, and after childbirth would

[27] Maternal Mortality Estimation Inter-Agency Group (WHO, UNICEF, United Nations Population Fund, and World Bank) 2022.

prevent most deaths. Currently, 59 percent of women in Bangladesh do not have the recommended four antenatal visits during their pregnancy (63 percent in Chattogram, 70 percent in Sylhet), 35 percent continue to give birth at home (Chattogram 39 percent, Sylhet 48 percent), and less than half receive a timely postnatal visit. Four ANC visits frequency has declined in Bangladesh over the last five years from 46 percent in 2017 to 41 percent in 2022 with only an estimated 21 percent receiving higher-quality ANC services (21 percent in Chattogram and 14 percent in Sylhet) using a composite measure of four or more visits, one with a medically trained provider, and measurement of blood pressure and weight, urine test, and counseling about pregnancy danger signs (2017/18 BDHS). Home birth is preferred for reasons that include not seeing the importance or value of a facility birth, cost, fear of cesarean section, and lack of family/husband permission. When women do seek maternal health care, facilities are often unable to deliver quality services, further discouraging utilization. Among maternal deaths recorded in the 2016 BDHS, 85 percent were among women who sought care from a health facility before they died. One-third of these women stopped in three or more facilities, never receiving the care they needed to survive. For example, despite hemorrhage being the leading cause (31 percent) of maternal mortality in Bangladesh, only one-third of birth facilities can provide a blood transfusion.

- **Child and maternal nutrition in Bangladesh has improved substantially over recent decades,** with stunting prevalence among children under five years almost halving from 43 percent to 24 percent between 2004 and 2022. Partly due to the impact of the COVID-19 pandemic, however, there is some evidence of stagnation or deterioration: wasting increased to 11 percent, and underweight remained stagnant at 22 percent. The persistence of high prevalence of low birth weight and small for gestational age babies are critical risk factors for nutrition outcomes, including stunting and NCDs in later life. These suboptimal nutrition indicators highlight multisectoral gaps, including coverage and quality of health services across the continuum of care. This program aims to accelerate the integration of MMS into PHC ANC programs, including at community clinics. MMS is an evidence-based intervention that effectively enhances maternal nutrition, reduces adverse outcomes, and fosters overall health during and after pregnancy. Moreover, compared to traditional iron and folic acid (IFA) supplements, MMS during pregnancy has been shown to have significant positive effects on perinatal health outcomes and fetal and child growth, including lower rates of stillbirth, low birth weight, and small for gestational age live births. Transitioning from IFA to MMS will yield substantial maternal and newborn health benefits including a significant return on investment in terms of disability-adjusted life years averted. Overall, integrating MMS into ANC programs at scale represents a critical strategy for improving Bangladesh's maternal and child health outcomes.
- **Overall, Bangladesh has seen a substantial decline in fertility to a level just above replacement level, but it has not declined further over the past decade.** The CPR rose rapidly in Bangladesh but has now stagnated nationally with high subnational variations and lower levels in the divisions of Sylhet and Chattogram, which are the Program's focus areas. CPR among adolescent married women is much lower than the national CPR. The unchanged level of fertility, despite a rapid increase in the level of contraceptive prevalence, has both demand- and supply-side contributing factors. On the demand side, these include high rates of child marriage, with 51 percent of women married before the age of 18 years; reliance on short-acting methods of contraception with low uptake of longer-acting methods of contraception which contribute to higher discontinuation/pause rates and user-failure—short-acting methods condoms (45 percent) and oral contraceptive pills (42 percent), compared to longer-acting methods injectables (34 percent), implants (11 percent), and IUD (0.6 percent).
- **The health system in Bangladesh is struggling to manage the rising prevalence of NCDs.** Among adults ages 18 years and older living with hypertension, 58 percent are undiagnosed, 63 percent are untreated, and 87

percent have uncontrolled hypertension (2017–2018). Similar breakpoints exist in the cascade of care for diabetes. Among approximately 11.4 million adults ages 18 and older living with diabetes in 2017, 60 percent were undiagnosed, 63 percent were untreated, and 87 percent had uncontrolled diabetes. Major breakpoints in the cascades of care highlight system-wide shortcomings, particularly weak primary care capacity for screening and adherence support, inadequate coordination, and poor continuity of care. Overall, NCD services in Bangladesh suffer from limited availability and high fragmentation, without a systematic, comprehensive approach to care. A patient pathways analysis for urban Bangladesh found that people living with major NCDs commonly access diagnosis and initial treatment services at secondary and tertiary levels of the health system rather than at the public sector PHC facilities, while private pharmacies serve as the primary source of care for maintaining treatment after diagnosis. These findings suggest failures in the public primary care system to screen and identify new cases and provide long-term treatment and monitoring. Instead, people living with NCDs are either forgoing care, leading to poor outcomes, or bypassing the primary level to seek services from higher-level public hospitals or private providers, leading to health sector inefficiencies and high out-of-pocket expenditures.

RA2 Health system strengthening, responsive to the evolving needs of the population

6. The program will support the GoB's initiatives to accelerate the transformation of components of the health system to deliver effective health services through human resources availability, a functioning referral system, and supply chain management.

- **Bangladesh has significantly fewer midwives in the health system and a higher reliance on medical doctors than recommended.** The population cesarean section rate has risen dramatically and at 45 percent far exceeds global recommendations. This is in part due to the high utilization of the private sector for childbirth, where nearly 80 percent of women give birth via cesarean section. In the Bangladesh context of weak private sector regulatory capacity, increasing the availability and quality of public sector health services has the potential to improve the quality of antenatal, intrapartum, and postnatal care for women and newborns. Supporting evidence-based labor and delivery care in public health facilities with an interprofessional team, including midwives, is critical to addressing the fear of more vulnerable women who give birth at home to avoid Caesarian section. Over the last decade, Bangladesh has made huge progress in reversing the current situation of over-medicalization, including caesarian section. Midwives are needed at all levels of health facilities, and this Program will focus on strengthening midwifery care at the foundation of the health system—PHC with strong referral links to secondary and tertiary care.
- **The referral system between levels of care in the public health system is weak.** When complications arise, a well-functioning referral system is a critical domain of high-quality care for women and newborns. The rapid transfer to a level of the health system capable of providing definitive care is critical to ending preventable maternal and newborn mortality and stillbirth. In Bangladesh, although the physical infrastructure of primary, secondary, and tertiary health facilities exists across the country, there is a gap in the functioning of an effective care network. Referral patterns tend toward over-referring without stabilization (too much too soon), driven by fear of consequences of adverse outcomes, and under-referral (too little too late), driven by the reluctance of rural communities to move, especially at night. The ambulance service only functions intermittently, necessitating families to rely on private vehicles or bicycle-cart, disadvantaging more vulnerable families due to OOP costs. The divisions of Sylhet and Chattogram also include some of the most challenging geographical access in Bangladesh, further impeding effective referral. This Program will invest in expanding referral coverage especially for the target division's underserved rural areas.

- **Consistent availability of medications and convenience of medication refill are a critical part of long-term care for NCDs.** However, an irregular supply of medications at public primary health care facilities and the high cost of medicines from drug outlets pose critical challenges, escalating OOP spending and exacerbating financial burdens on families. An important aspect of the Program is the provision of selected NCD medicines from primary-level public health facilities, ensuring uninterrupted availability. By ensuring the free dispensing of these medicines and the Government's up-front payment (that is, transferring the payment burden from users to the Government), the Program aims to reduce individuals' OOP spending. Stable patients should be supported with ideally multi-month repeat prescriptions. Decentralized, community-based dispensing and/or distribution of essential drugs for NCD patients can be effective options to improve access, reduce patients' opportunity costs, and increase treatment adherence. Based on a successful piloting of the distribution of essential NCD drugs from community clinics in Sylhet division (85 community clinics currently provide refill of NCD drugs for stable patients), the Government intends to scale up to 1,000 community clinics by June 2029. Additionally, through two other DLIs focusing on vaccination (DLI 2) and family planning (DLI 3), the Program enhances service coverage, implying that more people can avail these services from public health care facilities and thereby indirectly (through these two DLIs) contributing to reduced financial burdens (which, if bought from NGOs or private facilities, would incur costs to users—especially for long-acting family planning methods). The PforR program is expected to be crucial in minimizing OOP spending on medicines or vaccines, offering cost-effective interventions that promote sustainability, reduce morbidity, and improve overall quality of life.
- **A strong GRM is critical for accountability.** Receiving, responding to, and addressing grievances from beneficiaries is generally well functioning in the DGHS health facilities. However, there is scope to strengthen further and broaden the DGHS system and expand to cover the DGFP facilities where the system is not in place. For initiation of GRM in DGFP facilities, an SOP/Operating Manual will be prepared and approved; capacity building of staff will be conducted; the GRM system will be integrated into the MIS of the DGFP for reporting grievances including receiving, responding, and addressing separately for each facility; and the system will be rolled out.

RA3 Building resilient health systems to prepare and respond to climate change

7. This will support the GoB's agenda to protect its large risk-prone population, ranking it among the top 10 countries in the world. Despite the disaster preparedness progress made in recent decades, the country has been lagging in adopting a holistic and multisector approach to mainstreaming climate change adaptation by developing adequate institutional capacity and manpower.

- **The Program will incentivize several activities to strengthen the climate resilience of the health system.** Following the assessment of climate change, health vulnerability, and the health system's capacity at the *upazila* level, *upazilas* will be supported in developing contingency plans based on identified climate vulnerabilities and gaps and other available evidence. The capacity of health care workers at UzHCs on how to detect and respond to climate-driven health risks, as identified through the assessment, will also be critical.

C. Expenditure Framework

8. The total budget over the five-year period of the Government's 5th HPNSP is estimated to be US$9.65 billion. The proposed Program would support the Government program with an estimated PforR Program boundary of US$900 million

for five years during 2024–29. The GoB will support the expenditure framework through the annual development budget executed by the MoHFW, which includes the HSD and the ME&FWD.

9. The proposed PforR is a well-defined subset of the Government program, covering two of the eight administrative divisions—Chattogram and Sylhet. Funding for the PforR operation includes (a) US$379 million in IDA credit, and (b) US$25 million second round grant from the GFF. The scale of the Program aligns with the anticipated outcomes of improved and equitable maternal and child health, including coverage and quality of PHC services and maternal nutritional services and building resilient health systems to respond to climate change within Chattogram and Sylhet divisions. The program will be supported by the selected eight operational plans. The eight operational plans in the PforR are among the highest-spending plans in the MoHFW. The operational plans are listed in Table 3.1:

Table 3.1. Alignment between the Government's program and RAs

Government's Operational Plans	Program RAs
Maternal, Neonatal and Child Health Care (MNCH)	RA1 and RA2
Maternal, Child, Reproductive and Adolescent Health (MCRAH)	RA1 and RA2
Clinical Contraception Service Delivery Program (CCSDP)	RA1
Family Planning – Field Service Delivery (FP-FSD)	RA1 and RA2
Community-Based Health Care (CBHC)	RA1 and RA2
Upazila Health Care (UzHC)	RA1, RA2, and RA3
Primary Health Care (PHC)	RA1 and RA2
National Nutrition Services (NNS)	RA1
Non-Communicable Disease Control (NCDC)	RA1, RA2, and RA3

10. The PforR excludes capital expenditures such as civil works; new constructions; high-value medical equipment and health sector procurement at the Operational Procurement Review Committee level; land acquisitions; and some recurrent line items such as salary allowances, operating costs, fuel cost, capital grants, taxes, and so on, which will be funded by the Government as most of these are not eligible to be funded under the World Bank's Country Financing Parameter. The economic codes to be considered in the PforR program include vaccines, medicines, medical and surgical supplies, IUD/hormonal contraceptive implants, domestic/local training, printing and stationery, and repair and maintenance. The MoHFW budget has been growing on average 10 percent in the past five years, so the risks to the Government program arising from budgetary constraints are low.

D. Economic Justification

11. **A cost-benefit analysis of the proposed PforR Program was undertaken based on the PEF and the measurable economic benefits flowing from the successful implementation of the proposed Program.** The assumptions are based on the literature on the economic benefits (for example, reduced treatment cost or OOP and increased labor productivity) of improved health outcomes (for example, lives saved from reduced mortality of under 5 children and mothers) and Theory of Change. The PforR Program boundary is US$900 million spread over five years. The PforR would yield a net present value of benefits of US$316 million and produce an IRR of 9 percent over a 20-year period using a discount rate of 5 percent recommended for lower-middle-income countries.[28]

[28] Haacker, M., T. B. Hallett, and R. Atun. 2020. "On Discount Rates for Economic Evaluations in Global Health." *Health Policy and Planning* 35 (1): 107–114.

12. The results show that the PforR investment is justifiable. The robustness of these results is demonstrated in the sensitivity analysis that estimates a net present value of US$296 million, even with a 50 percent reduction in the benefits of the Program.

13. **Direct benefit.** Reduced OOP spending for children due to reduced morbidity from vaccine-preventable diseases and reduced OOP on medicines due to increased availability of NCD medicines at primary health care facilities are considered as the direct benefit. Per capita OOP spending and per capita OOP on medicine data were taken from the Bangladesh National Health Accounts 1997–2020.

14. **Indirect benefit.** The indirect benefits included productivity increase due to nutritional improvement among women workers, premature death, and system efficiency. The gains were calculated as increased productivity in terms of daily per capita GDP. Gains from lives saved from reduced mortality were multiplied by the value of statistical life (VSL). VSL was estimated using the 2019 guideline.[29]

Table 3.2. Summary of Key Parameters and Assumptions Used in the Analysis

Key Parameters and Assumptions	Value	Source
Discount rate	5%	Haacker, Hallett, and Atun 2020.
Annual GDP growth (real)	6.9% (2021)	Up to 2021 World Development Indicators (WDI), 2022–2028 International Monetary Fund (IMF) projection, and beyond 2028 assumed 7.2%
GDP per capita	US$1,684	Up to 2021 WDI; 2023–2028 IMF projection, and then assumed at 7.2% growth rate. Per capita GDP was estimated dividing the projected GDP by the projected population figure taken from the World Population Prospects 2022 estimates.
VSL	US$130,773	Estimated following the methodologies presented in Robinson et al. (2019)
MoHFW budget growth	5%	Assumed gradual increase up to 10% at the end of 20 years
Efficiency gain from performance-based financing	0.5%	Efficiency gains 0.5 percent for first five years from 2024, then 1 percent for the next five years, then 1.5 percent for the next five years, and 2 percent for the remaining years
Public sector contribution to under-5 children's lives saved from reduced under-5 mortality rate	80%	Assumption
Public sector contribution to maternal lives saved from reduced maternal mortality	50%	Assumption
Per capita OOP	US$54 (2020)	Bangladesh National Health Accounts 1997–2020. From 2021 forecasted based on past trends
Per capita OOP on medicines	US$23.9 (2020)	Bangladesh National Health Accounts 1997–2020. From 2021 forecasted based on past trends
Under-5 mortality	31% (2022)	BDHS. Beyond that used under-5 mortality rate projections from World Population Prospects 2022

[29] Robinson, L. A., et al. 2019. "Reference Case Guidelines for Benefit-Cost Analysis in Global Health and Development."

Key Parameters and Assumptions	Value	Source
Maternal Mortality	136 per 100,000 live births (2023) Sample Vital Registration System	Reduced then to 70 by 2030 (SDG target) and then 41 by the end of 20 years based on average MMR for upper-middle-income countries (Bangladesh aspires to achieve this status in 2041.)
Morbidity reduction among children due to vaccination	30%	Assumption
OOP spending for children	10%	Chandrasiri, J., C. Anuranga, R. Wickramasinghe, and R. P. Rannan-Eliya. 2012. *The Impact of Out-of-Pocket Expenditures on Poverty and Inequalities in Use of Maternal and Child Health Services in Bangladesh: Evidence from the HIES 2000–2010.* Country Brief. Mandaluyong City, Philippines: ADB.
Productivity of female labor force	2% (benefit accruing after the completion of the Program)	Assumption based on Scholz, B. D., R. Gross, W. Schultink, and S. Sastroamidjojo. 1997. "Anaemia Is Associated with Reduced Productivity of Women Workers Even in Less-Physically-Strenuous Tasks." *Br J Nutrition* 77 (1): 47–57.

ANNEX 4. SUMMARY FIDUCIARY SYSTEMS ASSESSMENT

1. The objective of the IFSA is to conclude whether the Program fiduciary systems provide reasonable assurance that the financing proceeds will be used for the intended purposes, with due attention to the principles of economy, efficiency, effectiveness, transparency, and accountability. The World Bank conducted an IFSA of all participating agencies within the MoHFW. The assessment integrates findings in the Program's FM, procurement, and governance aspects.

2. An extensive review of the PFM cycle (including budget planning process under Medium Term Budgetary Framework, Budget Management Committee meeting frequencies, functioning of integrated budgeting and accounting system [iBAS++], overall internal control framework within the MoHFW, audits conducted by the OCAG, and oversight functions of the Parliament's Public Accounts Committee), procurement system, and governance and anti-corruption was undertaken.

3. The IFSA findings indicate that a moderate level of fiduciary risk is associated with the Program. Nonetheless, the assessment acknowledges the MoHFW's extensive experience in implementing sector-wide programs since 1998 and highlights the strength and stature of the fiduciary systems. Notably, the MoHFW's dedicated outfit for FM indicates its robust institutional framework, complemented by a dedicated internal audit team for strengthening internal oversight.

4. In addition, with the mitigation of identified risks through DLIs and PAPs, the procurement system is assessed to be adequate to the extent the planning, bidding, evaluation, contract award, and contract administration arrangements and practices provide reasonable assurance that the Program will achieve the intended results through its procurement processes and procedures.

5. As the Program funds will use the Treasury Model, all receipts and expenditures will be channeled through the government system of budgetary allocations to the Consolidated Fund. The MoF, the main authority for the budget, releases funds for spending. The Program funds will flow to the implementing agency through the existing budget lines, broken down to the sub-detailed level by the economic classification of codes. As the MoHFW is the implementing agency, there will not be flow of funds to any other agency. The Controller General of Accounts (CGA) is the key institution for processing of payments through pre-audit. Hence, the Chief Accounts and Finance Officer of the CGA will be responsible for the preparation of government accounts for the Program. The CGA currently uses the iBAS. In the case of the excluded items from the Program boundary, these expenditures will also be recorded in the iBAS as per the respective codes.

6. The assessment indicates more robust budget planning processes within the MoHFW are needed to ensure realistic budgeting aligned with the implementation capacity on the ground. It also underscores the importance of strengthening expenditure monitoring and oversight mechanisms to optimize budget execution. While overarching PFM reforms, including the introduction of the iBAS++, have modernized processes and enhanced transparency, critical challenges persist in internal control, auditing, and human resource management. At the national level, the introduction of iBAS++ has significantly improved the quality and timeliness of government financial data and reporting. While the reconciliation of expenditure data from various sources such as Line Directors and accounting offices is no longer a major issue after iBAS++ implementation, the assessment finds that disaggregated budget data below the district level are still not readily available, affecting the quality of financial information for monitoring and decision-making at the operational levels.

7. While the overall internal control framework within the MoHFW is broadly adequate, with guidelines provided in the Treasury Rules and General Financial Rules, there are persistent weaknesses in compliance at the level of Line Directors implementing the 4th HPNSP. This is reflected in serious financial irregularities (SFIs) repeatedly flagged in audit reports.

The assessment also raises concerns about weaknesses in the management of nonfinancial assets such as equipment and infrastructure. Significant yearly allocations are being made, but adequate systems to monitor the existence and condition of these assets on the ground are lacking.

8. The audits conducted by the OCAG on the expenditure of 4th HPNSP in FY 2021–22 highlight major audit findings that raise concerns about fiduciary risks. The assessment underscores the necessity of enforcing robust internal controls and improving oversight to prevent the recurrence of financial irregularities. Mitigation measures in PAP include the resolution of unresolved SFIs identified by the OCAG. The Program audit responsibility will lie with the OCAG as per the audit rules of the GoB. The audited financial statements of the Program for each FY will be submitted to the World Bank within nine months of the close of the financial year.

9. From a legislative oversight perspective, while the Parliament's Public Accounts Committee is actively reviewing audit reports and issuing recommendations to ministries, the executive's response in implementing these recommendations remains slow. The assessment underscores the need for comprehensive capacity-building efforts.

10. The CMSD manages procurements of medical equipment and international tenders for the Directorate of Health Services and the Directorate of Family Planning. Apart from this, all procuring entities (Line Directors, hospitals, health education institutes, projects, and so on) also procure health sector goods and make other procurements. The CMSD could not achieve the status of sole procuring entity of the MoHFW. Procurement is fragmented in the MoHFW. Because of this, not only the CMSD but also other procurement entities are assessed and addressed in the report.

11. Regarding program procurements, relevant Line Directors are also the procuring entity and involve in procurements as per administration and delegation of financial powers. The respective planning wing of the ministry is coordinating all the operational plans/Line Directors.

12. Though the World Bank PforR supports the Government program on two areas, medical and surgical supplies and training and professional development, part of the World Bank finance will be used for procurements of supplies, including MMS. Procurements under the World Bank PforR Program are mainly managed by the CMSD, the Line Director of the DGHS. Hence, the procurement aspect of the health sector fiduciary system is assessed with focus on the CMSD, Line Director of the DGHS.

13. Despite the sufficient preparation and engagement of the Government in encouraging procuring agencies to use the e-GP, the health sector has still not gained momentum in using the e-GP system for their procurement. Compared to other ministries, the HSD lags in e-GP usage due to reluctance and constraints in capacity in information and communication technology operations.

14. To capture the storage and distribution of goods, the CMSD has developed Electronic Logistics Management Information System (e-LMIS) software and deployed it. However, it is not fully implemented, and 100 percent use of the system is expected by the end of the program.

15. Inadequate procurement and contract management capacity of the ministry, coupled with a lack of use of e-GP, including e-Contract Management System at all levels, had been a serious constraint. Though the public procurement system is robust in procurement management, the health sector still faces challenges in the procurement activity and supply chain mechanism due to the absence of capacity (in both manual and electronic systems). Accordingly, the health sector faces capacity gaps to assess needs appropriately; prepare estimates, tenders, and technical specifications; and procure and manage contracts.

16. There are not enough trained procurement professionals in the MoHFW to conduct procurement at different levels. Health professionals with little knowledge of procurement take on procurement responsibilities on a part-time basis. The positions should be filled by procurement professionals trained in procurement and contract management. The MoHFW urgently needs to organize training on procurement and contract management of staff who will be involved in the program implementation to build their capacity in all procuring entities in the health sector.

17. The IFSA revealed the absence of efficient monitoring of assets bought for health facilities. The health facilities should generate yearly inventory and assets reports through an asset management software.

18. The IFSA identified an inadequate complaint-handling system per the Procurement Act and Rules to redress the complaints and integrity issues. During program implementation, the complaint-handling system at all levels of the MoHFW will be improved. To ensure the procurements are carried out in compliance with the country's Procurement Act and Rules, the ministry will conduct procurement post review annually either as part of an internal audit or independently.

19. To mitigate the identified fiduciary risks and strengthen the program's FM and procurement environments, the IFSA recommends undertaking the mitigation actions detailed in the PAP (Annex 6).

20. **Financial management.** The following are the mitigation measures in relation to FM issues:

- Tailor structured training programs to bolster the capacity of finance staff, focusing on key areas such as bookkeeping, accounting, financial regulations, and internal controls.
- Ensure recruitment and training of internal audit personnel.
- Ensure adequate coverage across all operational levels within the MoHFW and strengthen internal oversight mechanisms.
- Conduct a thorough review of the asset management system.
- This review will be followed by implementing robust measures to address shortcomings and enhance the efficiency and effectiveness of asset management practices. Dedicated task forces will be established to systematically address the significant backlog of unresolved SFIs and audit observations within a stipulated time frame.
- Convene the Budget Management Committee meeting, as per the terms of reference of the committee. This will provide a platform for stakeholders to review budget execution rates, identify potential bottlenecks, and take corrective actions as necessary. This approach will help ensure efficient utilization of allocated resources and minimize the risk of underspending or misallocating funds.
- The establishment of dedicated task forces to address unresolved SFIs and audit observations underscores the program's commitment. This will help address past deficiencies and prevent future occurrences.

21. A governance and anti-corruption assessment found that the anti-corruption measures in the health sector are inadequate. The Program recognizes potential corruption risks, and the health sector has introduced several initiatives to combat corruption. Program-specific measures to enhance accountability include the following:

- Adherence to the World Bank's ACGs
- Building of capacity and awareness of the governance and anti-corruption focal point to manage and report on corruption issues

- Stocking of PHC facilities with all the essential drugs
- Generation and publishing of regular verification reports on the supply and receipt of essential drugs
- Conduct of comprehensive training to relevant stakeholders on anti-corruption policies and measures to give life to the prioritized anti-corruption efforts
- Tracking of the number of women who received timely micronutrient supplies
- Generation and publishing of regular verification reports on micronutrient supplies and distribution.

22. Procurement-related risks identified will be mitigated through various measures, including the following:

- CMSD and Line Director of DGHS to use 100 percent e-GP
- Full implementation of e-LMIS Software ASMS-OTS for storage and distribution of CMSD-procured goods
- Organizing of training on procurement and contract management to build capacity for all procuring entities in the health sector who will be involved in the Program implementation, having procurement-trained officials posted at ministries/facilities conducting procurement, and health facilities generating yearly inventory and asset reports through asset management software
- Post procurement review carried out as part of an internal audit or independently
- The ministry to implement an efficient and effective complaint-handling mechanism consistent with the public procurement law and rules.

23. The implementation support from the World Bank task team through regular fiduciary review missions will provide valuable insights and guidance to Program stakeholders. The task forces will be tasked with developing action plans and timelines for resolution, ensuring accountability and transparency in addressing financial and procurement irregularities. These missions will be opportunities to assess progress, identify emerging risks, and provide targeted capacity-building support where needed, strengthening the program's overall fiduciary framework and ensuring compliance with international best practices.

ANNEX 5. SUMMARY ENVIRONMENTAL AND SOCIAL SYSTEMS ASSESSMENT

1. The ESSA provides a comprehensive review of relevant government systems and procedures that address environmental and social issues associated with the Program. It 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 the Program implementation.

2. As per World Bank guidance, the PforR will not support any activities that are likely to have significant adverse impacts that are sensitive, diverse, or unprecedented on the environment and/or affected people. Therefore, those activities are not eligible for financing and are excluded from the Program.

3. The PforR Program is not likely to affect any biodiversity, natural habitat, or cultural heritage. There is no civil construction, land acquisition, or displacement. The main environmental concern is likely to be the slight increase in the generation of medical waste and the lack of conditions, arrangements, and practice to dispose them properly. MWM has been previously identified as a significant challenge in the health sector in Bangladesh as highlighted in several reports and assessments. Medical waste causes 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.

4. The Program covers areas of Chattogram division where a number of small ethnic community members reside. Given their cultural, language, and socioeconomic difference from mainstream society and inaccessibility of their housing/accommodation, they may be excluded from consultation and service delivery. Further, vulnerable and disadvantaged people, including women, persons with disability, children, and people living in poverty may also face exclusion from consultation and project benefits. Throughout the Program, there will be interactions between medical health professionals, service providers, and beneficiaries (mostly women, newborns, and children) in areas that may be difficult to monitor. This may potentially give rise to SEA/SH concerns. Without adequate supervision, guidelines, and code of conduct, SEA/SH issues may occur and may not be reported. This is likely to affect the vulnerable people in the communities.

5. 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 the health risks of such poor practices can contribute to increased risk of infection in health care facilities.

6. However, the PforR will support the GoB in improving maternal and child HNP services in Sylhet and Chittagong (areas lagging in terms of overall health indicators), as well as strengthen the entire health systems. This will improve the health and well-being of the people in the lagging areas. Ultimately, the outcome would be a healthy generation with 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.

7. The MoHFW has extensive experience in implementing programs and projects. The 4th HPNSP was successfully implemented by the MoHFW. Further, a number of World Bank-financed IPF projects have been undertaken by the MoHFW, and the capacity of the MoHFW has been enhanced to address and manage environmental and social risks and impacts. Adequate legal provisions are in place to safeguard against adverse impacts of pollution activities (Environment Conservation Act 1995 and the Environment Conservation Rules 1997) and for the management of medical waste (Medical

Waste Rules 2008). The Department of Environment is mandated to take necessary actions for violations of the provisions of the abovementioned acts and rules. Also, health care waste management guidelines issued by the DGHS address operational procedures for handling and disposing of various 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 of medical waste. There are inadequate facilities for onsite storage of medical waste at the healthcare facilities (HCF) at all levels, and in most of the cases, there is no central disposal area where these wastes can be disposed of, and setting up a proper collection and disposal system for health care waste at the district, *upazila*, and union levels is required. Against this backdrop, it was felt that the existing MWM rule need not be changed. There was an attempt to undertake this, but it is yet to materialize.

8. Findings indicate that the legal and policy framework as well as the political commitments to gender and social inclusion have laid the foundation for 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 (for example, wage loss) while seeking care and high out-of-pocket expenditure; harmful cultural practices and stigma associated with particular services (for example, 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; and 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 several laws including the National Action Plan to Prevent Violence against Women and Children 2013–2025 and the Women and Children Repression Prevention Act, 2000, (2003) and (Amendment) Bill, 2020. The district- and *upazila*-level health facilities also have One-Stop Crisis Centers and cells to provide psychosocial, medical, and referral services.

9. The sector program to be implemented by the MoHFW needs different types of stakeholders to make the health service delivery a success. Some stakeholders would provide direct support, some would be involved in an indirect capacity, and some would be on the recipient end. The 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 the beneficiaries. Consulting with them yielded many inputs including the need for inclusive health care, management of medical waste at the facilities, and access to GRM.

10. The MoHFW maintains an online GRS that is being adapted to all programs and projects undertaken by the MoHFW. It addresses grievances, the right to information, complaints, compliments, and recommendations. The online GRS has provisions for filing complaints through web-based system, telephone number, and SMS. Further, each health care facility has a complaints box for taking complaints. The GRS is publicly available, and one can see how the complaints are being solved, including the time frame.

11. The Program ESSA presented in this assessment report identified the potential environmental and social risks and opportunities and analyzed the program's compatibility with respect to the core principles. The following recommended actions have been made for improving the social and environmental management systems, where appropriate.

Table 5.1. Recommendations/ Measures to Strengthen Environment and Social Management

Objective	Measures	Responsibility and Time Frame	Indicator
Environmental Systems Management:			
Health care waste management practice and implementation strengthening	The MoHFW would establish onsite health care waste treatment/disposal facilities at the district-, *upazila*-, and union-level HCF for proper disposal of health care waste and appoint adequate technical staff for operation and maintenance of the onsite disposal facilities.	MoHFW Throughout the program implementation period	Onsite health care waste treatment/disposal facilities established and human resources assigned
	The 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 Throughout the program implementation period	Budget provision and PPE supply ensured
	The MoHFW would complete the revision of the MWM Rules 2008 for better health care waste management in the country.	MoHFW 18 months from effectiveness	MWM Rules 2008 revised
	Ensure proper record keeping, assigning a focal person for supervision of MWM activities and constructing burial pits for sharps and infectious wastes.	MoHFW 6 months from effectiveness	Focal person assigned and record-keeping system established
	Monitoring and biannual reporting on the implementation of MWM, particularly focused on the *upazila* and union health complex	MoHFW 6 months from effectiveness	Reporting system developed and reports generated
Budget provision	Allocate sufficient budget at *upazila* and union health facilities to manage health care wastes for capacity development, operation and maintenance, and manpower assignment.	MoHFW 6 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 for essential services to reach hard-to-reach areas, the 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 meetings and number of people reached
	Carry out information, education, and communication campaigns to raise awareness about health issues and the service availability to ensure marginalized people are willing to and have access to health services.	DGFP and DGHS Continuous	Number of consultation meetings and number of people reached
SEA/SH risk mitigation	Develop awareness-raising media material (posters and leaflets) and distribute/display in all tiers of health facilities.	DGFP and DGHS 6 months from effectiveness	Media material developed

Objective	Measures	Responsibility and Time Frame	Indicator
	Dedicate/connect to national SEA/SH Helpline and provide a telephone number, SMS, and email to raise SEA/SH issues.	DGFP and DGHS 6 months from effectiveness	Helpline established
	Train dedicated manpower in health facilities to deal with SEA/SH cases. Develop Code of Conduct for all health facility workers.	DGFP and DGHS 6 months from effectiveness	Manpower selected and trained; code of conduct developed
Strengthening GRM	DLI 10, which focuses on strengthening the GRM of the MoHFW, to be made accessible to all beneficiaries. Raise awareness among the communities about the existence of such a system at the community level.	DGFP and DGHS 6 months from effectiveness	GRM established and promulgated
	Develop and promulgate the GRM Manual to all health sector staff assigned to receive and manage grievances.	DGFP and DGHS 6 months from effectiveness	GRM Manual developed

ANNEX 6. PROGRAM ACTION PLAN

Action Description	Source	DLI#	Responsibility	Timing		Completion Measurement
Training programs will be organised for FM staff at Financial Management and Audit Unit (FMAU) and LD's office to strengthen capacity on accounting functions to enable them to produce financial reports efficiently	Fiduciary Systems	NA	FMAU of HSD	Other	Within first three years of program implementation	Training programs to be organized and communicated to the Bank during the program implementation support mission.
FMAU conduct internal audit through the newly recruited professionals and provide report to Audit Committee. Capacity building of the FM staff to be included	Fiduciary Systems	NA	FMAU of HSD	Recurrent	Continuous	Internal audit to be conducted and report to be shared with the Bank.
Current asset management system will be reviewed to identify the loopholes. Support will be provided to plug the identified loopholes.	Fiduciary Systems	NA	HSD and DGHS	Other	Within the first two year of program implementation.	Asset management system to be deemed adequate.
A stock-take of the unresolved serious financial irregularities (SFIs) will be carried out. FMAU-HSD and	Fiduciary Systems	NA	FMAU of HSD and ME&FWD	Recurrent	Semi-Annually	Notified through the FM task group meeting.

FMAU-ME&FWD will take up the task to resolve SFIs as per requirement.						
Execution of the Budget Implementation Plan (BIP) will be followed up by the Budget Management Committee (BMC), OPIC, OPSC and ADP review committee meetings. These meetings will be held regularly.	Other	NA	HSD and ME&FWD	Recurrent	Continuous	Meeting minutes to be shared with the Bank team during the program implementation support mission.
Use of available e-procurement facility by Line Directors of DGHS and DGFP	Fiduciary Systems	NA	DGHS and DGFP	Recurrent	Yearly	Adequate use of e-gp. Data to be shared with the World Bank using denominator as 50% of the total Procurement Value. Targets for each year are 40%, 50%, 60%, 80% and 100% by end of the five year.
Review and implement the e-LMIS Software ASMS-OTS for Storage and distribution of CMSD procure goods	Fiduciary Systems	NA	DGHS and Hospital Wing of HSD	Other	Review and implement E-LMIS with the aim to cover progressively to reach 100% by end of program implementation	To be reported during the program implementation support mission.
Organizing trainings on procurement to	Fiduciary Systems	NA	FMAU of HSD, DGHS and DGFP	Recurrent	Continuous	Trainings to be organized through the program

build capacity for all procuring entities (PEs) in the health sector who will be involved in the program implementation						implementation period. At least 20 staff per year will be trained on procurement and contract management. Updates will be shared during the program implementation support mission
Generate yearly inventory and assets report by district hospitals through asset management software	Fiduciary Systems	NA	FMAU of HSD	Recurrent	Continuous	Report to be shared with the Bank during the implementation support mission.
Post procurement Review, including procurement performance to be done by the internal audit unit of FMAU, HSD	Fiduciary Systems	NA	FMAU of HSD	Recurrent	Yearly	Review to be completed and notified to the Bank team
The Health Sector will ensure an efficient and effective complaint handling mechanism consistent with the public procurement laws and rules	Fiduciary Systems	NA	FMAU of HSD and ME&FWD	Other	Within the first two years of program implementation	Efficient and effective complaint handling mechanism to be established and notified to the Bank team.
Proportion of health facilities (District Hospitals) generating yearly inventory and assets report through asset	Other	NA	HSD	Other	Within the first two years of program implementation	This will need to be notified to the Bank team during the program implementation support mission.

management software						
Primary health care facilities (UzHC) with uninterrupted drug supply of essential NCD drugs	Other	NA	DGHS	Other	Up to 100 UzHC in 5 year	The results will need to be reported and verified by IMED
Newly registered pregnant women receiving MMS during any antenatal care visits at the community clinics in Sylhet and Chattogram divisions, reported for the previous calendar year	Other	NA	DGHS	Other	Targets will need to be achieved within theprogram implementation period	The achievement reports will need to be reported and verified by IMED
Recorded grievances resolved in Directorate General of Health Services (DGHS) only	Other	NA	DGHS	Other	Targets will need to achieved within the program implementation period	The achievement reports will need to be reported and verified by IMED.
MoHFW would establish onsite health care waste treatment/disposal facilities at the district (district hospitals), upazila (UzHC) and at the union level (UH&FWC) health care facilities for proper disposal of health care waste.	Other	NA	MoHFW	Recurrent	Continuous	Will need to be reported during the program implementation support mission
Semi-annual coordination meetings of DGHS and DGFP to	Other	NA	DGHS and DGFP	Recurrent	Continuous	Meeting minutes to be issued including status of agreed actions

review the progress on priority Reproductive Maternal Newborn Child Adolescent Health (RMNCAH) and Nutrition indicators and identify key actions to improve RMNCAH-N outcomes.						