Document of

The World Bank

Report No: PAD2355

INTERNATIONAL DEVELOPMENT ASSOCIATION

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED CREDIT

IN THE AMOUNT OF SDR361.2 MILLION
(US$500 MILLION EQUIVALENT)

AND A

GRANT

IN THE AMOUNT OF US$15 MILLION

TO THE

PEOPLE'S REPUBLIC OF BANGLADESH

FOR A

BANGLADESH HEALTH SECTOR SUPPORT PROJECT

July 7, 2017

Health, Nutrition and Population Global Practice
South Asia Region

CURRENCY EQUIVALENTS

(Exchange Rate Effective May 31, 2017)

Currency Unit =	Bangladesh Taka (BDT)
BDT 80.78 =	US$ 1.00
BDT 100 =	US$ 1.23
SDR 1.38 =	US$ 1.00
SDR 1.00 =	US$ 0.72

FISCAL YEAR
July 1 – June 30

Regional Vice President:	Annette Dixon
Country Director:	Qimiao Fan
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	E. Gail Richardson
Task Team Leaders:	Patrick M. Mullen and Kari L. Hurt

ABBREVIATIONS AND ACRONYMS

AMS	Asset Management System
CAG	Comptroller and Auditor General
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CMSD	Central Medical Stores Depot
CPF	Country Partnership Framework
CY	Calendar Year
DALY	Disability-adjusted Life Year
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DH	District Hospital
DHIS2	District Health Information System, Version 2
DLI	Disbursement-Linked Indicator
DLR	Disbursement-Linked Result
DP	Development Partner
e-GP	Electronic Government Procurement
EMF	Environment Management Framework
FAP	Fiduciary Action Plan
FMAU	Financial Management and Audit Unit
FTPP	Framework for Tribal People's Plan
FY	Fiscal Year
GDP	Gross Domestic Product
GFF	Global Financing Facility
GRS	Grievance Redress System
HED	Health Engineering Department
HIES	Household Income and Expenditure Survey
HNP	Health, Nutrition and Population
HS	Health Services
HSDP	Health Sector Development Program
HSSP	Health Sector Support Project
IDA	International Development Association
IFA	Integrated Fiduciary Assessment
IMED	Implementation Monitoring and Evaluation Division
IPF	Investment Project Financing
IUFR	Interim Unaudited Financial Report
MCWC	Maternal and Child Welfare Center
MDG	Millennium Development Goal
ME&FW	Medical Education and Family Welfare
MIS	Management Information System

MOF	Ministry of Finance
MOHFW	Ministry of Health and Family Welfare
MOPA	Ministry of Public Administration
MWM	Medical Waste Management
NCD	Non-communicable Disease
NCT	National Competitive Tender
NNS	National Nutrition Services
NHA	National Health Accounts
NGO	Nongovernmental Organization
OOP	Out of Pocket Expenses
OP	Operational Plans
PDO	Project Development Objective
PIP	Program Implementation Plan
PMMU	Program Management and Monitoring Unit
PPFP	Postpartum Family Planning
SDG	Sustainable Development Goal
SIP	Strategic Investment Plan
SMF	Social Management Framework
SWAp	Sector-wide Approach
TPP	Tribal People's Plan
UHC	*Upazila* Health Complex
UHFWC	Union Health and Family Welfare Center
UNICEF	United Nations Children's Fund
WB	World Bank
WHO	World Health Organization

BASIC INFORMATION

Is this a regionally tagged project?	Country(ies)	Financing Instrument
No		Investment Project Financing

[ ] Situations of Urgent Need of Assistance or Capacity Constraints

[ ] Financial Intermediaries

[ ] Series of Projects

Approval Date	Closing Date	Environmental Assessment Category
28-Jul-2017	31-Dec-2022	B - Partial Assessment

Bank/IFC Collaboration
No

Proposed Development Objective(s)

The Project Development Objective (PDO) is to strengthen the health, nutrition and population (HNP) sector's core management systems and delivery of essential HNP services with a focus on selected geographical areas.

Components

Component Name	Cost (US$, millions)
Component 1. Governance and Stewardship	175.00
Component 2. Health, Nutrition and Population Systems Strengthening	369.50
Component 3. Provision of Quality Health, Nutrition and Population Services	555.50

Organizations

Borrower : People's Republic of Bangladesh

Implementing Agency : Ministry of Health and Family Welfare

PROJECT FINANCING DATA (US$, Millions)

[✓] Counterpart Funding	[ ] IBRD	[✓] IDA Credit	[ ] IDA Grant	[✓] Trust Funds	[ ] Parallel Financing

Total Project Cost:	Total Financing:	Financing Gap:
1,100.00	900.00	200.00
	Of Which Bank Financing (IBRD/IDA): 500.00	

Financing (in US$, millions)

Financing Source	Amount
Borrowing Agency	385.00
Global Financing Facility	15.00
IDA-61270	500.00
Total	**900.00**

Expected Disbursements (in US$, millions)

Fiscal Year	2018	2019	2020	2021	2022	2023
Annual	50.00	75.00	73.00	100.00	100.00	102.00
Cumulative	50.00	125.00	198.00	298.00	398.00	500.00

INSTITUTIONAL DATA

Practice Area (Lead)
Health, Nutrition & Population

Contributing Practice Areas

Governance

Climate Change and Disaster Screening

This operation has been screened for short and long-term climate change and disaster risks

Gender Tag

Does the project plan to undertake any of the following?

a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF

Yes

b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment

Yes

c. Include Indicators in results framework to monitor outcomes from actions identified in (b)

Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Substantial
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate
4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Moderate
6. Fiduciary	High
7. Environment and Social	Moderate
8. Stakeholders	Substantial
9. Other	
10. Overall	Substantial

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

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✓	
Natural Habitats OP/BP 4.04		✓
Forests OP/BP 4.36		✓
Pest Management OP 4.09		✓
Physical Cultural Resources OP/BP 4.11		✓
Indigenous Peoples OP/BP 4.10	✓	
Involuntary Resettlement OP/BP 4.12		✓
Safety of Dams OP/BP 4.37		✓
Projects on International Waterways OP/BP 7.50		✓
Projects in Disputed Areas OP/BP 7.60		✓

Legal Covenants

Sections and Description

Schedule 2, Section I.A: The Recipient shall maintain throughout the period of Project implementation a DLI Monitoring Committee: (i) coordinated by the Planning Wing of the Health Services Division of MOHFW and the Planning Branch of the Medical Education and Family Welfare Division of MOHFW, (ii) comprised of representatives from, inter alia, other departments of the aforementioned divisions, development partners and relevant Recipient's entities; and (iii) responsible for, inter alia, monitoring progress towards achievement of the DLIs, supporting line directors in implementation, and producing internal reports on DLI achievement to be submitted for verification in accordance with the Verification Protocols.

Sections and Description

Schedule 2, Section 1.C: The Recipient shall carry out the Project in accordance with its respective obligations under the Fiduciary Action Plan.

Sections and Description
Schedule 2, Section II.A: The Recipient shall monitor and evaluate the progress of the Project and prepare Project Reports on the basis of indicators acceptable to the Association. The Report shall cover the period of one fiscal year and shall be furnished to the Association not later than 90 days after the end the period covered by the report.

Sections and Description
Schedule 2, Section II.B.2: The Recipient shall prepare and furnish to the Association not later than 45 days after the end of each calendar quarter, interim unaudited financial reports for the Project covering the quarter, in form and substance satisfactory to the Association.

Sections and Description
Schedule 2, Section II.B.3: The Recipient shall have its Financial Statements audited. Each audit of the Financial Statements shall cover the period of one fiscal year of the Recipient. The audited Financial Statements for each such period shall be furnished to the Association not later than 9 months after the end of such period.

Conditions

PROJECT TEAM

Bank Staff

Name	Role	Specialization	Unit
Patrick M. Mullen	Team Leader(ADM Responsible)	Team Lead	GHN06
Kari L. Hurt	Team Leader	Team Lead	GHN19
Ishtiak Siddique	Procurement Specialist(ADM Responsible)	Procurement	GGO06
Suraiya Zannath	Financial Management Specialist	Financial Management	GGO24
Ajay Ram Dass	Team Member	Administrative Support	GHN19
Bushra Binte Alam	Team Member	Public Health	GHN19
Dinesh M. Nair	Team Member	Public Health	GHNGF
Ferdous Jahan	Team Member	Social Safeguards	GSU06
Hasib Ehsan Chowdhury	Team Member	Operations	GGO24

Iffat Mahmud	Team Member	Operations	GHN19
Iqbal Ahmed	Environmental Specialist	Environmental Safeguards	GEN06
Juan Carlos Alvarez	Counsel	Legal	LEGES
Naoko Ohno	Team Member	Adolescent Health	GHN19
Nkosinathi Vusizihlobo Mbuya	Team Member	Nutrition	GHN02
Owen K. Smith	Team Member	Health Financing	GHN06
S M Asib Nasim	Team Member	Public Health	GHNDR
Sabah Moyeen	Safeguards Specialist	Social Safeguards	GSU06
Satish Kumar Shivakumar	Team Member	Disbursements	WFALA
Shabnam Sharmin	Team Member	Administrative Support	GHNDR
Shahadat Hossain Chowdhury	Team Member	Administrative Support	SACBD
Shakil Ahmed	Team Member	Health Financing	GHN19
Son Nam Nguyen	Team Member	Public Health	GHN01
Tahmina Begum	Team Member	Health Economics	GHNDR
Tanvir Ahmed	Team Member	Environmental Safeguards	GEN06

Extended Team

Name	Title	Organization	Location

BANGLADESH
BANGLADESH HEALTH SECTOR SUPPORT PROJECT

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I. STRATEGIC CONTEXT

A. Country Context

1. Bangladesh is one of the world's most populous countries with an estimated 160 million people living in a geographical area of about 144,415 sq.-km. With per capita income of US$1,409 in 2016, it is well above the lower middle income country category threshold which it crossed in FY2014. During recent years, economic conditions improved in the country with headline inflation declining to 5.9 percent in FY16 from 7.3 percent in FY2014, while the fiscal deficit was contained at around 3.1 percent of gross domestic product (GDP) in FY2016. The FY2017 budget targets 5 percent deficit with 28.7 percent growth in expenditures. The current account surplus rose to 1.7 percent of GDP in FY2016. The GDP grew well above the average for developing countries in recent years, averaging 6.5 percent since 2010, with an officially reported growth of 7.1 percent in in FY2016, driven by manufacturing and services. Progress on reducing extreme poverty and boosting shared prosperity through human development and employment generation has continued with the poverty incidence based on the international US$1.90 per capita per day poverty line (measured on the basis of the Purchasing Power Parity exchange rate) declining from 44.2 percent in 1991 to a 18.5 percent in 2010 (latest available poverty data) and a projected 14.9 percent in 2016. Bangladesh's performance against the Millennium Development Goals (MDGs) is impressive. Between 2000 and 2014, the under-five mortality rate declined from 94 to 46 per 1,000 live births, while the maternal mortality ratio decreased from 399 to 176 per 100,000 live births. Child undernutrition also declined but at a slower rate, as 36 percent of under-five children were stunted in 2014, compared to 51 percent in 2000. Inequalities persist, as for example, 49 percent of under-five children were found stunted among the lowest quintile of socioeconomic status (NIPORT, Mitra and Associates, and ICF International 2016; WHO *et al*. 2015). Such progress notwithstanding, the country needs more effort in improving its growth rate to meet its goal of achieving upper middle income status by 2021. For accelerating private sector-led growth with improved investment climate, the key challenges are the need for increased infrastructure and power, with much improved quality in spending public resources, better regulations and enhanced skills of its vast and rapidly increasing labor force.

2. Bangladesh has embraced the Sustainable Development Goals (SDGs) for 2030, including SDG 3, which focuses on ensuring health and promoting well-being. A specific SDG objective is to achieve universal health coverage, which encompasses assuring access to HNP services without causing financial hardship (Government of Bangladesh 2015b).

B. Sectoral and Institutional Context

3. The HNP service delivery system in Bangladesh is composed of community-level and facility-based services delivered by the government, non-governmental organizations (NGOs), and private for-profit providers. This pluralism is thought to have contributed to Bangladesh's successes in improving HNP outcomes (Ahmed *et al*. 2013). Each part of the system has largely distinct sources of financing: private providers are mostly financed by household out-of-pocket payments (OOP), NGO providers are supported by international funding as well as OOP, and government services depend on the government budget, including on-budget international financing. The government retains its overall stewardship role, particularly through monitoring and evaluation of outcomes and service delivery indicators.

4. At the same time, government financing and attention are largely focused on the government service delivery system, encompassing around 225,000 staff, 18,000 primary health care facilities, 430 local-level (*Upazila*) facilities offering inpatient care, and 130 secondary and tertiary hospitals across the country. The Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP) under the Ministry of Health and Family Welfare (MOHFW) are each responsible for different types of services and facilities, sometimes leading to fragmented management of the system. While the MOHFW is primarily responsible for HNP services in rural areas, government services in urban areas are coordinated by the Ministry of Local Government, Rural Development, and Cooperatives along with the MOHFW.

5. The government and development partners, including the World Bank, have supported the government's health sector through a sector-wide approach (SWAp) since 1998, adopting a series of multiyear strategies, programs, and budgets (1998–2003, 2003–2011, and 2011–2016) for management and development of the sector, supported by both domestic and international financing. In fact, the World Bank has been a partner to the Government of Bangladesh in support of the health sector since 1975 and has supported the Bangladesh SWAp since 1998 through three investment financing operations. The most recent, the Health Sector Development Program (HSDP) (P118708), with a total International Development Association (IDA) commitment of US$508 million, supported the government's third sector program (2011–2016). These operations have also provided platforms for significant pooled co-financing by other development partners; under the HSDP, this totaled US$365 million. During the implementation of the HSDP, several fiduciary governance risks such as poor application of procurement procedures and insufficient financial management controls were documented. In response to this, with the support of the MOHFW in 2015, the World Bank undertook an Integrated Fiduciary Assessment (IFA) of the sector program in close coordination with the other development parnters contributing to the pooled funds. The result was an agreed Action Plan to strengthen fiduciary oversight and systems, with steps through the end of 2017. Implementation of the IFA Action Plan was supported by additional financing to the HSDP, approved in June 2016 in the amount of US$150 million, which linked disbursement to achievement of the agreed actions. The HSDP, which will successfully close in June 2017, has supported substantial achievement of the IFA Action Plan. The government's next sector program and the World Bank's proposed support builds on this momentum by incentivizing the completion of institutional reforms and the roll out of systems that will strengthen internal controls and continue to support strengthening of fiduciary management systems.

6. The government's Fourth Health, Population and Nutrition Sector Program is a national program that covers the 5.5 years between January 2017 and June 2022 and is estimated to cost US$14.7 billion. The program's objectives, results framework, and approach are described in a Strategic Investment Plan (SIP) that was developed on the basis of wide consultation of stakeholders and approved in April 2016 (Government of Bangladesh 2016a). The SIP is operationalized by a Program Implementation Plan (PIP), approved in March 2017 by the Executive Committee of the National Economic Council chaired by the Prime Minister. The PIP is further detailed by 29 Operational Plans, each of which focuses on a specific technical area and describe the activities, budgets and intermediate indicators necessary to achieve the higher-level objectives of the program. The overall objective of the government's Fourth Health, Population, and Nutrition Sector Program is "to ensure that all citizens of Bangladesh enjoy health and well-being by expanding access to quality and equitable health care in a healthy and safe living environment." The MOHFW considers it as a first, foundational, program toward the achievement of the SDGs by 2030.

7. The government's Fourth Health, Population and Nutrition Sector Program will build on a successful history of the previous sector programs, with well-established planning and consultation processes as well as monitoring and coordination mechanisms. The government's program encompasses three components: (a) Governance and Stewardship, (b) HNP Systems Strengthening, and (c) Provision of Quality HNP Services.

8. As Bangladesh builds on significant progress in the HNP sector and pursues progress towards the SDGs, including the target of universal health coverage, it will face significant challenges. These can be characterized in three ways: (a) foundational financing and system development priorities, (b) the unfinished MDG agenda, and (c) emerging challenges.

Foundational Priorities

9. As Bangladesh transitions to a middle-income economy, international experience indicates that domestic public spending on health will grow while international support will diminish in importance at the same time as external financing will increasingly rely on government systems for implementation. There are a number of financing, governance, and system management challenges that need to be addressed to set the foundation for this transition and future progress towards the SDGs, including the target of universal health coverage.

10. A key foundational priority is to improve governance and accountability systems. Improving governance of the HNP sector is a priority for the government's Fourth Health, Population and Nutrition Sector Program, and includes increasing accountability through strengthening the role of citizens in the oversight of HNP services. The MOHFW currently maintains a website that captures citizens' feedback sent either by text messages or by phone. However, the sytem is not fully institutionalized nor are the feedback and the actions taken to address the feedback sufficiently analyzed or communicated back to the public.

11. Government health spending as a proportion of GDP has remained under 1 percent over the past decade. International financing accounts for about 23 percent of government health spending, but this proportion is expected to decline (Vargas *et al*. 2016). At the same time, between fiscal years 2014—15 and 2016—17, the government's allocation to the MOHFW increased from 4.3 percent to 5.1 percent of a growing national budget, leading to an increase of 37.7 percent in absolute terms. This was due in large part to a government-wide increase in public employee salaries. The 2016—17 HNP budget of about US$2.24 billion is equivalent to US$14 per capita. There is a need to improve the efficiency and allocation of government HNP spending through improvements to the planning and budgeting process, as well as funds flow and budget execution. In addition, there is considerable scope for increasing budget delegation to the service delivery level.

12. Crucial to effective utilization of public resources allocated to the sector are the core systems for management of the government service delivery system (Ahmed *et al*. 2015). These include systems and capacity for financial management, procurement, supply chain and asset management. Policy and procedural reforms, institutional restructuring, staffing, training, and use of information systems are necessary measures to improve each of these systems. Similarly, human resource management is critical to effective service delivery; challenges include poor retention in rural areas, absenteeism, and limits to accountability (El-Saharty *et al.* 2015). The government expanded its health workforce during its third

sector program, but important gaps remain, including shortages of qualified staff in hard-to-reach areas and insufficient numbers of qualified midwives and nurses. Finally, a critical oversight and management tool is the health management information system. Although there is a well-designed electronic national health information system implemented across the country, there are gaps in reporting completeness and timeliness and a need to improve the analysis and use of data.

Unfinished Agenda

13. The HNP-related MDGs were focused on maternal and child health and nutrition, as well as communicable disease control. These have long been areas of focus for the government's HNP sector programs. Strategies for reproductive health services, including family planning, as well as maternal and child health services, are well developed, and implementation can be characterized at the scale-up and consolidation stages. Publicly financed services are provided by a mix of government, NGO, and sometimes private sector providers (especially in the case of family-planning services), funded from domestic sources as well as on- and off-budget international support. The government's Fourth Health, Population and Nutrition Sector Program is grounded on the implementation of an Essential Service Package that encompasses high-impact interventions and specifies service standards for different levels of health services.

14. A number of service utilization indicators have reached high levels; for example, the proportion of one-year-old children covered with all recommended vaccinations rose from 73 percent in 2004 to 84 percent in 2014. There is a need to maintain these gains, achieve still higher levels, improve quality, and reduce inequalities. This immunization levels were only 61 percent in Sylhet division and 69 percent among the lowest socio-economic quintile countrywide. Similarly, the proportion of married women (ages 15—49 years) who currently used modern contraceptive methods increased from 47 percent in 2004 to 54 percent in 2014. Importantly, there was no difference in utilization levels between the poor and the better-off; however, regional disparities were evident, as the proportions were 47 percent in Chittagong division and 41 percent in Sylhet division (NIPORT, Mitra and Associates, and ICF International 2016).

15. At the same time, there are gaps in overall coverage of some basic services. With regard to maternal health care, the proportion of deliveries cared for in health facilities rose from 12 percent in 2004 to 37 percent in 2014, but this level is an insufficient basis to assure continuity of care from delivery to emergency obstetric care to prevent maternal mortality. Indeed, along with facility-based delivery care, referral and transport systems need to be put in place, as well as capacity for emergency obstetric care, including necessary staff. At the same time, a disturbingly large proportion (61 percent) of deliveries in health facilities (public and private) involve caesarian sections. Inequalities are also evident, as only 22.6 percent of deliveries in Sylhet division were in a health facility in 2014 (NIPORT, Mitra and Associates, and ICF International 2016).

16. Although the prevalence of child undernutrition has been declining, improvement over time has been slow (with an average annual decline of one percentage point since 2000), so that over one-third of children under the age of five (or over 6 million children) were found stunted in 2014. This proportion was 49 percent among the lowest quintile of socio-economic status and a still high 19 percent among the highest quintile (NIPORT, Mitra and Associates, and ICF International 2016).

17. Women and girls in Bangladesh face various barriers and impediments that make it difficult if not impossible for sexual and reproductive health rights to be realized. The basic issue of awareness regarding sexuality and reproductive health is considered a taboo subject for young girls. Violence against women is another major concern and a key determinant of the status of women. There is no single policy or strategy document issued by the government on sexual and reproductive health rights. The main aim of the National Population Policy 2012 is population control, with the objective of empowering women and eliminating gender discrimination and removing barriers to family planning and maternal and child health care.

Emerging Challenges

18. Preparing the ground for achieving progress toward the SDGs will include addressing a variety of challenges in the HNP sector that, if not always new, are emerging in the sense that their importance will only grow over time.

19. The health and nutrition of adolescents have not been adequately addressed to date, with a variety of repercussions for young women in particular, as well as for their children. Although the incidence of marriage at young ages is slowly decreasing, in 2014, the median age at first marriage was 16 years. This has led to high fertility in the 15—19 year age group (113 births per 1,000 women), which also contributes to higher risk of maternal mortality. Compared to overall averages, young women also experience higher infant mortality and are more likely to be under-nourished (NIPORT, Mitra and Associates, and ICF International 2016).

20. Bangladesh has experienced a rapid demographic transition through large drops over the past two decades in child mortality and fertility combined with increased life expectancy. This has been accompanied by an epidemiological transition whereby non-communicable diseases (NCDs) such as cardio-vascular disease, hypertension, diabetes and cancer, represent a growing proportion of the causes of death and disability (El-Saharty *et al.* 2013). In 2013, non-communicable diseases were estimated to cause 70 percent of deaths (IHME 2015). Primary-level services for prevention, diagnosis, and management of non-communicable diseases are currently limited.

21. At the same time, the population of Bangladesh is becoming increasingly urbanized. In 2011, although average under-five mortality was lower among the urban population than the rural population, rates among the urban poor were worse than among the rural poor (Ellis and Roberts 2016). Insufficient government or government-financed primary health care service delivery and high dependence on private sector services result in financial barriers to access for the poor.

C. Higher Level Objectives to which the Project Contributes

22. The primary focus of the World Bank's 2016–2020 Country Partnership Framework (CPF) for Bangladesh (Report No. 103723-BD) is to remove constraints to growth and competitiveness to accelerate poverty reduction. Social inclusion is one of three focus areas, because human development provides a foundation for economic growth while protection of the poor is necessary for inclusive growth. The strategy aims to consolidate HNP gains while continuing to improve equity and addressing the next generation of challenges. The CPF also emphasizes support to policy dialogue and reform, including strengthening governance and fiduciary systems. Results-based financing is specified as a mechanism to

support such next-generation work on policy and system reform, particularly in the social sectors (World Bank, 2016a). In contributing to the CPF by supporting human development and reducing inequalities, the proposed project will advance the World Bank's twin goals of ending extreme poverty by 2030 and boosting shared prosperity. Similarly, by supporting improved delivery and coverage of public HNP services, offered free of charge to the population of Bangladesh, the proposed project will contribute to the objective of universal health coverage, including the HNP Global Practice goals of ensuring access to health services and financial protection for everyone by 2030 and ensuring that, by the same year, no one is pushed into or kept in poverty by paying for health care.

23. The CPF sets out selectivity criteria for World Bank support: (a) consistency with the government's Seventh Five Year Plan, (b) support to priorities identified by the World Bank's Systematic Country Diagnostic, and (c) alignment with the World Bank's comparative advantage. First, the Government of Bangladesh's Seventh Five Year Plan (2016-2020) asserts, "The healthy population is an engine for economic growth." It aims to achieve progress towards the SDGs, including the target of universal health coverage, and sets out a number of more immediate objectives, including improving supply and utilization of a range of HNP services (Government of Bangladesh, 2015b). Second, human development figures among the 'foundational' priorities identified by the World Bank's Systematic Country Diagnostic, particularly focussed on reducing inequities in access to quality health services to improve the health of women and children. Third, the project's alignment with the World Bank's comparative advantage is discussed in the economic analysis in section VI below.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

24. The Project Development Objective (PDO) is to strengthen the health nutrition and population (HNP) sector's core management systems and delivery of essential HNP services with a focus on selected geographical areas.

B. Project Beneficiaries

25. In supporting part of the government's Fourth Health, Population and Nutrition Sector Program, including improved governance and management systems for the government health system as a whole, the proposed project will benefit, directly and indirectly, the entire 160 million population of Bangladesh. Targeted support to improved service delivery will particularly benefit the 50 million people in Sylhet and Chittagong divisions, which will contribute to reducing inequalities in HNP service delivery.

C. PDO-Level Results Indicators

26. Indicators of progress towards the two parts of the PDO are described in Table 1:

Table 1. PDO Indicators

Elements of the PDO	*PDO Indicators*
Strengthening of the HNP sector's core management systems	1. Increase in the number of Community Clinics providing complete essential data on service delivery, including gender-disaggregated (DLI 8) 2. Increase in the number of *Upazila* Health Complexes with at least 2 accredited diploma midwives (DLI 7)
Strengthening of delivery of essential HNP services, with a focus on selected geographical areas	3. Increase in the number of normal deliveries in public health facilities in Sylhet and Chittagong divisions (DLI 10) 4. Increase in the number of District Hospitals with improved capacity to provide comprehensive emergency obstetric and neonatal care (CEmONC) services in Sylhet and Chittagong divisions (DLI 11) 5. Increase in the percentage of registered children aged under 2 years receiving specified nutrition services in Sylhet and Chittagong divisions (DLI 14)

III. PROJECT DESCRIPTION

A. Project Components

27. The project's components are aligned with the three components of the government's Fourth Health, Population and Nutrition Sector Program, as described above. The results that will be supported by the project under each project component were selectively chosen through an extensive consultation process. They are designed to address key challenges, as described above, that Bangladesh faces as it pursues the SDGs: (a) foundational priorities; (b) unfinished agenda; and (c) emerging challenges.

28. The total project cost of US$1.1 billion is part of the government's sector program that will most directly contribute to the results to be supported by the project. The total project cost encompasses expenditures supported by the IDA credit, a grant from the Global Financing Facility (GFF), and anticipated pooled grant co-financing from other development partners, as well as activities to be financed entirely by the government that will contribute to the results supported by the project. A number of development partners have agreed in principle to co-finance the project, hence, the total project cost includes a financing gap to absorb these resources once formally approved. Should not all of the anticipated funds materialize, the government financing from its sector program would be mobilized given the priority of the results supported by the project. The project results are defined by disbursement-linked indicators (DLIs), achievement of which will determine disbursement of the proposed IDA credit, GFF grant, and any pooled grant co-financing. The DLIs are detailed in Annexes 1 (DLI Matrix) and 2 (DLI Verification Protocols). Further information on the project description including anticipated activities, inputs, and expenditure items comprising the total project cost is included in Annex 3.

Component 1. Governance and Stewardship

29. **Foundational priorities.** As Bangladesh transitions to a middle-income economy, there are a number of challenges that need to be addressed to set the foundation for progress toward the SDGs. This component focuses on such foundational priorities, specifically in the areas of governance and accountability, as well as on health sector financing. DLIs to be achieved under this component are listed in Table 3. A key foundational priority is to improve governance and accountability systems, including for

citizen engagement. To this end, the project will support further development of the MOHFW's system for patients and their families to communicate complaints and grievances (DLI 1). This will help ensure that the feedback loop is completed and citizens are informed of actions taken in response to their feedback. Activities will include developing guidelines and systems, training of health sector staff to contribute to the system, raising public awareness of the system, reporting back to the public on their feedback, and analyzing and adjusting the performance of the system. Actions will also include publicly disclosing information on the system, the grievances received, actions taken, and overall performance of the health system in responding.

30. In addition, as part of setting the foundation for increased government health spending in the medium term to achieve progress toward the SDGs, the project will support improvements in budget planning and allocation. The MOHFW budget comprises a number of Operational Plans that are focused on different functional areas. The Operational Plans translate the PIP into detailed activities and budgets. The proposed project will support improved budget planning to achieve project results through the Operational Plans. In addition, the project will support an increase in budget allocation and execution toward repair and maintenance to support basic service delivery as a step toward increasing delegation of budget authority to the service delivery level (DLI 2).

31. To achieve the results supported under Component 1, activities will include communication and awareness-raising, staff engagement in development and management of the citizen feedback system and executing the maintenance budget, training in budget planning and contracting, and working-level meetings between the national- and local-level authorities, particularly on the execution of repair and maintenance budgets.

Table 2. Results under Component 1 (Governance and Stewardship)

	IDA Allocations (US$, millions)
Foundational Priorities	
DLI 1. Citizen feedback system is strengthened	25.0
DLI 2. Budget planning and allocation are improved	56.0
Component 1 Total	**81.0**

Component 2. Health, Nutrition and Population Systems Strengthening

32. **Foundational priorities.** This component will focus on foundational priorities that relate to further development of core sector management systems; the DLIs to be achieved are listed in Table 3. Under this component, a major area of focus for the project will be system reform and development, including financial management, procurement, supply chain management, and asset management.

33. The project will support further development of the MOHFW's financial management capacity, specifically through improving the capacity of the Financial Management and Audit Unit (FMAU), in particular so that it can implement the internal audit function (DLI 3). Asset management will be improved through the expansion of an asset management system (AMS) at the district hospital (DH) level that is currently being piloted (DLI 4). The project will contribute to reform of the MOHFW's procurement processes through three DLIs. These will support implementation in the HNP sector of Bangladesh's government-wide electronic procurement system (DLI 5). Procurement capacity will also be developed

through advancing the restructuring of the Central Medical Stores Depot (CMSD), which manages a large proportion of the supply of essential medicines for government health services (DLI 6). In addition to being aligned with government priorities, strengthening of these systems addresses weaknesses identified by the 2015 IFA. The actions agreed as part of the DLIs represent the next steps needed to make further progress on the previous actions agreed and implemented as part of the IFA Action Plan. Further details on these links can be found in Annex 5.

34. In addition, the project will help address a critical human resource gap affecting the delivery of maternal and female-friendly HNP services. The project will support increases in the availability of qualified midwives to improve maternal care at the primary care level, specifically focusing on the posting and retention of qualified midwives at *Upazila* Health Complexes (UHCs) (DLI 7).

35. Finally, under this component, the project will support further development of the health management information system, specifically the MOHFW's District Health Information System, version 2 (DHIS2). This will include improvements in data completeness and quality. In addition, recognizing that adequate data are a prerequisite to addressing gender disparities, the project will support collection and analysis of gender-disaggregated data on HNP service delivery (DLI 8).

36. Toward the results to be achieved under Component 2, activities will include staff engagement in the development of policy and guidelines, the implementation of information systems building on the infrastructure that already exists at the facility level including staff effort toward ensuring the completeness and accuracy of the data, communications and awareness-raising, staff recruitment and retention in reorganized departments, training, operations, monitoring, and reporting.

Table 3. Results under Component 2 (Health, Nutrition and Population Systems Strengthening)

	IDA Allocations (US$, millions)
Foundational Priorities	
DLI 3. Financial management system is strengthened	51.0
DLI 4. Asset management is improved	18.2
DLI 5. Procurement process is improved using information technology	19.8
DLI 6. Institutional capacity is developed for procurement and supply management	16.0
DLI 7. Availability of midwives for maternal care is increased	45.5
DLI 8. Information system is strengthened, including gender-disaggregated data	20.0
Component 2 Total	**170.5**

Component 3. Provision of Quality Health, Nutrition and Population Services

37. **Unfinished agenda.** Bangladesh has made significant progress on the MDG agenda, but important priorities pose ongoing challenges. This component will support the government to address major elements of this unfinished agenda, with results focused on maintaining gains, achieving still higher levels, improving quality, and reducing inequalities. Relevant DLIs are listed in Table 4. Support will focus on essential services at the primary and first-referral levels for reproductive (including family planning), maternal, neonatal, child, and adolescent health and nutrition. The service delivery will follow a 'women-friendly' approach that focuses on the rights of women to have access to quality care for themselves as

individuals, and as mothers, and for their infants. The project will support improved coverage of these services, including through reducing geographic inequalities by focusing on results in Sylhet and Chittagong divisions for which key indicators are below national averages.

Table 4. Results under Component 3 (Provision of Quality Health, Nutrition and Population Services)[1]

	IDA Allocations (US$, millions)
Unfinished agenda	
DLI 9. Post-partum family planning services are improved*	32.7
DLI 10. Utilization of maternal health care services is increased*	20.6
DLI 11. Emergency obstetric care services are improved*	39.2
DLI 12. Immunization coverage and equity are enhanced*	50.0
DLI 13. Maternal nutrition services are expanded*	28.0
DLI 14. Infant and child nutrition services are expanded*	28.0
Emerging challenges	
DLI 15. School-based adolescent HNP program is developed and implemented*	25.0
DLI 16. Emerging challenges are addressed	25.0
Component 3 Total	**248.5**

Note: * Focused on Sylhet and Chittagong divisions.

38. In conjunction with system development results supported under Component 2, notably increased availability of midwives, several DLIs supported by Component 3 will reflect improvements in maternal health care, contributing to reducing the risk of maternal mortality. Specifically, Component 3 will support increased utilization of public health facilities for normal deliveries (DLI 10) as well as improved capacity of DHs to provide emergency obstetric care services (DLI 11). This component will also support improving the readiness of health facilities to provide family-planning services to married couples immediately after their child's birth (DLI 9). These DLIs will focus on service delivery improvements in Sylhet and Chittagong divisions.

39. Under this component, the project will also support maintaining high levels of immunization coverage in Sylhet and Chittagong divisions, where coverage levels fluctuate and are often below national averages (DLI 12).

40. Maternal and child nutrition has long been an area of focus for the government and partners, with the current strategy focused on developing cross-sectoral coordination while mainstreaming nutrition-related services in the routine HNP service delivery system. However, this approach has been hampered by capacity issues, including health staff workload constraints, while impact on household behaviors has been limited. This component will support improvements in nutrition services delivered through the government system, focusing on maternal nutrition interventions provided through antenatal care services (DLI 13), and on expansion of infant and child nutrition interventions through primary care services (DLI 14). The project will support effective implementation of individualized monitoring and case management through a system of individual records for registered pregnant mothers, infants, and children.

[1] In addition, US$15 million will be allocated from the GFF to results to be achieved under Component 3 (see Annex 1).

41. **Emerging challenges.** Component 3 also includes support to address several challenges that are emerging and for which government responses are currently at the stage of policy and program development. The policy basis for interventions to improve adolescent health and nutrition is currently in the initial stages of development. A strategy has been drafted, while implementation of relevant interventions (specifically a school-focused health program) is nascent. The project will support further program development and implementation (DLI 15). This will be coordinated with planned World Bank support to adolescent health and nutrition interventions delivered through secondary education services. The government's Fourth Health, Population and Nutrition Sector Program envisions the development and implementation of a strategy to address the growing challenge of non-communicable diseases. This would include behavior-change communication, surveillance, screening, diagnosis, treatment, and management. The project will support initial work in this area, with a focus on hypertension diagnosis and referral (DLI 16). Finally, the government's sector program includes work on urban health as an emerging challenge, emphasizing the need to expand access to basic health services in urban areas, both through government services and through partnerships with the NGO and private sectors. The project will support improved coordination in this area (DLI 16).

42. Toward the results to be supported under Component 3, activities will include facility-level staff recruitment and retention; staff-level engagement in development; implementation and monitoring of needs assessments; micro-plans and policy guidelines; training, supervision and support particularly from the district health office; community outreach and mobilization; awareness-raising communications; facility-level monitoring and reporting; technical support towards evaluation; and vaccines as well as investments in medical equipment, supplies, and consumables where needed.

B. Project Cost and Financing

43. The proposed operation uses the Investment Project Financing (IPF) instrument, with all disbursements under the project linked to verified achievement of results (disbursement-linked results or DLRs) under each of the DLIs. The World Bank will reimburse the government for expenditures incurred under the Fourth Health, Population and Nutrition Sector Program that are linked to the achievement of the PDO. In turn, the government will earmark the additional resources mobilized under this operation to finance its sector program through the budgets of the MOHFW's different Operational Plans. The choice to use the DLI mechanism is appropriate because the project will support the achievement of the government's priorities using a results-based approach. The Program-for-Results instrument was explored as an alternative; in the context of the government's system for budgeting external financing, the use of this instrument would have made the resources from this operation indistinguishable from other government revenues. In discussion with the government, it was determined that the transition from input-based to results-based financing in the HNP sector would have greater prospects for success if the MOHFW could specifically identify through its Operational Plans the IDA and pooled grant financing being provided on-budget through this operation. The use of the IPF instrument will allow this to be done, as the resources will be shown as 'Reimbursable Project Aid' in accordance with the government budget system. This greater visibility will enhance ownership and commitment by the MOHFW to the achievement of the results to be supported by the project.

44. The government's Fourth Health, Population and Nutrition Sector Program, covering the period 2017—22, is estimated to cost US$14.7 billion in total. The part of the government's program to which

the project will most directly contribute is estimated to cost a minimum of US$1.1 billion (the total project cost) based on an analysis of related expenditures under the previous sector program (including relevant expenditures from the government's development budget as well the recurrent cost of operating government health services to achieve the objectives). World Bank financing will be composed of an IDA credit of US$500 million equivalent and a grant of US$15 million from the GFF (TF070955). In addition, an estimated US$200 million in grant co-financing is anticipated to be contributed to the project by other development partners (Table 5). The project will reimburse up to US$515 million (or US$715 million depending on pooled co-financing from other development partners) of certain defined expenditures under the total project cost (the contribution of eligible expenditures to the project cost), based on the verified achievement of the DLIs. Government funding will contribute to project results, financing expenditures necessary to achieve project results. Further details on the activities and inputs determined to estimate the total project and the breakdown of the cost by the Eligible Expenditure Program and government financing are available in Annex 3.

45. Like previous World Bank financed operations supporting Bangladesh's health sector programs, the proposed project includes likely pooled co-financing by other development partners, anticipated to total US$200 million. Such co-financing, to be finalized during the first year of implementation, will be linked to the DLIs and results that are described in Annex 1. The specific allocation and price per DLI achieved will largely follow the same relative allocation and pricing defined under the IDA credit, although there may be a small scope for modifications depending on final agreements with the relevant development partners.

Table 5. Project Cost and Financing (US$, millions)

Project Components	*Total Project Cost*	*Government Financing*	*IDA Financing*	*GFF (Pooled with IDA)*	*Anticipated Co-financing from Other Development Partners (Pooled with IDA)*
Component 1	175.0	62.0	81.0	0.0	32.0
Component 2	369.5	131.0	170.5	0.0	68.0
Component 3	555.5	192.0	248.5	15.0	100.0
Total	1,100.0	385.0	500.0	15.0	200.0

C. Lessons Learned and Reflected in the Project Design

46. The government's Fourth Health, Population and Nutrition Sector Program is built on a successful history of previous sector programs as well as on a thorough analysis of sector issues. There is general recognition that the SWAp as a modality has worked well in the Bangladesh context, particularly with regard to progress toward the MDGs (Adams *et al*. 2013), although there are a number of remaining challenges as described earlier. While support from the World Bank and other development partners has largely financed inputs, there has been positive recent experience with results-based elements of the previous financing operation. The World Bank financed operation (HSDP) supporting the government's third sector program included several results-based financing components that have been successfully implemented and that have shifted the main focus of attention and dialogue toward service delivery results, system development, and policy change. In particular, the final phase of the HSDP, supported by

additional financing, linked disbursement to specified results. Specifically, the additional financing phase supported 15 DLIs, of which 11 DLIs were related to fiduciary and system development — including 6 from the 2015 IFA Action Plan — and 4 reflected service delivery improvements.

47. The proposed project will build on this experience, continuing the shift toward a results focus while strengthening governance and fiduciary management systems. As under the additional financing phase of the HSDP, the proposed project will focus on support to a mix of actions, processes, outputs, and service delivery results. Service delivery output and outcome-oriented DLIs reflect the fact that technical strategies and required inputs to deliver essential services are, for the most part, well defined and costed, not the least through the Essential Service Package to be supported by the government's sector program. The more process-oriented DLIs, particularly under Components 1 and 2, reflect both the fact that a continued focus on system reforms is needed and that a step-by-step approach is required to achieve them. Finally, several DLIs, addressing emerging challenges, encompass initial policy development, planning, and piloting that are intended to provide the basis for the government to take decisions on further concrete action in those areas in the future.

48. The proposed project also builds on earlier lessons through wide stakeholder consultation on defining the specific areas of the sector program to be supported by the operation as well as the specifics of the DLIs and the measurement and verification process. It also reflects lessons learned from the additional phase of the HSDP and good international experience through the building of national capacity to monitoring and verification of the results, ensuring that the process is credible with reasonable level of effort and cost. Additional information on the lessons learned reflected in the project design is available in Annex 3.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

49. The project will rely on existing institutional and implementation arrangements that are in place to manage the sector and to implement the government's Fourth Health, Nutrition and Population Sector Program. The MOHFW is responsible for the implementation of the sector program as a whole, including the achievement of the results to be supported by the proposed project. Following a recent policy decision, the MOHFW now has two divisions: Health Services (HS) Division and Medical Education and Family Welfare (ME&FW) Division. These divisions will encompass current entities, including the DGHS, DGFP, Directorate General of Health Economics Unit, and Directorate General of Nursing and Midwifery. Line Directors are responsible for the development and implementation of the 29 Operational Plans, including budgets that together constitute the PIP.

50. 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 Development Partner Consortium. The HNP Development Partner Consortium is the forum for the coordination of development partners in the sector, with a Chair and Co-chair elected every two years. The MOHFW, in collaboration with development partners, leads an annual program review in the third quarter of every calendar year (CY). Thematic task

groups, with membership from the MOHFW and development partners, review implementation progress of the sector program in various technical areas.

51. The Planning Wing of the HS Division and the Planning Branch of the ME&FW Division — supported by a Program Management and Monitoring Unit (PMMU) — are responsible for planning, monitoring, and reporting on the progress of the sector program. These entities will serve as the primary points of contact for monitoring and communicating to the World Bank on routine project-related matters. A DLI Monitoring Committee, coordinated by the Planning Wing of the HS Division and the Planning Branch of the ME&FW Division, including other relevant officials of the two divisions of the MOHFW, pooled funding development partners, and other parts of the government, will be responsible for monitoring progress toward the achievement of the DLIs. It will also support Line Directors in implementation, assist in producing the internal reports on DLI achievement to be submitted for verification, and coordinate with the independent verification agent. Greater detail on the institutional and implementation arrangements is available in Annex 4.

B. Results Monitoring and Evaluation

52. Monitoring of the DLIs will rely on government administrative reporting and information systems, including the DHIS2. Details on the measurement and verification of the DLIs are provided in Annex 2. The Planning Wing of the HS Division and the Planning Brach of the ME&FW will be instrumental for management, coordination, monitoring, and evaluation to track progress of the government's sector program, including the results supported by the project. The Planning Wing and Planning Branch supported by the PMMU will be equipped with adequately skilled professionals and other necessary capacity to undertake these tasks.

53. **Verification**. Of the total of 16 DLIs, 7 reflect actions or processes, 7 are outputs, and 2 measure intermediate outcomes. Actions and processes 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 management information systems. Verification of output- and outcome-oriented DLIs at the facility level will involve the application of standard health management information system data quality audit methods (MEASURE Evaluation 2008). Thus, verification will involve two tasks at two levels: (a) reviewing evidence at the MOHFW level that certain actions and processes have taken place and (b) applying the standard data quality audit methodology at the health facility level for DLIs dependent on reporting through management information systems (MIS) (Table 6).

Table 6. DLI Types, Reporting Systems, and Verification Methods

Types	*Number*	*Characteristics*	*Level of Reporting and Verification*	*Reporting Systems*	*Verification Methods*
Actions and processes	7	Technical guidelines, assessments, policy, resources, and staffing	MOHFW	Government reports	Evidence that the actions/processes have taken place
Outputs	7	Capacity to manage and deliver services	Health facilities	Health management information systems	Data quality audit
Intermediate outcomes	2	Number of services delivered			

54. The Implementation Monitoring and Evaluation Division (IMED) of the Ministry of Planning, which is functionally and financially independent from the MOHFW, will carry out the verification of achievement of DLIs. In line with its mandate, IMED has experience with monitoring social sector programs, including the health sector. The Seventh Five Year Plan affirms a leading role for IMED in results-based monitoring of government programs while recognizing the need for the development of its capacity and experience in this area (Government of Bangladesh 2015b). IMED's capacity to undertake the verification process will be strengthened through support to the development of verification protocols and their implementation, training, and other necessary technical assistance. The verification process will be reviewed from time to time by the existing governance structure of the SWAp, involving both the government and development partners. The MOHFW will agree with IMED on the arrangements, terms of reference, logistics, and other support as well as the need for supplemental technical assistance. Verification arrangements will be regularly reviewed and revised as necessary.

C. Sustainability

55. The government's sector program has a broad ownership base, which the project will support. No parallel arrangements will be needed because the project will be implemented through the government's existing structures. The DLIs for the proposed project were selected through extensive consultation and discussions among the government, development partners, and other stakeholders active in the sector. The proposed project will support the strengthening of government systems to foster the sustainability of the results achieved.

D. Role of Partners

56. As described above, development partners supporting the sector, including the World Bank, will continue to work in partnership with the MOHFW through the existing SWAp consultation and coordination mechanisms. The government's third sector program was supported by a number of development partners through co-financing of the World Bank operation as well as through directly provided or financed technical assistance. These arrangements are expected to continue. There will be a coherent multi-year consolidated technical assistance plan to support the MOHFW in strengthening its institutional capacity at different levels and in achieving the results of its sector program. This plan will be

supported, in parallel, by development partners. A coordination cell will be established in the DGHS to coordinate, monitor, and provide supportive supervision to the implementation of the Operational Plans and health organizations for facilitating the improvement and strengthening of overall health systems and health care delivery. Development partners will provide technical support to this coordination cell.

57. The objectives of the GFF are closely aligned with those of the government's sector program. The GFF will support these objectives within the SWAp framework, emphasizing partnership, government leadership, and prioritization. The government's SIP and PIP form a sound basis for an investment case. These clearly describe the government's strategies and resource allocation to accelerate progress, while the process of their development included extensive consultation of stakeholders across the country. The GFF support will focus on the strengthening of service delivery for reproductive (including family planning), maternal, newborn, child, and adolescent health and nutrition; collaborating with the education sector to address the needs of adolescents; and implementing Bangladesh's health financing strategy.

58. The MOHFW and development partners, including the World Bank, want to ensure that there is a continued robust effort to further strengthen MOHFW's fiduciary management systems, including anticorruption mechanisms. To inform the strengthening of institutional capacity for financial management and procurement, an IFA was undertaken by the World Bank with the active support from development partners. Based on this, an IFA Action Plan was endorsed by the MOHFW as well as development partners, many of whom have supported the implementation of the IFA Action Plan. The agenda of the IFA was incorporated in the government's Fourth HNP sector program and will be supported by the proposed project. Development partners will continue to be essential in monitoring the progress of this agenda, providing technical support to address gaps that are identified during the project implementation, and highlighting this in the broader sector policy dialogue.

V. KEY RISKS

59. There are a few project risks that are rated as High or Substantial by the Systematic Operations Risks-Rating Tool related to (a) political and governance, (b) fiduciary, and (c) stakeholders. Political and governance risks are rated as **Substantial** due to the possibility of events with potential adverse consequences on the achievement of the results supported by the project. Fiduciary-related risks of the sector are rated as **High** and are well recognized as discussed in the sector context and financial management and procurement sections below. These will be mitigated to the extent possible through the DLIs that focus on the strengthening of the fiduciary management systems as well as through a complementary Fiduciary Action Plan (FAP) that will be monitored and supported during implementation (see Annex 5). **Substantial** stakeholder risks reflect the wide and diverse range of stakeholders and development partners active in the sector. The SWAp coordination and monitoring arrangements will be continued, which will largely mitigate stakeholder risks. It is noted though that Bangladesh, as an emerging middle-income country, is going through a natural evolution in its development partner assistance with more bilateral support with countries in the region, private sector investments, and a reduction in grant-based financing from traditional partners. While the government is taking the lead on ensuring coherence across the changing development partner landscape, the World Bank recognizes the changes and will be open to collaborating with the new partners investing in the health sector. Certain development partners have agreed in principle to co-finance the operation, and hence, the total project costs include a financing

gap to absorb these resources once formally approved. Should not all of the anticipated funds materialize, the risk is mitigated by the government financing of its sector program and priority of the projects results. On the basis of the above risk assessment, and given the relative importance of these risks relative to other risks rated as Moderate, the overall risk of the proposed operation is therefore rated **Substantial**.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

60. **Development impact.** In general terms, improving access to primary health care can boost economic growth by promoting human capital formation and increasing labor supply and productivity. Primary health care interventions and health systems strengthening to support these interventions have been shown to produce health benefits as well as to reduce the costs of poor health. Better health outcomes also have a high intrinsic value, which highlights the economic significance of improved health in addition to its potential to raise household and national income levels. The research literature estimates high rates of return in this regard. In addition to the high intrinsic value of better health and favorable rates of return to investing in early childhood, the economic impact of the project may derive from (a) prevented health care costs incurred by patients/households; (b) prevented individual income loss, through labor lost due to morbidity; and (c) prevented costs to the health system for care of patients. Healthier people can work more productively and thus earn a higher return in the labor market. The proposed project will contribute to human capital development and increase productivity directly by reducing incapacity. The project will, therefore, contribute to inclusive and sustainable economic growth in Bangladesh.

61. The proposed project is expected to contribute to reduced morbidity and mortality in Bangladesh through the delivery of cost-effective basic HNP interventions at the primary level and equitably increased access to health care services. The Global Investment Framework for Women's and Children's Health demonstrates how investment in women's and children's health will secure high health, social, and economic returns. This initiative estimated that investments in reproductive, maternal, newborn, and child health in lower-middle-income countries such as Bangladesh yield high rates of return, producing economic and social benefits up to 11 times greater than their cost. These returns include greater economic growth through improved productivity and prevention of deaths (Stenberg *et al*. 2014).

62. The cost-effectiveness of HNP interventions has been established in the research literature, using as a standard measure cost per Disability-adjusted Life Year (DALY) averted. An intervention is considered cost-effective if the cost per DALY averted is less than three times the national annual per capita income and highly cost-effective if it is less than the annual per capita income (WHO 2001). Given Bangladesh's per capita income of US$1,409 in 2016, the government's fourth sector program prioritizes services that are highly cost-effective in terms of their estimated cost per DALY averted. For example, the cost-effectiveness of a standard maternal and child health service package is estimated to range between US$24 and US$585 per DALY averted, while that of a standard package of prenatal and delivery care ranges from US$92 to US$148 per DALY averted. Immunization is highly cost-effective, at US$8 per DALY averted (Laxminarayan *et al*. 2006).

63. A recent costing of Bangladesh's Essential Service Package at the *Upazila* level estimated current per capita expenditure at US$2.90, while the requirement for the delivery of a revised service package under the government's fourth sector program is projected at US$8.50 per capita (Government of Bangladesh 2016b). This figure is modest compared to international estimates of US$44–US$80 per capita required to deliver a basic package of health services (WHO 2001).

64. A cost-benefit analysis of the proposed project, with a total estimated cost of US$1.1 billion over 5.5 years, models the benefits of anticipated improvements in service delivery and HNP outcomes, with assumptions based on the literature on the economic impact of such improved outcomes. Conservative estimates of direct benefits are confined to anticipated reduced household OOP expenditures on medicines, while indirect benefits are estimated as increased labor productivity due to fewer days lost from illness, premature death, and caring for the sick. With benefits accruing over a 20-year period, the model estimates a net present value of the proposed project of US$2.0 billion and an internal rate of return of 22 percent. More information on the economic and financial analysis can be found in Annex 3.

B. Technical

65. The elements of the government's sector program (SIP, PIP, and Operational Plans) have been developed in a highly consultative manner with the participation of all key stakeholders, including development partners. Under the SWAp coordination mechanisms, development partners' collective appraisal of the SIP, as well as of the Essential Service Package to be delivered by the program, has confirmed that the technical interventions are evidence-based, cost-effective, and relevant to Bangladesh's context. Although public expenditure in the HNP sector remains low, there have been encouraging increases in the government budget allocation to the MOHFW during the last two years. The government has endorsed the PIP and its estimated cost, and the financing plan for its program is credible.

66. As described earlier, the results to be supported by the project have been selectively chosen to focus on critical issues that need to be addressed to lay the foundations for Bangladesh to achieve progress toward the SDGs, including the objective of universal health coverage. A number of such areas to be supported are not yet fully developed with regard to strategies and programs. This is the case in particular with regard to adolescent health and nutrition, management of non-communicable diseases, and urban health services. In such areas, DLIs focus on strategy development and initial implementation steps; this work would then form the basis for future decisions and actions by the government.

67. Several important areas that receive prominence in the government's SIP have not been included, notably oversight, regulation, and partnership with the private sector, as well as the related question of pharmaceutical quality. Strategies, and especially concrete plans and resource allocation, are not very well developed in these areas at this point. Issues related to private sector health service provision and the pharmaceutical sector are subject to analytical and technical work supported by development partners outside of the scope of the project. Given the importance of hospital services to the government health system, hospital functioning and efficiency could also potentially have been addressed by the project, but this would have considerably expanded the technical scope of the operation.

68. The transition to a fully results-based disbursement strategy is well founded but presents certain risks, including challenges related to appropriate definition of DLIs to balance between predictable disbursements and ambitious objectives. Technical risks will be mitigated by the strategic importance of

the proposed operation to the sector, its technical soundness, the MOHFW's record of implementation, and the technical support from development partners that is available. Despite the fact that the government's sector program is well established, the technical design of the project poses moderate risks due to the transition to a results-based modality. In addition, the MOHFW has been recently bifurcated into two divisions, each headed by a Secretary. While it is anticipated that this will not affect the achievement of project results, this may have some implications on coordination at the national and at the service delivery levels. The technical risk is assessed as **Moderate.**

C. Financial Management

69. **Fiduciary scope, risks, and mitigation measures.** The proposed project will apply procedures and fiduciary requirements acceptable to the World Bank, in accordance with the World Bank's Operational Policy 10.00. A fiduciary assessment for the entirety of the project was conducted and was informed by the World Bank's current work with the government's public financial management and procurement systems, particularly the experience of supporting the HSDP. The assessment further drew upon the IFA that was conducted in 2015 and the implementation of the resulting IFA Action Plan that was supported by the additional financing phase of the HSDP.

70. Following several cases resulting in complaints and investigations, the World Bank undertook an IFA in 2015, which resulted in an Action Plan agreed with the MOHFW and with other co-financing development partners. Certain initial actions were taken that provided the basis for the World Bank to consider an additional financing phase of the HSDP. These included taking disciplinary actions against officials involved in financial irregularities, developing a procurement and supply chain portal to follow the procurement process from planning through delivery, expanding the logistics management information system for the Family Planning Directorate to track delivery and provide more accurate forecasting, and improving needs planning through the adoption of equipment plan standards by facility type. After having taken these actions, the MOHFW made progress against the agreed IFA Action Plan and the DLIs under the additional financing phase of the HSDP. The IFA Action Plan had seven areas of improvement, and the additional Financing included seven DLIs to mark short-term progress against that Action Plan. Progress against each of the seven areas has been made and five of the seven DLIs have been achieved and verified. The proposed Health Sector Support Project (HSSP) will support further progress on this agenda through both DLIs focused on institutional reforms and rollout of systems that would help with management and control. These DLIs include completing the restructuring of important fiduciary units that include the appropriate staffing with relevant professional qualifications and experience. They also include the rolling out of an electronic government procurement (e-GP) system which will increase transparency and systematization of the procurement process. Together with the grievance redressal system, the e-GP system will also provide a clear channel for feedback and complaints on procurement. Finally, as a DLI, the project supports the roll out of systems that will support the service provider level for better management and control of physical assets. Further, there is a set of complementary measures — carrying forward the IFA Action Plan into realization over the next sector program — that have been agreed as a FAP. The MOHFW has committed to make progress against this plan during the course of project implementation and for which technical partners, including the World Bank, would provide

technical support. The details of the progress of the IFA Action Plan and its linkages with the design of the HSSP through the DLIs and FAP are included in Annex 5.

71. The types of financial management risks that these sets of actions are designed to mitigate include delays in detailed budget preparation; the pending restructuring of the FMAUs of the ministry, which delays strengthening of the internal audit and control functions of the MOHFW; the absence of qualified financial management staff across the line directorates; delays in resolving audit observations; and the need to strengthen internal controls through greater automation of the financial management system. Until such time as there is further progress in these areas, the financial management risk profile of the project remains high.

72. **Financial management arrangement.** Disbursement under the operation will be based on fulfilment by the MOHFW of the following requirements: (a) furnishing evidence satisfactory to the World Bank that it has achieved the respective DLIs, including third-party verification; and (b) furnishing to the World Bank interim unaudited financial reports (IUFRs) on a quarterly basis documenting eligible expenditures against which withdrawal is requested for reimbursement. The DLIs as shown in Annex 1 are indicated as scalable and non-scalable results. The disbursement amount on the scalable results will be determined on a pro-rata basis. Although there are targets, these are for monitoring purposes. The results can be financed, according to the formula, up to the allocated amounts. Although there is a planned timeline, the results are also not affixed to a particular timeline. They can be achieved earlier or later and disbursement will be made accordingly. The IUFRs will indicate the total of the eligible expenditures during the reporting period and will apportion the eligible expenditures to the different financing agreements (Credit, GFF Grant Agreement, and other, if applicable), sufficient to justify the disbursement for that agreement. If the eligible expenditures are lower than the total value of the DLIs achieved, disbursement will be adjusted accordingly—a situation that is not expected to occur. The World Bank will indicate the final value of the eligible expenditures reimbursed by the Financing Agreement in its disbursement decision. Any eligible expenditures not reimbursed can be carried over to subsequent periods. Retroactive financing of US$80 million equivalent (16 percent of the IDA Credit) is available under the IDA Credit to finance payments made for eligible expenditures during the period between January 1, 2017, and the date of the signed Financing Agreement. Retroactive financing is required given that the government program will have already started on January 1, 2017 and it will be disbursed against the achievement of key results that are necessary for later project implementation.

73. The Comptroller and Auditor General (CAG) of Bangladesh is accepted as the independent auditor to carry out the audit of the annual financial statements. The government has audit arrangements in place for the entire sector program. The audit of the project, covering all project costs regardless of financing source, will be carried out following these overall country systems with a particular agreed statement of audit needs. The CAG will audit the annual financial statements, prepared by the Chief Accounts Officer of MOHFW for both development and non-development expenditure under the government's sector program. Due to the size and complexity of the audit, the audits will be due nine months after the end of the fiscal year. The World Bank will review the audit for material observations related to the project, and the MOHFW will be responsible for following up on and resolving audit observations. Further information on the audit and the other financial management arrangements can be found in Annex 4.

D. Procurement

74. As mentioned above, the proposed project will apply procedures and fiduciary requirements acceptable to the World Bank and an assessment of the project was conducted based on the World Bank's experience with the public financial management reforms in the country, implementation experience in the sector, and the 2015 IFA. Annex 5 also demonstrates the progress of the procurement system strengthening under the IFA, the HSDP additional financing phase, and the future work under the proposed project.

75. **Procurement risks and mitigation measures.** The sector risks that these agreements are designed to mitigate can be characterized in two broad areas. First, there is the upstream process; there are issues in the transparency and efficiency of procurement processes, raising concerns about the integrity of the process and about value for money. Improvements should include needs-based planning, strengthening the internal control of procurement processes as well as expenditure management, and restructuring of the CMSD in line with its functions as a procuring organization. There is also a need to standardize technical specifications and regularly update market information on suppliers and manufacturers in order to encourage wider competition. Transparency can be increased through implementation of the government's policy on e-procurement. Second, there are a number of risks to be addressed on the downstream process. The CMSD and the DGFP require strengthening to improve contract monitoring and management. An asset and inventory management system needs to be institutionalized, rolled out and made mandatory for use by health facilities.

76. **Procurement arrangements:** The details of the activities to achieve project design and the definition of the total project costs is included in Annex 3. In short, it involves two parts: (a) government financing of its expenditures towards the project objectives, which will be procured following country systems; and (b) an Eligible Expenditure Program that will be reimbursed by the operation, consisting of salaries of government officers and other employees of those institutions responsible for the results. Therefore, there will be no procurement required to follow the World Bank procurement guidelines. This arrangement will ensure that implementing institutions are clear about the country procurement procedures that are to be followed and maintain the focus of the results-based financing. Based on the project design (detailed in Annex 3), the total project cost itself does not involve significant procurement, with the exception of the procurement of vaccines which is done by the Extended Program of Immunization under the Maternal, Neonatal, and Child Health Operational Plan. This will be funded under the government financing portion of the project. The government has a positive track record on procuring vaccines through the United Nations Children's Fund (UNICEF) and has expressed its commitment to continuing this arrangement. The transition process toward procuring vaccines entirely using government systems and procedures needs to be supported to ensure sufficient advance planning, ability to make advance payments, and stock management. Should the government change its procurement procedure for vaccines during implementation, the fiduciary assessment will be updated. The government's procurement rules and regulations to procure the other types of inputs necessary to achieve the project objectives (such as minor consultant services, training, workshops, and supplies) are generally appropriate to achieve the necessary diligence, efficiency, quality, and timeliness for the intended purposes. At the

same time, the project design includes measures that go toward the strengthening of the MOHFW's institutional arrangements and capacities to implement these rules and procedures.

77. Given the above issues, the need for additional progress under the operation and FAP, as well as the scope of the proposed project, the procurement management risk is assessed as **Substantial**. Further information on the procurement arrangements can be found in Annex 4.

E. Social (including Safeguards)

78. The project will likely have positive social impacts through its support to citizen feedback, and increasing voice and accountability, as part of the proposed Component 1. It will also strengthen the focus on improving equity by linking disbursement with improved results in the poorest performing areas of the country, some of which are also home to Bangladesh's small ethnic and vulnerable communities (tribal groups). Gender will be addressed through the collection and analysis of gender-disaggregated data on service delivery, as well as gender-specific interventions, such as improving the coverage of midwife services and nutrition counseling for mothers and children. Certain areas of the government's program supported by the project require attention to ensure the greatest potential social development and beneficiary impact. For instance, there is a need to further develop consensus and strategies for greater local management autonomy and budget delegation and other means of increasing local responsiveness to the feedback of different groups (gender, ethnic minorities, disabled groups, and other marginalized/vulnerable groups). There are currently functioning mechanisms at the community level, but applying these models to higher and more complex facilities may require experimentation such as with citizen reporting cards and other stakeholder feedback mechanisms. Improving maternal health and adolescent nutrition, especially for girls, and preventing communicable diseases particularly in hard-to-reach areas require sustained awareness-raising campaigns and systems of community consultation to understand both the needs and barriers to access. The results focus of the operation mitigates against some of the risk that these issues will not receive the necessary attention, as beneficiary outreach and communication will be necessary to achieve the results identified. As a result, the overall social risk is determined to be **Moderate**.

79. **Safeguards**. An assessment of the safeguards triggered by the project was undertaken for the entirety of the project. The project triggers World Bank's Operational Policy 4.10 because of its proposed activities in the Chittagong Hill Tracts and other areas populated by indigenous/tribal people. The project will not support any civil works requiring land acquisition, displacement of people, or adverse livelihood impacts for people with or without title on public or private lands. Hence, the World Bank's Operational Policy 4.12 (Involuntary Resettlement) is not triggered.

80. The MOHFW has developed a Social Management Framework (SMF) and a Framework for Tribal People's Plan (FTPP) to provide guidance on issues of gender, equity, voice, and accountability as well as tribal peoples. The SMF and FTPP will apply to the project and provide the basis to prepare and implement the site-specific plans including Tribal People's Plans (TPPs), as and when required, once sites are selected and screened. These must be approved, disclosed, and implemented before interventions can occur. The FTPP documents the improvements and lessons learned from the implementation of a TPP prepared in 2011 and also identifies existing gaps and mitigation measures required to be implemented under the project. The World Bank has reviewed the compliance of the SMF and FTPP to its safeguard policies. Both frameworks have been publicly disclosed on the MOHFW website as well as by the World Bank's

InfoShop. The Planning Wing of the HS Division and the Planning Branch of ME&FW Division of the MOHFW will monitor adherence to the SMF and FTPP with the concerned line directorates. The Health Economics Unit will take a lead on issues relating to gender, equity, voice, and accountability. Further information on the safeguard arrangements can be found under Annex 4.

81. **Citizen engagement**. The proposed project will support the MOHFW to develop guidelines for its grievance redressal system to ensure greater responsiveness and transparency to the public. The MOHFW uses a web-based, text message-based and phone-based platforms for citizen engagement. Under Component 1, DLI 1 focuses on further enhancement of the system to improve the handling of complaints, both with regard to time and process, according to clearly established guidelines. Progress in the implementation of the grievance redressal system will be measured by an indicator included in the project Results Framework (Annex 1). There is a citizen charter of the MOHFW available on its website, which identifies 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 points.

82. **Gender**. The proposed project will support gender inclusiveness. This will contribute to the government's Gender Equity Strategy and Action Plan (2014–2024) that has strategic objectives to strengthen the gender aspects of the sector program, including the health sector response to victims of gender-based violence. The strategy aims to introduce gender-sensitive policies, plans, and evidence-based approaches; ensure equitable access to and utilization of services using a lifecycle approach aiming to protect the health of young girls, adolescents, and elderly women within a rights-based perspective; and mainstream gender in the MOHFW programs with a focus on gender-sensitive planning and ensuring gender-balanced human resources. The proposed project will support a number of results that are in line with this strategy and will improve access to HNP services for women and girls. The project will encourage the collection and analysis of gender-disaggregated data on HNP service delivery and utilization, ultimately influencing gender-related discussions and policy decisions. In addition, the project will support the deployment of female midwives, which will contribute to making services more woman-friendly. Further it will support increased coverage of facility-based deliveries as well as improved capacity to provide emergency obstetric care, reducing the risk of maternal mortality. The project will support improved delivery of family planning services. It will also aim to develop a school-based adolescent health program, including both boys and girls, and will improve nutrition services for mothers and pregnant women.

F. Environment (including Safeguards)

83. Health care interventions supported under Component 3 are likely to generate medical waste which, if not managed properly, can degrade the environment and affect public health directly or indirectly. Because the project targets service delivery in primary health care facilities in Chittagong and Sylhet Divisions and not in tertiary and secondary hospitals, the amount of medical waste generation will be low. However, contracted medical waste management (MWM) services are generally absent in these regions, due to which there is a risk of degradation of human health and the surrounding environment if it is not properly managed. The World Bank's Operational Policy 4.01 is triggered, and an Environmental Management Framework (EMF) is designed as a safeguard instrument to mitigate probable negative impacts. Overall, the quality of policy and regulatory documents related to health care waste management is adequate, especially those approved in recent years. However, based on previous experience in the HNP sector, there remain concerns about the capacity for implementing environmental policies, funding

adequacy, and monitoring and enforcement capacity of the responsible government entities. Considering all these factors, the environmental risk is **Moderate**.

84. A monitoring cell will be constituted at the DGHS to ensure proper monitoring and supervision of MWM related activities. The EMF has been publicly disclosed in English and Bangla on the MOHFW website as well as by the World Bank's InfoShop. Activities planned under the proposed project will not include any physical interventions such as construction, rehabilitation, or renovation works. Hence, negative environmental effects, including loss or conversion of natural habitats, or changes in land or resource use, are not anticipated. No civil works will be supported by the proposed project. Further information on the safeguard arrangements can be found in Annex 4.

85. **Climate and disaster risk.** Due to its geographic location, population density, and system and resource constraints, Bangladesh is among the countries most vulnerable to climate change, including its health impacts (Mani and Wang 2014). The proposed project was screened for climate and disaster risk on October 18, 2016. The potential impact on the project due to exposure to climate- and disaster-related risks was assessed as low to moderate with the exception of sea-level rise and storm surge where the risk is high. Direct health impacts of climate and disaster risks could include the spread of water- and insect vector-borne diseases as well as increased risks of drowning and injuries associated with storms and flooding. There is also evidence of increased risks of maternal and neonatal mortality due to high levels of salinity in drinking water associated with sea-level rise (Dasgupta, Huq and Wheeler 2015). Results areas relating to improving maternal and child health as well as emerging areas like strengthening hypertension screening and treatment, will off-set some of the risks associated with climate change. The EMF of the proposed project will also help mitigate risks through measures to promote environmental health.

G. World Bank Grievance Redress

86. Communities and individuals who believe that they are adversely affected by a World Bank (WB) supported project may submit complaints to existing project level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project-affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB noncompliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service.
For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework
COUNTRY : Bangladesh
Health Sector Support Project

Project Development Objectives

The Project Development Objective (PDO) is to strengthen the health, nutrition and population (HNP) sector's core management systems and delivery of essential HNP services with a focus on selected geographical areas.

Project Development Objective Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Increase in the number of Community Clinics providing complete essential data on service delivery, including gender-disaggregated (DLI 8)		Number	0.00	7000.00	Annual	DGHS records	DGHS
Description: Indicative indicator for progress towards part 1 of the development objective.							
Name: Increase in the number of Upazila Health Complexes with at least 2 accredited diploma midwives (DLI 7)		Number	0.00	150.00	Annual	MOHFW records	MOHFW

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Description: Indicative indicator for progress towards part 1 of the development objective.							
Name: Increase in the number of normal deliveries in public health facilities in Sylhet and Chittagong divisions (DLI 10)		Number	128805.00	146000.00	Annual	DGHS records	DGHS
Description: Indicative indicator for progress towards part 2 of the development objective.							
Name: Increase in the number of District Hospitals with improved capacity to provide comprehensive emergency obstetric and neonatal care (CEmONC) services in Sylhet and Chittagong divisions (DLI 11)		Number	0.00	10.00	Annual	DGHS records	DGHS
Description: Indicative indicator for progress towards part 2 of the development objective.							
Name: Increase in the percentage of registered children aged under 2 years receiving specified nutrition services in Sylhet and Chittagong divisions (DLI 14)		Percentage	0.00	35.00	Annual	DGHS records	MOHFW

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Description: Indicative indicator for progress towards part 2 of the development objective.							

Intermediate Results Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Annual GRS performance report for previous CY is published (DLI 1)		Yes/No	N	Y	One-off	DGHS records	DGHS
Description: To measure implementation progress of component 1.							
Name: Increase in percentage from FY16 baseline in repair and maintenance expenditure at the levels of Upazila and below (DLI 2)		Percentage	0.00	100.00	Annual	MOHFW records	MOHFW
Description: To measure implementation progress of component 1.							
Name: MOHFW FMAU completes internal audit for the previous fiscal year (DLI		Yes/No	N	Y	One-off	MOHFW records	MOHFW

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
3)							
Description: To measure implementation progress of component 2.							
Name: Increase in the number of district-level referral facilities in which AMS is implemented (DLI 4)		Number	1.00	15.00	Annual	MOHFW records	MOHFW
Description: To measure implementation progress of component 2.							
Name: Increase in percentage of NCTs using e-GP issued by MOHFW (DLI 5)		Percentage	0.00	75.00	Annual	MOHFW records	MOHFW
Description: To measure implementation progress of component 2. The indicator is defined as the National Competitive Tenders (NCTs) using e-GP system as a percentage of all specified NCT issued by the MOHFW.							
Name: MOPA approves CMSD restructuring proposal (DLI 6)		Yes/No	N	Y	One-off	MOHFW records	MOHFW
Description: To measure implementation progress of component 2.							
Name: Increase in percentage of targeted public health facilities		Percentage	0.00	35.00	Annual	MOHFW records	MOHFW

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
meeting readiness criteria for delivery of PPFP services in Sylhet and Chittagong divisions, reported for the previous CY (DLI 9)							
Description: To measure implementation progress of component 3.							
Name: Increase in the number of districts reaching at least 85% coverage of measles-rubella vaccination among children ages 0-12 months in Sylhet and Chittagong divisions (DLI 12)		Number	14.00	15.00	Annual	Coverage Evaluation Survey	Expanded Program on Immunization (EPI), DGHS
Description: To measure implementation progress of component 3.							
Name: Increase in the percentage of registered pregnant women receiving specified maternal nutrition services in Sylhet and Chittagong divisions, reported for the previous CY (DLI 13)		Percentage	0.00	25.00	Annual	DGHS records	DGHS
Description: To measure implementation progress of component 3.							

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Increase in percentage of registered infants and children aged under 2 years receiving specified nutrition services in Sylhet and Chittagong divisions, reported for the previous CY (DLI 14)		Percentage	0.00	35.00	Annual	DGHS records	DGHS
Description: To measure implementation progress of component 3.							
Name: Orientation of teachers and peer girl students is completed in at least 30% of public secondary schools in each targeted district in Sylhet and Chittagong divisions (DLI 15)		Yes/No	N	Y	One-off	DGHS records	DGHS
Description: To measure implementation progress of component 3.							
Name: Assessment is completed of hypertension diagnosis and referral services at the primary level in at least 2 Upazilas (DLI 16)		Yes/No	N	Y	One-off	DGHS records	DGHS

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Description: To measure implementation progress of component 3.							
Name: People who have received essential health, nutrition, and population (HNP) services	✓	Number	0.00	5777000.00	Annual	DHIS	MOHFW
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)	✓	Number	0.00	3242000.00	Annual	DGHS	DGHS
Number of children immunized	✓	Number	0.00	4720000.00	Annual	DGHS	DGHS
Number of women and children who have received basic nutrition services	✓	Number	0.00	234000.00	Annual	DGHS	DGHS
Number of deliveries attended by skilled health personnel	✓	Number	0.00	823000.00	Annual	MOHFW	MOHFW
Description:							

Target Values

Project Development Objective Indicators

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
Increase in the number of Community Clinics providing complete essential data on service delivery, including gender-disaggregated (DLI 8)	0.00		1000.00	2000.00	4000.00	6000.00	7000.00
Increase in the number of Upazila Health Complexes with at least 2 accredited diploma midwives (DLI 7)	0.00		150.00	150.00	150.00	150.00	150.00
Increase in the number of normal deliveries in public health facilities in Sylhet and Chittagong divisions (DLI 10)	128805.00	130000.00	132000.00	135000.00	138000.00	142000.00	146000.00
Increase in the number of District Hospitals with improved capacity to provide comprehensive emergency obstetric and neonatal care (CEmONC) services in Sylhet and Chittagong divisions (DLI 11)	0.00	5.00	6.00	7.00	8.00	9.00	10.00
Increase in the percentage of registered children aged under 2 years receiving specified nutrition services in Sylhet and Chittagong divisions (DLI 14)	0.00	10.00	15.00	20.00	25.00	30.00	35.00

Intermediate Results Indicators

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
Annual GRS performance report for previous CY is published (DLI 1)	N	N	N	N	Y	Y	Y
Increase in percentage from FY16 baseline in repair and maintenance expenditure at the levels of Upazila and below (DLI 2)	0.00	0.00	20.00	40.00	60.00	80.00	100.00
MOHFW FMAU completes internal audit for the previous fiscal year (DLI 3)	N	N	N	N	Y	Y	Y
Increase in the number of district-level referral facilities in which AMS is implemented (DLI 4)	1.00	1.00	3.00	6.00	9.00	12.00	15.00
Increase in percentage of NCTs using e-GP issued by MOHFW (DLI 5)	0.00	0.00	0.00	25.00	35.00	50.00	75.00
MOPA approves CMSD restructuring proposal (DLI 6)	N	N	N	Y	Y	Y	Y
Increase in percentage of targeted public health facilities meeting readiness criteria for delivery of PPFP services in Sylhet and Chittagong divisions, reported for the previous CY (DLI 9)	0.00	0.00	0.00	5.00	15.00	25.00	35.00
Increase in the number of districts reaching at least 85% coverage of measles-rubella vaccination among	14.00	15.00	15.00	15.00	15.00	15.00	15.00

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
children ages 0-12 months in Sylhet and Chittagong divisions (DLI 12)							
Increase in the percentage of registered pregnant women receiving specified maternal nutrition services in Sylhet and Chittagong divisions, reported for the previous CY (DLI 13)	0.00	0.00	5.00	10.00	15.00	20.00	25.00
Increase in percentage of registered infants and children aged under 2 years receiving specified nutrition services in Sylhet and Chittagong divisions, reported for the previous CY (DLI 14)	0.00	10.00	15.00	20.00	25.00	30.00	35.00
Orientation of teachers and peer girl students is completed in at least 30% of public secondary schools in each targeted district in Sylhet and Chittagong divisions (DLI 15)	N	N	N	N	N	N	Y
Assessment is completed of hypertension diagnosis and referral services at the primary level in at least 2 Upazilas (DLI 16)	N	N	N	N	N	N	Y
People who have received essential health, nutrition, and population (HNP) services	0.00	904000.00	1834000.00	2781000.00	3756000.00	4759000.00	5777000.00
People who have received essential health, nutrition, and population (HNP) services - Female (RMS requirement)	0.00	515000.00	1049000.00	1586000.00	2130000.00	2684000.00	3242000.00

Indicator Name	Baseline	YR1	YR2	YR3	YR4	YR5	End Target
Number of children immunized	0.00	770000.00	1550000.00	2330000.00	3120000.00	3920000.00	4720000.00
Number of women and children who have received basic nutrition services	0.00	4000.00	22000.00	54000.00	101000.00	162000.00	234000.00
Number of deliveries attended by skilled health personnel	0.00	130000.00	262000.00	397000.00	535000.00	677000.00	823000.00

ANNEX 1: DLI MATRIX

IDA Financing[2]

	Disbursement-Linked Indicators, Disbursement-Linked Results and Allocated Amounts Applicable to the Project					
DLR Period	***FY2017***	***FY2018***	***FY2019***	***FY2020***	***FY2021***	***FY2022***
Component 1. Governance and Stewardship						
DLI 1. Citizen feedback system is strengthened - US$25 million						
DLRs		DLR 1.1 Assessment of current GRS is completed (1)	DLR 1.2 GRS guidelines are approved (1)	DLR 1.3 An annual GRS performance report for previous CY is published (2)		
Targets				1 annual report	1 annual report	1 annual report
Allocated Amounts		DLR 1.1 US$5 million	DLR 1.2 US$5 million	DLR 1.3 US$15 million (US$5 million per annual report)		
DLI 2. Budget planning and allocation are improved - US$56 million						
DLRs	DLR 2.1 OPs approved including activities and budgets for achievement of DLIs (1)	DLR 2.2 Increase in the percentage (%) from FY2016 baseline in repair and maintenance expenditure at the levels of *Upazila* and below (2)				
Targets	13 OPs	20% increase	40% increase	60% increase	80% increase	100% increase
Allocated Amounts	DLR 2.1 US$26 million (US$2.0 million per OP)	DLR 2.2 US$30 million (US$0.1 million per 1% increase from FY 2016 baseline)				

[2] The stated amounts are stated in the US$ equivalent of their SDR value. The values may not be exact due to rounding.

Component 2. Health, Nutrition and Population Systems Strengthening						
DLI 3. Financial management system is strengthened - US$51 million						
DLRs	DLR 3.1 MOHFW submits FMAU recruitment rules to MOPA (1)	DLR 3.2 MOPA endorses FMAU recruitment rules (1)	DLR 3.3 MOF concurs to FMAU recruitment rules (1)	DLR 3.4 MOPA approves FMAU recruitment rules (1)	DLR 3.5 At least 50% of required FMAU staff are recruited (1)	
					DLR 3.6 An internal audit for the previous FY is completed by FMAU (2)	
Targets					1 internal audit	1 internal audit
Allocated Amounts	DLR 3.1 US$3 million	DLR 3.2 US$3 million	DLR 3.3 US$10 million	DLR 3.4 US$5 million	DLR 3.5 US$10 million	
					DLR 3.6 US$20 million (US$10 million per audit)	
DLI 4. Asset management is improved - US$18.2 million						
DLRs	DLR 4.1 Assessment and plan are approved for AMS scale-up (1)					
	DLR 4.2 Number of District Hospitals in which AMS is implemented (2)					
Targets	1 District Hospitals	3 District Hospitals	6 District Hospitals	9 District Hospitals	12 District Hospitals	14 District Hospitals
Allocated Amounts	DLR 4.1 US$4.7 million					
	DLR 4.2 US$13.5 million (US$0.3 million per District Hospital)					
DLI 5. Procurement process is improved using information technology - US$19.8 million						
DLRs		DLR 5.1 e-GP is initiated for procurement by MOHFW (1)	DLR 5.2 NCTs using e-GP as percentage (%) of all specified NCTs issued by MOHFW (2)			
Targets			25% of NCTs	35% of NCTs	50% of NCTs	75% of NCTs
Allocated Amounts		DLR 5.1 US$5 million	DLR 5.2 US$14.8 million (US$0.08 million per 1% of NCTs)			
DLI 6. Institutional capacity is developed for procurement and supply management - US$16 million						
DLRs		DLR 6.1 CMSD restructuring proposal is endorsed by MOPA and submitted to MOF (1)	DLR 6.2 MOF concurs to CMSD restructuring proposal (1)	DLR. 6.3 MOPA approves CMSD restructuring proposal (1)		
Allocated		DLR 6.1 US$3 million	DLR 6.2 US$3 million	DLR 6.3 US$10 million		

Amounts						
DLI 7. Availability of midwives for maternal care is increased - US$45.5 million						
DLRs	DLR 7.1 At least 2,500 midwife posts are created by MOHFW and recruitment of midwives is underway (1)	DLR 7.2 Number of *Upazila* Health Complexes with at least 2 accredited diploma midwives (2)				
Targets		150 *Upazila* Health Complexes	Maintain 150 *Upazila* Health Complexes	Maintain 150 *Upazila* Health Complexes	Maintain 150 *Upazila* Health Complexes	Maintain 150 *Upazila* Health Complexes
Allocated Amounts	DLR 7.1 US$20 million	DLR 7.2 US$25.5 million (US$0.034 million per *Upazila* Health Complex)				
DLI 8. Information system is strengthened, including gender-disaggregated data - US$20 million						
DLRs		DLR 8.1 Number of Community Clinics providing complete essential data to DHIS2, including gender-disaggregated, reported for the previous CY (2)				
Targets		1,000 Community Clinics	2,000 Community Clinics	4,000 Community Clinics	6,000 Community Clinics	7,000 Community Clinics
Allocated Amounts		DLR 8.1 US$20 million (US$0.1 million per 100 Community Clinics)				
Component 3. Provision of Quality Health, Nutrition and Population Services						
DLI 9. Post-partum family planning services are improved - US$32.725 million						
DLRs	DLR 9.1 Facility readiness criteria and assessment instrument for PPFP services are approved (1)	DLR 9.2 Reporting and training guidelines for PPFP services are approved (1)	DLR 9.3 Assessment and action plan are completed for expansion of PPFP services in targeted health facilities in Sylhet and Chittagong divisions (1)			
			DLR 9.4 Percentage (%) of targeted Public Health Facilities meeting readiness criteria for delivery of PPFP services in Sylhet and Chittagong divisions, reported for the previous CY (2)			
Targets			5%	15%	25%	35%
Allocated Amounts	DLR 9.1 US$5 million	DLR 9.2 US$3 million	DLR 9.3 US$5.205 million			
			DLR 9.4 US$19.52 million (US$0.244 million per 1% of targeted facilities)			

DLI 10. Utilization of maternal health care services is increased - US$20.575 million						
DLRs	DLR 10.1 Number of normal deliveries in Public Health Facilities in Sylhet and Chittagong divisions (2)					
Targets	130,000	132,000	135,000	138,000	142,000	146,000
Allocated Amounts	DLR 10.1 US$20.575 million (US$0.25 million per 10,000 deliveries)					
DLI 11. Emergency obstetric care services are improved - US$39.2 million						
DLRs	DLR 11.1 Facility assessment instrument for CEmONC is approved (1)	DLR 11.2 Assessment and action plans are approved for development of CEmONC services in targeted District Hospitals in Sylhet and Chittagong divisions (1)				
	DLR 11.3. Number of District Hospitals with capacity to provide CEmONC services in Sylhet and Chittagong divisions, reported for the previous CY (2)					
Targets	5 District Hospitals	6 District Hospitals	7 District Hospitals	8 District Hospitals	9 District Hospitals	10 District Hospitals
Allocated Amounts	DLR 11.1 US$3 million	DLR 11.2 US$4.7 million				
	DLR 11.3 US$31.5 million (US$0.7 million per District Hospital)					
DLI 12. Immunization coverage and equity are enhanced - US$50 million						
DLRs	DLR 12.1 Immunization micro-plans for CY17 are approved for each district in Sylhet and Chittagong divisions (1)					
	DLR 12.2 Number of districts reaching at least 85% coverage of measles-rubella vaccination among children ages 0-12 months in Sylhet and Chittagong divisions, reported for the previous CY (2)					
Targets	All 15 districts	All 15 districts	All 15 districts	All 15 districts	All 15 districts	All 15 districts
Allocated Amounts	DLR 12.1 US$5 million					
	DLR 12.2 US$45 million (US$0.5 million per district)					
DLI 13. Maternal nutrition services are expanded - US$28 million						
DLRs	DLR 13.1 Technical standards for maternal	DLR 13.2 Reporting and quality assessment	DLR 13.3 Assessment is completed of			

	nutrition services are approved (1)	guidelines for maternal nutrition services are approved (1)	maternal nutrition service quality in Sylhet and Chittagong divisions (1)			
		DLR 13.4 Percentage (%) of registered pregnant mothers receiving specified maternal nutrition services in Sylhet and Chittagong divisions, reported for the previous CY (2)				
Targets		5%	10%	15%	20%	25%
Allocated Amounts	DLR 13.1 US$3 million	DLR 13.2 US$3 million	DLR 13.3 US$7 million			
		DLR 13.4 US$15 million (US$0.2 million per 1% of registered pregnant mothers)				
DLI 14. Infant and child nutrition services are expanded - US$28 million						
DLRs	DLR 14.1 Technical standards for infant and child nutrition services are approved (1)	DLR 14.2 Reporting and quality assessment guidelines for infant and child nutrition services are approved (1)	DLR 14.3 Assessment is completed of infant and child nutrition service quality in Sylhet and Chittagong divisions (1)			
	DLR 14.4 Percentage (%) of registered infants and children aged under 2 years receiving specified nutrition services in Sylhet and Chittagong divisions, reported for the previous CY (2)					
Targets	10%	15%	20%	25%	30%	35%
Allocated Amounts	DLR 14.1 US$3 million	DLR 14.2 US$3 million	DLR 14.3 US$7.15 million			
	DLR 14.4 US$14.85 million (US$0.11 million per 1% of registered infants and children aged under 2 years)					
DLI 15. School-based adolescent HNP program is developed and implemented - US$25 million						
DLRs		DLR 15.1 Revised teacher training manual is approved (1)	DLR 15.2 Assessment of current school-based services in Sylhet and Chittagong divisions is jointly completed with the education sector (1)	DLR 15.3 Training-of-trainers is completed for school-based adolescent HNP program in Sylhet and Chittagong divisions (1)	DLR 15.4 Orientation of teachers and peer girl students is completed in at least 30% of public secondary schools in each targeted district in Sylhet and Chittagong divisions (1)	
Allocated Amounts		DLR 15.1 US$3 million	DLR 15.2 US$5 million	DLR 15.3 US$7 million	DLR 15.4 US$10 million	

DLI 16. Emerging challenges are addressed - US$25 million						
DLRs		DLR 16.1 Urban Health Coordination Committee meets and agrees on actions to improve coordination on urban health (1)	DLR 16.2 Guidelines for screening, referral and treatment of hypertension are approved (1)	DLR 16.3 Plan and technical materials are approved for implementation of hypertension diagnosis and referral services (1)	DLR 16.4 Hypertension diagnosis and referral services are implemented at the primary level in at least 2 *Upazilas* (1)	DLR 16.5 Assessment is completed of hypertension diagnosis and referral services at the primary level in at least 2 *Upazilas* (1)
Allocated Amounts		DLR 16.1 US$5 million	DLR 16.2 US$3 million	DLR 16.3 US$3 million	DLR 16.4 US$11 million	DLR 16.5 US$3 million

Notes:
1. This DLR is non-scalable and shall be achieved once only. The timeframe for achievement of this DLR is indicative, but no later than June 30, 2022.
2. This DLR is scalable and may be achieved once annually in each FY, but not later than June 30, 2022.

GFF Financing

	Disbursement-Linked Indicators, Disbursement-Linked Results and Allocated Amounts Applicable to the Project					
DLR Period	*FY2017*	*FY2018*	*FY2019*	*FY2020*	*FY2021*	*FY2022**
DLI 1. Post-partum family planning services are improved - US$4.5 million						
DLRs			DLR 1 Percentage (%) of targeted Public Health Facilities meeting readiness criteria for delivery of PPFP services in Sylhet and Chittagong divisions, reported for the previous CY (2)			
Targets			5%	15%	25%	
Allocated Amounts			DLR 1 US$4.5 million (US$0.1 million per 1% of targeted facilities)			
DLI 2. Infant and child nutrition services are expanded - US$5 million						
DLRs	DLR 2 Percentage (%) of registered infants and children aged under 2 years receiving specified nutrition services in Sylhet and Chittagong divisions, reported for the previous CY (2)					
Targets	10%	15%	20%	25%	30%	
Allocated Amounts	DLR 2 US$5 million (US$0.05 million per 1% of registered infants and children aged under 2 years)					

DLI 3. School-based adolescent HNP program is developed and implemented - US$5.5 million						
DLRs			DLR 3.1 Assessment of current school-based services in Sylhet and Chittagong divisions is jointly completed with the education sector (1)	DLR 3.2 Training-of-trainers is completed for school-based adolescent HNP program in Sylhet and Chittagong divisions (1)	DLR 3.3 Orientation of teachers and peer girl students is completed in at least 30% of public secondary schools in each targeted district in Sylhet and Chittagong divisions (1)	
Allocated Amounts			DLR 3.1 US$2 million	DLR 3.2 US$2 million	DLR 3.3 US$1.5 million	

Notes:

1. This DLR is non-scalable and shall be achieved once only. The timeframe for achievement of this DLR is indicative, but must be achieved no later than December 31, 2021.
2. This DLR is scalable and may be achieved once annually in any given FY, but must be achieved no later than December 31, 2021.

* FY2022 goes from July 1, 2021 to December 31, 2021.

ANNEX 2: DLI VERIFICATION PROTOCOLS

DLI	*Definition/Description of Results*	*Scalability of Disbursements (Yes/No)*	*Protocol to Evaluate Achievement of the DLI and Data/Result Verification*		
			Data Source/Agency	*Verification Entity*	*Procedure*
DLI 1. Citizen feedback system is strengthened	This DLI reflects further development of MOHFW's GRS (MOHFW Web-based Complaint and Suggestion Box developed and operated by MIS DGHS: *http://app.dghs.gov.bd/complaintbox/?actn=adsrch*) so that it can track each grievance, its corresponding response(s), and time taken for response(s). Results will include an assessment of the current system, approval of response guidelines by the DGHS, and annual report on grievances and responses published on the DGHS website. The annual reports will include data on the number of grievances and responses.	No	GRS documentation and reports (MOHFW)	IMED	Verification of government adoption and content of relevant documents, as well as of public release of relevant reports

DLI	*Definition/Description of Results*	*Scalability of Disbursements (Yes/No)*	*Protocol to Evaluate Achievement of the DLI and Data/Result Verification*		
			Data Source/Agency	*Verification Entity*	*Procedure*
DLI 2. Budget planning and allocation are improved	This DLI reflects improved budget planning and allocation. One result is effective planning in the form of approved Operational Plans that include activities and budgets necessary to achievement of the DLIS. Other results reflect increased expenditure on repair and maintenance of physical facilities under the DGHS and DGFP at the level of *Upazila* and below. The definition of this annual expenditure (both non-development and development) includes the specific economic codes for repair and maintenance. Here, the broad economic code for repair and maintenance is 4900. For non-development expenditure relevant functional codes include 2714 (*Upazila* Health Offices), 2744 (*UHC* and Rural Health Centers), 7487 (*Upazila* Family Planning Offices) and expenditure incurred at the level of *Upazila* and below by the Health Engineering Department (HED) (2717) and the National Electro-Medical Equipment Maintenance Workshop / NEMEW (2775 operation code 0060). For development expenditure incurred at the level of *Upazila* and below. By relevant Operational Plans that include Community-Based Health Care (CBHC) (operation code 5028 under function code 2711), Maternal, Neonatal, Child and Adolescent Health (MNCAH) (operation code 5018 under function code 2711), Family Planning Field Services Delivery (FPFSD) (operation code 5006 under function code 7481), and Physical Facilities Development (PFD) (operation code 5005 under function code 2701). For DLR 2.2, for each FY, annual expenditure on repair and maintenance at the *Upazila* level and below (as defined above) will be adjusted for inflation and compared to the FY2016 baseline of BDT902 million (US$11.57 million). The source for inflation adjustment will be the Consumer Price Index estimated by the Government of Bangladesh	Yes	The Controller General of Accounts for non-development expenditure through the Chief Accounts Officer Health (MOHFW) and also HED (2717). For development expenditure Line Director of relevant Operational Plans (CBHC, MNCAH, FPFSD, and PFD).	IMED	Verification of existing government controls of the accuracy of expenditure statements

DLI	*Definition/Description of Results*	*Scalability of Disbursements (Yes/No)*	*Protocol to Evaluate Achievement of the DLI and Data/Result Verification*		
			Data Source/Agency	*Verification Entity*	*Procedure*
DLI 3. Financial management system is strengthened	This DLI aims to strengthen the FMAU of the HS Division of the MOHFW, which is responsible for providing fiduciary oversight. Completion of the restructuring will enable the FMAU to competently carry out the internal audit function and thus ensure operation of an effective internal control system. Currently, the internal audit function is carried out annually by outsourced private auditors. Following the restructuring, the FMAU will take up the function and carry out internal audit as a continuous process throughout the year and provide recommendations to the management to improve internal control functions. Results will include government clearances of recruitment rules, the FMAU staffing and implementation of internal audits.	No	Documentation (MOHFW, MOPA)	IMED	Verification of government adoption and content of relevant documents, as well as the FMAU staffing and implementation of internal audits
DLI 4. Asset management is improved	This DLI reflects implementation of an AMS in district-level referral facilities. The system will contribute to improved planning, purchasing, repair, and maintenance of assets procured by MOHFW. Results include adoption of a scale-up plan and the annual number of district-level facility (DH, medical college hospital or general hospital at the district level) in which the AMS is being implemented.	DLR 4.1: No DLR 4.2: Yes	Documentation (MOHFW)	IMED	Verification of government adoption and content of relevant documents; DHs reported to be implementing the AMS to be included in data quality audit
DLI 5. Procurement process is improved using information technology	This DLI reflects improvement to the MOHFW procurement process through implementation of the government's e-GP system. e-GP is a business-to-government requisitioning, ordering and purchasing of goods and services over the internet. Results are initiation of e-GP for procurement under the Fourth Sector Program as well as the annual proportion of NCTs issued by MOHFW that use the e-GP system. This DLI refers only to NCTs issued by the CMSD, HED of the DGHS and Logistics & Supply Unit of DGFP. NCT is a method of competitive tendering process in which local bidders usually participate and foreign bidders are not expected to be interested. "NCTs issued" indicate invitation for tenders/bids published through the e-GP in the previous FY.	DLR 5.1: No DLR 5.2: Yes	Documentation (MOHFW)	IMED	Verification that e-GP has been initiated and of data on NCTs from e-GP database

DLI	*Definition/Description of Results*	*Scalability of Disbursements (Yes/No)*	*Protocol to Evaluate Achievement of the DLI and Data/Result Verification*		
			Data Source/Agency	*Verification Entity*	*Procedure*
DLI 6. Institutional capacity is developed for procurement and supply management	This DLI reflects development of institutional capacity for medicine supply through restructuring of the CMSD, which is a department under MOHFW. The CMSD restructuring will involve revision of its organogram and staffing approved in line with the MOHFW proposal (completed at baseline). Results are steps in government clearances of the restructuring.	No	Documentation (CMSD, MOHFW)	IMED	Verification of government adoption and contents of relevant documents
DLI 7. Availability of midwives for maternal care is increased	This DLI reflects improved availability of skilled human resources for maternal care, specifically trained midwives. Results are steps in midwife recruitment as well as the annual number of UHCs with at least 2 diploma-accredited midwives on staff for at least 6 months in the last CY. For DLR 7.1, "recruitment of midwives is underway" means that that vacancy announcement posted in the public domain, short-listing done and written tests completed for at least 300 midwives.	DLR 7.1: No DLR 7.2: Yes	Records of Administration/ Human Resource Management Unit, MOHFW, Directorate General of Nursing and Midwifery and DGHS MIS/ Administration (MOHFW)	IMED	UHCs reported to have 2 midwives on staff to be included in data quality audit
DLI 8. Information system is strengthened, including gender-disaggregated data	This DLI reflects improved data completeness at the Community Clinic level. Data completeness, including gender-disaggregated data will be defined by MOHFW through a committee tasked with identifying the critical data that needs to be reported by Community Clinics.	Yes	Documentation and information system reports (MOHFW)	IMED	Community Clinics reported to be part of the information system to be included in data quality audit

DLI	*Definition/Description of Results*	*Scalability of Disbursements (Yes/No)*	*Protocol to Evaluate Achievement of the DLI and Data/Result Verification*		
			Data Source/Agency	*Verification Entity*	*Procedure*
DLI 9. Post-partum family planning services are improved	This DLI reflects improved capacity to deliver PPFP services by 617 targeted public health facilities in Sylhet and Chittagong divisions, specifically DHs, UHCs, Maternal and Child Welfare Centers (MCWCs) and Union Health and Family Welfare Centers (UHFWCs). Readiness to deliver PPFP services reflects availability of trained human resources, equipment and contraceptives and supplies. Results are technical criteria, assessment and plans, as well as the annual proportion of targeted public health facilities meeting readiness criteria for delivery of PPFP services in Sylhet and Chittagong divisions. For DLR 9.1, facility readiness criteria include availability of trained human resources, equipment and contraceptives and logistics supplies. Assessment instrument includes a checklist to verify the readiness criteria in the facilities. This will be approved by DGFP. For DLR 9.3 Assessment completed means draft reports submitted to DGFP. The facility assessment would be conducted in at least 30 facilities by the Family Planning Clinical Supervision and Quality Improvement Team and local managers. The report will include details of current situation and an action plan to respond to the findings.	DLR 9.1, 9.2, 9.3: No DLR 9.4: Yes	Reports Line Directors-DGFP (Clinical Contraceptive Service Delivery Program, Maternal Neonatal Child Reproductive and Adolescent Health) and Line Directors-DGHS (Maternal Neonatal Child and Adolescent Health, Hospital Services Management) (MOHFW)	IMED	Verification of government adoption and contents of relevant documents; facilities reported to meet readiness criteria to be included in data quality audit
DLI 10. Utilization of maternal health care services is increased	This DLI reflects improvements in maternal health care provided by public health facilities in Sylhet and Chittagong divisions. Public health facilities include DHs, MCWCs, UHCs, and UHFWCs. Normal deliveries exclude Caesarian sections and assisted deliveries. Results are adopted plans, as well as annual increases from the CY2016 baseline of 128,805 in the number of normal deliveries in public health facilities in Sylhet and Chittagong divisions.	Yes	Information system MIS-DGHS, MIS-DGFP	IMED	Verification of government adoption and contents of relevant documents and data quality audit at the facility level

DLI	*Definition/Description of Results*	*Scalability of Disbursements (Yes/No)*	*Protocol to Evaluate Achievement of the DLI and Data/Result Verification*		
			Data Source/Agency	*Verification Entity*	*Procedure*
DLI 11. Emergency obstetric care services are improved	This DLI reflects increased capacity of DHs in Sylhet and Chittagong divisions to deliver CEmONC services. Such capacity is measured by ability to maintain the 9 signal functions: (a) Administer parenteral antibiotics (b) Administer uterotonic drugs (that is, parenteral oxytocin) (c) Administer parenteral anticonvulsants for preeclampsia and eclampsia (that is, magnesium sulfate). (d) Manually remove the placenta (e) Remove retained products (for example, manual vacuum extraction, and dilation and curettage) (f) Perform assisted vaginal delivery (for example, vacuum extraction and forceps delivery) (g) Perform basic neonatal resuscitation (for example, with bag and mask) (i) Perform surgery (for example, caesarean section) (j) Perform blood transfusion Results are assessment and plans, as well as the annual number of DHs with improved capacity to provide CEmONC services in Sylhet and Chittagong divisions. For DLR 11.1, the facility assessment instrument will be approved by DGHS. For DLR 11.2, the facility assessment will be done in the DHs in the 15 districts of Sylhet and Chittagong divisions by the Line Director of Hospital Services Management of DGHS to assess the ability to deliver CEmONC services. The assessment report and action plans will be approved by DGHS.	DLR 11.1, 11.2: No DLR 11.3: Yes	Reports (DGHS, Hospital Services, MOHFW)	IMED	Verification of government adoption and contents of relevant documents; DHs reported to have capacity to provide CEmONC services to be included in data quality audit

DLI	*Definition/Description of Results*	*Scalability of Disbursements (Yes/No)*	*Protocol to Evaluate Achievement of the DLI and Data/Result Verification*		
			Data Source/Agency	*Verification Entity*	*Procedure*
DLI 12. Immunization coverage and equity are enhanced	This DLI reflects maintenance of high levels of coverage and equity of coverage of immunization, focusing on Sylhet and Chittagong divisions. Coverage of measles-rubella vaccination among children (ages 0–12 months) is chosen as an indicator of the performance of routine immunization services. Result are plans, as well as the annual number of districts reaching the specified target for measles-rubella vaccination coverage in Sylhet and Chittagong divisions. For DLR 12.1, micro-plans will include details of locations of all under-5 children to be immunized, deployment mapping of vaccinators as well as mechanism to trace children who missed a scheduled immunization. These will be approved by the Program Manager for the Expanded Program on Immunization.	DLR 12.1: No DLR 12.2: Yes	Coverage Evaluation Survey (DGHS, MOHFW)	IMED	Verification of government adoption and contents of relevant documents; existing Coverage Evaluation Survey data quality assurance measures
DLI 13. Maternal nutrition services are expanded	This DLI reflects improvements in maternal nutrition services delivered by public health facilities, with a focus on Sylhet and Chittagong divisions. Results are technical standards, guidelines and quality assessment, as well as the proportion of registered pregnant women receiving specified maternal nutrition services in Sylhet and Chittagong divisions. Specified maternal nutrition services are: (a) iron and folic acid supplements, (b) weight measurement, and (c) counseling. Delivery of specified services will be recorded and reported through a system of individual records for registered pregnant mothers. Targeted health facilities are 3,179 Community Clinics in the two divisions, while other types of facilities may be added in the future by agreement. For DLR 13.1 Technical standards will include guidelines for service providers on counselling elements, iron folic acid requirement, weight measurement and needed referral services. This will be approved by the Institute of Public Health and Nutrition.	DLR 13.1, 13.2, 13.3: No DLR 13.4: Yes	Reports DGHS-Institute of Public Health and Nutrition (IPHN) (MOHFW)	IMED	Verification of government adoption and contents of relevant documents; Facilities reported to be delivering maternal nutrition services to be included in data quality audit

DLI	*Definition/Description of Results*	*Scalability of Disbursements (Yes/No)*	*Protocol to Evaluate Achievement of the DLI and Data/Result Verification*		
			Data Source/Agency	*Verification Entity*	*Procedure*
DLI 14. Infant and child nutrition services are expanded	This DLI reflects improvements in infant and child nutrition services delivered by public health facilities, with a focus on Sylhet and Chittagong divisions. Results are technical standards, guidelines and quality assessment, as well as the proportion of registered infants and children aged under 2 years receiving specified nutrition services in Sylhet and Chittagong divisions. Specified infant and child nutrition services are age-appropriate counselling for mothers, specifically (a) for children aged under 6 months, counselling on breastfeeding, and (b) for children ages 6 to 23 months, counselling on complementary feeding. Delivery of specified services will be recorded and reported through a system of individual records for registered infants and children. Targeted health facilities are 3,179 Community Clinics in the two divisions, while other types of facilities may be added in the future by agreement. For DLR 14.1, technical standards will include guidelines for service providers on growth monitoring, using a growth monitoring chart, counselling and needed referral services. This will be approved by the Institute of Public Health and Nutrition.	DLR 14.1, 14.2, 14.3: No DLR 14.4: Yes	Reports DGHS-IPHN (MOHFW)	IMED	Verification of government adoption and contents of relevant documents; Facilities reported to be delivering infant and child nutrition services to be included in data quality audit

DLI	*Definition/Description of Results*	*Scalability of Disbursements (Yes/No)*	*Protocol to Evaluate Achievement of the DLI and Data/Result Verification*		
			Data Source/Agency	*Verification Entity*	*Procedure*
DLI 15. School-based adolescent HNP program is developed and implemented	This DLI reflects development of school-based adolescent health and nutrition services in coordination with the education sector, with a focus on Sylhet and Chittagong divisions. Results include plans, training, and orientation of teachers and peer girl students in public secondary schools in Sylhet and Chittagong divisions. For DLR 15.1, the revised teacher training manual will be approved by the DGHS. The key content of the revised training manual will include thematic areas like physical and mental changes, nutrition, menstrual hygiene, drug addiction, gender, sexually transmitted infection, early marriage, family planning, abortion, antenatal care etc. For DLR 15.2, the assessment will be a situation analysis done on a sample of public secondary schools to understand the current status of school health programs and services in Sylhet and Chittagong divisions. The sample will be determined by the respective District Health Manager and District Education Officer. Completion of the assessment will mean draft report submitted to the Line Director of DGHS-Maternal Neonatal Child and Adolescent Health. For DLR 15.3, training-of-trainers means at least 2 teachers of each selected school are trained by the Line Director of DGHS-Maternal Neonatal Child and Adolescent Health on the revised manual. Trained teachers will then train other teachers and peer support groups. For DLR 15.4, orientation will include at least a half-day training of teachers and peer girl students to make them aware of adolescent health and nutrition issues. Five districts are targeted in Sylhet and Chittagong divisions.	No	Reports of DGHS-Maternal Neonatal Child and Adolescent Health - School Health Program (MOHFW)	IMED	Verification of government adoption and contents of relevant documents; Secondary schools where orientation is reported completed to be included in data quality audit

DLI	*Definition/Description of Results*	*Scalability of Disbursements (Yes/No)*	*Protocol to Evaluate Achievement of the DLI and Data/Result Verification*		
			Data Source/Agency	*Verification Entity*	*Procedure*
DLI 16. Emerging challenges are addressed	This DLI reflects groundwork for responding to emerging challenges, specifically in the areas of urban health and non-communicable disease services. DLR 16.1 reflects improved coordination on urban health services between MOHFW, Ministry of Local Government Rural Development and Cooperatives, and urban local governments. Results include an assessment and draft actions agreed for improving coordination in urban areas. DLRs 16.2 to 16.5 reflect development and implementation of pilot non-communicable disease services, focusing on diagnosis and referral of hypertension. Guidelines, plan and technical materials are to be approved by DGHS. Hypertension diagnosis and referral services mean screening for hypertension by Community Clinic service providers and referral to UHCs for further follow-up and treatment if required. Assessment of the pilot to document lessons learned will be done by a team of technical experts. The assessment report will be submitted to the DGHS.	No	Reports Urban Health Coordination Committee; DGHS, MOHFW	IMED	Verification of government adoption and contents of relevant documents; Facilities reported to be implementing hypertension diagnosis and referral services to be included in data quality audit

ANNEX 3: DETAILED PROJECT DESCRIPTION

A. Strategic Relevance

The Government's Program

1. The government and development partners have pursued a sector wide approach (SWAp) since 1998, adopting a series of multiyear strategies, programs, and budgets (1998–2003, 2003–2011, and 2011–2016) for management and development of the sector, with both government and development partner financing. The Ministry of Health and Family Welfare (MOHFW) has prepared a Strategic Investment Plan (SIP) for its Fourth Health, Population, and Nutrition Sector Program (January 1, 2017, to June 30, 2022), which is consistent with the government's emerging priorities reflecting the Sustainable Development Goals (SDGs) and aligned with its Seventh Five-Year Plan. The SIP "calls for a substantive change in the way the sector is organized and managed" with emphasis on quality of care and strengthening stewardship and governance. The proposed Health Sector Support Project (HSSP) includes a set of results that will assist the MOHFW in realizing these goals. The SIP includes a results framework and a budget envelope that has been operationalized through preparation of a Program Implementation Plan (PIP) and numerous detailed Operational Plans (OPs). The PIP was approved by the government in March 2017 and the OPs in May 2017 with a retroactive start date of January 1, 2017.

2. The government's Fourth Health, Population and Nutrition Sector Program objective is "to ensure that all citizens of Bangladesh enjoy health and well-being by expanding access to quality and equitable healthcare in a healthy and safe living environment." The MOHFW considers it as a first, foundational, program towards the achievement of the SDGs by 2030. It builds on a successful history of the previous sector programs, with well-established planning and consultation processes as well as monitoring and coordination mechanisms. The government's fourth sector program encompasses three components: (a) Governance and Stewardship, (b) HNP Systems Strengthening, and (c) Provision of Quality HNP Services.

3. The approved PIP is costed at US$14.7 billion, of which US$6.9 billion will be allocated through the revenue, non-development budget towards the health sector and US$5.5 billion will be allocated through the development budget towards 29 different OPs. These costs are largely expected to be raised from general revenue (US$12.3 billion or 83.7 percent) and to a lesser extent from development partner external financing (US$2.4 billion or 19.5 percent), including concessional credit and grant sources.

4. The government's Fourth Health, Population and Nutrition Sector Program is built on a successful history of the previous sector programs and thorough analysis of sector issues. Its contents were developed in a highly consultative manner with the participation of all key stakeholders, including the DPs. Under the SWAp coordination, the DPs' collective appraisal of the SIP as well as the Essential Service

Package to be delivered by the program, have confirmed that the technical interventions are evidence-based, cost-effective and relevant to Bangladesh's context.

Lessons Learned

5. There is general recognition that the SWAp as a modality has worked well in the Bangladesh HNP sector. Impressive gains in health outcomes are associated with the three phases of sector-wide programming in Bangladesh. According to one analysis, "SWAps facilitated the alignment of funding and technical support around national priorities, and improved the government's role in program design as well as in implementation and DP coordination. Notable systemic improvements have taken place in the country systems with regards to monitoring and evaluation, procurement and service provision, which have improved functionality of health facilities to provide essential care. Implementation of the SWAp has, therefore, contributed to an accelerated improvement in key health outcomes in Bangladesh over the last 18 years. The HNP SWAp in Bangladesh offers an example of a successful adaptation of such an approach in a complex administrative structure." (Ahsan *et al.* 2015) The HSSP will support the governments' own agenda with specific attention to systems strengthening and service delivery in lagging areas, consistent with the assertion that "a post-Millennium Development Goals agenda for health in Bangladesh should be defined to encourage a second generation of health-system innovations under the clarion call of universal health coverage" (Adams *et al.* 2013).

6. "Much of Bangladesh's success has centered on progress towards the Millennium Development Goals. However, less successful have been improvements in maternal and child malnutrition and access to primary care" (Adams *et al*. 2013). Service delivery is continued by the parallel structures at different tiers of the health system (union, *upazila*, district), as the Directorate General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) are both implementing agencies under the MOHFW, leading to duplication and inefficient use of resources. Although there have been substantial improvements in key HNP indicators, still a majority of deliveries remain home-based (62 percent) without skilled attendance at delivery (42 percent). Some increase in post-partum family planning (PPFP) has been observed, but this service remains limited in coverage. Referral linkages in the health system remain weak, leading to a large percentage of women with obstetric complications failing to get the care they need in time. Bangladesh still has a high prevalence of chronic undernutrition with 36 percent of under-five children being stunted. The large burden of non-communicable diseases (NCDs) is an emerging challenge. The country is experiencing an epidemiological transition from communicable diseases to NCDs.

7. Increasing urbanization affects population demand for HNP services delivered at the primary level. There is collaboration between government, non-governmental organizations (NGOs) and the private sector, such as in the areas of family planning and immunization. However, there is confusion about where responsibility lies for HNP service delivery in urban areas with very little involvement of urban local government bodies.

8. Improving key maternal and child health outcomes will require extra effort. Quality service delivery with effective referral, efficient health service delivery mechanisms, and availability of skilled health service providers are some areas that will require further attention. The HSSP includes

disbursement-linked indicators (DLIs) targeting the lagging regions of Sylhet and Chittagong as outcomes in the 15 districts of these regions lag behind national averages.

9. System reforms supported by the World Bank's support to the first two SWAps have had mixed results. "Reforms like integration of health and [family planning] services, diversification of service delivery and modernization of the health sector through decentralization and local level planning were not seriously pursued" (Ahsan *et al*. 2015). Reforms related to systems strengthening progressed, as "the past decade can point to how budget systems have changed from being entirely projects to a pooled component managed in parallel (under the first SWAp), to the pool being a part of the government budget system (under the second and third SWAps)." (White 2007) The performance-based financing mechanism under the recently completed World Bank project that supports the SWAp has provided an opportunity for program implementers to set realistic annual targets and thereby ensured ownership and achievement of the intended results. The use of DLIs under the additional financing of the ongoing project has motivated the government in taking forward some of the otherwise difficult reforms like restructuring of the Financial Management and Audit Unit (FMAU). This was further applied to a broad fiduciary systems strengthening in the health sector agenda following a 2015 Integrated Fiduciary Assessment. This lead to a set of fiduciary related actions and agreements which were initially supported under a results-based financing additional financing phase of the Bank's support to the last sector program. After 18 years of input financing, the HSSP provides an opportunity to continue this shift toward policies and sector results, moving away from the focus on specific inputs seen with more traditionally designed sector investment operations. Building on these gains, the HSSP will provide a unique opportunity for the implementers to find locally relevant and sustainable solutions to overcome operational bottlenecks to the achievement of key results.

10. The proposed project also builds on earlier lessons through wide stakeholder consultation on defining the specific areas of the sector program to be supported by the operation as well as the specifics of the DLIs, the measurement and verification process. Finally, it reflects lessons learned from the additional financing phase of the HSDP and good international experience through the building of national capacity for monitoring and verification of the results, ensuring that the process is credible but also reasonable level of effort and cost. In country contexts similar to Bangladesh, the bidding and contracting out of verification can be a cause of delayed implementation and verification – resulting in disillusionment of the government with a results-based financing modality.

B. Detailed Project Description

11. The overall thrust of the proposed HSSP is to support the government in addressing areas where there are existing gaps and where there are emerging challenges. The results to be supported by the HSSP will focus on important issues that need to be addressed to lay the foundations for Bangladesh to achieve progress towards the SDGs, including the objective of universal health coverage. The proposed operation will further strengthen the momentum to achieve results by aligning incentives to support results within the government's own program and by aligning the incentives of the MOHFW and Ministry of Finance (MOF) to achieve defined results. Several important areas that receive prominence in the government's SIP have not been included, notably oversight, regulation and partnership with the private sector, as well as the related question of pharmaceutical quality. Strategies, and especially concrete plans and resource allocation, are not very well developed in these areas. The process of translating the government's

program into the areas of focus of this operation was based on a series on consultations with the government and DPs, taking into consideration that which was already being addressed through other means, appropriateness for this instrument, level of readiness and priority. This process of defining the technical areas of focus and boundaries of the HSSP can be summarized as shown in Table 7.

Table 7. Defining the HSSP Areas of Focus within the Broader Government Program

Components of the Government Program and HSSP	Broad Strategic Objective Areas of the Government Program	Specific Focus Areas of the Government Program Supported by the HSSP
Governance and Stewardship	Regulation of the private sector	
	General institutional development at all levels, including new areas of quality assurance and pharmaceutical quality	Focus on institutional development in support of enhancing accountability to the public
	Sustainable and equitable health financing (broad ranging)	Focus on ensuring budget planning and allocation to demonstrate effective budget processes to achieve defined results as well as to increase lower level service delivery funding necessary to complement the service delivery objectives and establish a stepping stone to greater budget delegation
HNP Systems Strengthening	To strengthen the capacity of the MOHFW's core health systems (financial management, procurement, infrastructure development)	Focus on core fiduciary systems of financial management and procurement
	Establish a high quality health workforce available to all through public and private health service providers	Focus on deployment and retention of midwives that would complement the service delivery for maternal care
	To strengthen the evidence base for health sector decision-making	Focus on the completeness of information and on monitoring the supply chain, complementing the service delivery priorities as well as using the reporting and verification process to support the improvement of data quality
Provision of Quality HNP Services	To improve equitable access to and utilization of quality health, nutrition and family planning services (includes all levels from primary to tertiary)	Focus on addressing equity through targeting of the remaining MDG agenda in the poorest performing areas and through targeting of specific referral capacity at the DH and basic service delivery at the *Upazila* level and below
	To promote healthy lifestyle choices within a heathy environment	Focus also on building necessary approaches to address emerging health needs in adolescent health, NCDs and urban health

12. The HSSP will build on implementation of the ongoing World Bank-financed investment project, entitled HSDP, which finances a slice of the government's Third HNP Sector Program. The project resources, commonly referred to as the "pooled funds", include an International Development Association (IDA) credit of US$358.05 million along with additional financing of US$150 million which is allocated to DLIs. Eight DPs provided grant funds of approximately US$365 million, administered by the World Bank.

13. The transition to a new results-based disbursement modality is well-founded but presents certain risks, including challenges related to adequate definition of DLIs to balance predictable level of external financing with stretch objectives. On the other hand, technical risks are mitigated by the strategic importance of the proposed operation to the sector, its technical soundness, the MOHFW's record of implementation, and the technical support of the DPs that is available. The initial technical risk assessment is **moderate**.

14. The HSSP is synchronized with the implementation of the government's Fourth Health, Population and Nutrition Sector Program and mirrors the program priorities. Table 8 shows the clear line of sight connecting the government's program to the DLIs supported by the HSSP and its development objective:

Table 8. Line of Sight between the Government's Program, the Project DLIs, and Objectives

Government's Operational Plans	Actions/Processes	Outputs	Outcomes	PDO Elements
Component 1. Governance and Stewardship				
OP 5-2711-5009. Health Information System and eHealth	Citizen feedback system is improved	**Citizen grievances receive responses (DLI 1)**	Improved accountability and responsiveness of HNP services	Strengthening of the HNP sector's core management systems
OP 5-2701-5002. Sector-Wide Program Management and Monitoring OP 5-2701-5005. Physical Facilities Development	Planning and budget allocation	**Spending on repair and maintenance at the service delivery level is increased (DLI 2)**		
Component 2. Health, Nutrition and Population Systems Strengthening				
OP 5-2701-5006. Improved Financial Management	**Financial management system is strengthened (DLI 3)**	Improved implementation of financial management functions, specifically internal audit (DLI 3)	Financing of services is more efficient, timely and accountable	Strengthening of the HNP sector's core management systems
OP 5-2701-5005. Physical Facilities Development OP 5-2711-5029. Hospital Services Management	**Asset management system is implemented (DLI 4)**	Improved efficiency in the purchase, use and maintenance of assets	Assets such as medical equipment are available and functioning to support service delivery	
OP 5-2711-5014. Procurement, Storage and Supplies Management – Health Services OP 5-7481-5003. Procurement, Storage and Supplies Management – Family Planning OP 5-2701-5005. Physical Facilities Development	**Procurement process is improved using information technology (DLI 5)**	Procurement is more efficient, transparent and timely	Improved availability at the service delivery level of medicines, family planning commodities and other supplies	
OP 5-2711-5014. Procurement, Storage and Supplies Management – Health Services	**Institutional capacity is**	Improved procurement		

Government's Operational Plans	Actions/Processes	Outputs	Outcomes	PDO Elements
	developed for procurement and supply management (DLI 6)	and supply		
OP 5-7401-5001. Nursing and Midwifery Education and Services	Training, recruitment and posting of qualified midwives	**Availability of midwives for maternal care is increased (DLI 7)**	Skilled human resources are in place and providing quality health care services	
OP 5-2711-5009. Health Information System and eHealth	**Information systems are strengthened, including gender-disaggregated data (DLI 8)**	Gender-disaggregated data from Community Clinics are collected and analyzed	Gender-informed information is effectively used to inform planning and policy	
Component 3. Provision of Quality Health, Nutrition and Population Services				
OP 5-7481-5005. Clinical Contraception Services Delivery Program	Resources, inputs and actions are applied to improve PPFP services, particularly in target areas	**PPFP services are improved, particularly in target areas (DLI 9)**	Utilization of family planning services is increased	Strengthening of delivery of essential HNP services, with a focus on selected geographical areas
OP 5-2711-5018. Maternal, Neonatal, Child and Adolescent Health OP 5-7481-5004. Maternal, Child, Reproductive and Adolescent Health	Resources, inputs and actions are applied to improve maternal health care service delivery, particularly in target areas	Delivery of maternal health care services is improved, particularly in target areas	**Utilization of maternal health care services is increased, particularly in target areas (DLI 10)**	
OP 5-2711-5029. Hospital Services Management	Resources, inputs and actions are applied to improve emergency obstetric care, particularly in target	**Emergency obstetric care services are improved, particularly in target areas (DLI 11)**		

Government's Operational Plans	Actions/Processes	Outputs	Outcomes	PDO Elements
	areas			
OP 5-2711-5018. Maternal, Neonatal, Child and Adolescent Health	Resources, inputs and actions are applied to improve immunization services, particularly in target areas	Immunization services are improved across districts, particularly in target areas	**Coverage of measles-rubella immunization increases, particularly in target areas (DLI 12)**	
OP 5-2711-5019. National Nutrition Services	Resources, inputs and actions are applied to improve maternal, infant and child nutrition services	**Maternal nutrition services are expanded (DLI 13)**	Utilization of maternal, infant and child nutrition services is increased and household knowledge and behaviors improve	
OP 5-2711-5019. National Nutrition Services		**Infant and child nutrition services are expanded (DLI 14)**		
OP 5-2711-5018. Maternal, Neonatal, Child and Adolescent Health	**An integrated and sustainable strategy for adolescent health within schools is demonstrated (DLI 15)**	School-based adolescent health and nutrition services are delivered	Utilization of adolescent health and nutrition services increases and knowledge and behaviors improve	
OP 5-2711-5026. Non-communicable Diseases Control OP 5-2701-5002. Sector-Wide Program Management and Monitoring	**NCD (hypertension) services are developed (DLI 16)** **Coordination on urban health services is improved (DLI 16)**	NCD services are delivered	Utilization of NCD services increases	

Component 1. Governance and Stewardship (Estimated Cost is US$175 million or 16 Percent of Total Project Cost)

15. The overall focus of this component is to support the government's core systems to improve its capacity to efficiently allocate and manage domestic and external resources applied to the sector. Improvements in these systems will leverage the effectiveness of domestic funding, which accounts for the bulk of financing for the sector.

16. Improving governance of the HNP sector is a priority for the government's Fourth Health, Population and Nutrition Sector Program, and includes increasing accountability through strengthening the role of citizens and their representatives in oversight of HNP services. DLI 1 will support further enhancement of the DGHS grievance redressal mechanism. The DGHS maintains a website which captures citizens' concerns/feedback sent either by text messages or by phone. As part of the additional financing of the HSDP, the website has been maintained. Under the proposed HSSP, efforts will be made to ensure that the feedback loop is completed and citizens are informed of the actions/initiatives taken by the government. There will also be efforts to improve efficiency of the system by reducing the average time taken to respond to complaints.

17. The budget for the MOHFW is developed through a number of OPs that are focused on different functional areas. The OPs translate the PIP into detailed activities and budgets. The HSSP will support improved results-based budget planning and will also support a step towards greater devolution of resources to the service delivery level through increased allocation of discretionary funding for minor repair and maintenance of health facilities through DLI 2 which will also complement the improvements in service delivery by providing necessary resources for capital maintenance and repair.

18. Table 9 provides an analysis of the activities and the expenditures to be incurred to achieve the expected results under this component.

Table 9. Activities Needed for Achieving Results under Component 1

DLI	Activities Needed for Achieving the Results	Inputs Required
DLI 1. Citizen feedback system is strengthened	• Develop guidelines for GRS • Maintain the DGHS phone-, SMS- and web-based GRS • Re-coding of the automated system where needed based on the guidelines • Train staff • Establish baseline for addressing the grievances in accordance with the guidelines • Monitor regularly to reduce average time taken to resolve grievances	Revenue Budget • Staff salaries Development Budget • Staff salaries • Technical assistance (off-budget) • Operating costs • Training
DLI 2. Budget planning and allocation are improved	• Effectively plan and budget for achievement of results under the OPs • Allocate more budget for repair and maintenance • Devote staff effort at the central and local level in the activities necessary to execute the resources	Revenue Budget • Staff salaries Development Budget • Staff salaries and allowances • Budget for repair and maintenance

DLI	Activities Needed for Achieving the Results	Inputs Required
	• Raise awareness among necessary central and local level officials on planning and executing repair and maintenance budgets • Monitor regularly to ensure utilization of allocated funds	• Staff travel to local level

Component 2. Health, Nutrition and Population Systems Strengthening (Estimated Cost is US$369.5 million or 34 Percent of Total Project Cost)

19. Bangladesh has experienced high governance-related risks in health sector activities. Recognizing this, the World Bank undertook an IFA in 2015 as mentioned earlier. The IFA identified a number of systemic fiduciary challenges, including (a) lack of contract management guidelines, which weakens monitoring; (b) suboptimal competition, irregularities, and inefficient use of project and program funds; (c) weak capacity of the FMAU, which limits compliance with financial procedures and control; and (d) absence of an AMS, which results in misuse of assets and waste. Key actions of the IFA Action Plan that have been implemented include use of independent consultants as part of bid evaluation committees, approval of restructuring framework of the FMAU by the MOHFW, and exclusion of local agents from eligibility to bid on the HSDP-related procurement.

20. Additionally, the MOHFW has taken a number of initiatives to improve overall governance in the HNP sector. These include (a) disciplinary actions against officials involved in financial irregularities identified in external audit reports; (b) development of a procurement and supply chain portal to process approval of procurement plans, monitor processing of procurement packages, track distribution of assets, and monitor status of installed equipment; (c) development of a standard table of equipment for various tiers of facilities, identifying the medical equipment needed to deliver services at the facilities; and (d) expansion of the DGFP's logistics management information system to service delivery points to track uptake of family planning commodities and forecast future requirements based on consumption.

21. Building on the progress made thus far, a major area of focus for the HSSP will be reform and development of financial management, procurement, supply chain management, and AMS (DLIs 3, 4, 5, and 6). The FMAU restructuring proposal that was finalized by the MOHFW and approved by the MOPA, which represent key achievements under the HSDP additional financing, will be implemented with the support of the HSSP, including recruitment of necessary staff (DLI 3). This will strengthen the internal control mechanism of the MOHFW. Until the time the FMAU is fully staffed and able to undertake internal financial audit itself, this task will be outsourced to a private audit firm as has been done under the government's third sector program. Along with this, an automated system for asset management (DLI 4) would ensure safeguarding of assets.

22. To ensure greater transparency and accountability in the procurement process, e-GP will be rolled out with the support of the HSSP (DLI 5). E-GP is a national priority of the government and all its procuring entities are being enrolled into the system. With the support of HSSP, staff will be trained and all national tenders will be processed using e-GP. Health sector procurement is highly technical, complex, and diverse involving a large volume of procurement. This requires a sustainable team of procurement managers, procurement experts, pharmacologists, biomedical engineers, supply chain management experts, and so

on, to effectively manage the procurement. However, the staff working in the CMSD are doctors, health technicians, and administrative persons who generally have no specific knowledge and experience in procurement. This has adversely affected the credibility of the procurement system of the CMSD resulting in low or no participation in bidding, high bid prices, rebidding, no interest from potential bidders, and other irregularities in the bidding process. The CMSD is responsible for procuring all medical equipment, medicines, and vaccines required by the health facilities across the country. There is currently no mechanism to ensure that a specialized team of experts will be available on a continuous basis. Under the HSDP additional financing, an assessment of the CMSD has been completed and a restructuring proposal finalized. With the support of the HSSP, the restructuring proposal will be approved by the relevant government agencies so that the additional positions and the required budgets are made available (DLI 6).

23. In the area of human resources, DLI 7 will support improvements in maternal health care through increased availability of qualified midwives. The DLI will support not only the initial staffing, but also incentives for retention by rewarding maintenance by the government of the midwives in the facilities over time.

24. With regard to the information system, the DGHS has put in place a comprehensive electronic system, the District Health Information System version 2 (DHIS2), and DLI 9 will focus on improving the quality of the information reported, starting with the completeness of the data reported by primary service delivery points. In addition, as it is recognized that adequate data are necessary for addressing gender disparities, DLI 9 will improve the collection and analysis of gender-disaggregated data on HNP service delivery.

25. Table 10 provides an analysis of the activities and the expenditures that will be incurred to achieve the expected results under this component.

Table 10. Activities Needed for Achieving Results under Component 2

DLI	Activities Needed for Achieving the Results	Inputs Required
DLI 3. Financial management system is strengthened	• The FMAU management recruits contract staff to perform internal audit functions • The FMAU management develops Recruitment Rules • The MOHFW follows-up with the MOPA to expedite the approval of the Recruitment Rules • After the MOPA approval, the MOHFW submits the Recruitment Rules to MOF for their approval • The FMAU initiates recruitment process following the MOF approval of the Rules • Staff are contracted • Firms/individuals are contracted to provide internal audit function as well as capacity building of newly appointed staff	Revenue Budget • Staff salaries Development Budget • Staff salaries • Operating costs • Contract staff services

DLI	Activities Needed for Achieving the Results	Inputs Required
	• Staff time and contractors undertake internal audits and monitoring of findings	
DLI 4. Asset management is improved	• Readiness assessment of facilities to use AMS are conducted. • The MOHFW installs the AMS software in the DHs. • With technical assistance, the MOHFW trains staff on the AMS • Hospital staff are involved in the inventory of major capital equipment, the input and the update of the AMS at the facility level • The MOHFW monitors use of the AMS	Revenue Budget • Staff salaries Development Budget • Staff salaries • Technical assistance (off-budget) • Training
DLI 5. Procurement process is improved using information technology	• MOHFW coordinates with the central procurement authorities on the roll out of the e-GP system. • The procuring entities train their staff on e-GP • The procuring entities arrange bidders' orientation session • The procuring entities invite bid through e-GP • The change to e-GP are communicated to all parties, including Ministry staff, contractors and others	Revenue Budget • Staff salaries Development Budget • Staff salaries • Operating costs • Training • Communication costs
DLI 6. Institutional capacity is developed for procurement and supply management	• The MOHFW follows-up with the MOPA to expedite the approval process of the CMSD restructuring. • After the MOPA approval, the MOHFW processes approval from the MOF.	Revenue Budget • Staff salaries Development Budget • Staff salaries
DLI 7. Availability of midwives for maternal care is increased	• Recruit midwives • Train midwives • Deploy and employ midwives • Monitor the retention and replace midwives if necessary	Revenue Budget • Staff salaries Development Budget • Staff salaries • Operating costs • Training
DLI 8. Information system is strengthened, including gender-disaggregated data	• The DGHS trains staff at the Community Clinics on the reporting requirements • Staff routinely populate the DHIS2 with data • The DGHS monitors staff • Completeness and quality of data are measured for improvement	Revenue Budget • Staff salaries Development Budget • Staff salaries • Operating costs • Training (Community Clinics are already equipped with hardware)

Component 3. Provision of Quality Health, Nutrition and Population Services (Estimated Cost is US$555.5 million or 50 Percent of Total Project Cost)

26. The overall focus of this component is to selectively support the government in addressing important unfinished elements of its MDG agenda focusing on reproductive, maternal, neonatal, child, and adolescent health and nutrition. These have long been areas of focus for the government's HNP sector programs. Strategies for reproductive health services, including family planning, as well as maternal and child health services, are well-developed and implementation can be characterized at the scale-up and consolidation stages. Services are provided and supported by a mix of government, NGOs, and sometimes private sector providers (especially in the case of family planning services), funded from domestic sources as well as on- and off-budget international support. The government's Fourth Health, Population, and Nutrition Sector Program is grounded in development and implementation of an Essential HNP Service Package that encompasses all of the necessary interventions and specifies service standards for different levels of health services.

27. To address equity gaps, DLIs 9 to 15 aim at supporting improvements in HNP service provision and utilization in the divisions of Sylhet and Chittagong, two of the low-performing areas of Bangladesh (Table 11 provides an overview of the status of key HNP indicator in these areas).

Table 11. Status of Key HNP Indicators in Sylhet and Chittagong in 2014

Indicator	National average	Sylhet	Chittagong
Total fertility rate (women ages 15-49)	2.3	2.9	2.5
Proportion of under-5 children who are underweight	32.6%	39.8%	36%
Under-5 child mortality rate (per 1,000)	46	67	50
Proportion of mothers who delivered at a health facility	37.4%	22.6%	35.2%
Proportion of children ages 11-23 months who are fully immunized	83.8%	61.1%	83.3%

Source: NIPORT, Mitra and Associates, and ICF International 2016.

28. In the MOHFW, there are two separate directorates, the DGHS and the DGFP, that deal with health and family planning services, respectively. DLIs 9 to 14 focus on improvements in service delivery in these areas in Sylhet and Chittagong divisions, reflecting maintenance of high levels of immunization coverage, increased numbers of normal deliveries in government health facilities, improved capacity for comprehensive emergency obstetric care, increased availability of PPFP services, improved adolescent health through involvement of schools, and strengthened maternal and child nutrition services.

29. Maternal and child nutrition has long been an area of focus for the government and partners, with the current strategy focused on developing cross-sectoral coordination while mainstreaming nutrition services in the government health and family planning service delivery system. However, this approach has been hampered by capacity constraints, including health worker workload limitations, while impact on household behaviors has been limited by a lack of community-based interventions. Hence, DLIs 13 and 14 will support improving the effectiveness of nutrition services delivered through the government system, with a focus on effective implementation of individualized monitoring and case management through a system of individual records for registered pregnant mothers, infants and children.

30. The policy basis for interventions to improve adolescent health and nutrition is in the initial stages of development. A strategy has been drafted, while implementation of relevant interventions (that is,

school-focused health programs) is nascent. Therefore, DLI 15 will focus on further work, emphasizing coordination with the education sector.

31. The HSSP will also support the government in starting to address selected emerging challenges in the HNP sector like increased prevalence of NCDs and urbanization. In all South Asian countries, the burden of diseases is shifting—NCDs now account for a larger proportion of forgone disability-adjusted life years (DALYs) than communicable diseases, maternal and child health issues, and nutrition causes combined. The government needs to tackle NCDs through its service delivery system, particularly at the primary level. The government's Fourth Health, Population and Nutrition Sector Program envisions development and implementation of a strategy, including behavior change communication, surveillance, diagnosis, treatment and management. DLI 16 would support the start of work in this area, specifically by improving services for diagnosis and referral of hypertension at the primary level.

32. Increasing urbanization of the population will lead to greater demand for government services, including HNP services delivered at the primary level. Urban local governments affiliated with the Ministry of Local Government, Development, and Cooperatives are considered responsible for HNP services in urban areas although the MOHFW provides some technical and other support. The government's Fourth Health, Population and Nutrition Sector Program emphasizes the need to expand access to basic HNP services in urban areas, both through government services and through partnerships with the NGO and the private sector. DLI 16 will support improved coordination on urban health with the aim of setting the foundation for action in the medium term.

33. Table 12 provides an analysis of the activities and the expenditures that will be incurred to achieve the expected results under this component.

Table 12. Activities Needed for Achieving Results under Component 3

DLI	Activities Needed for Achieving the Results	Inputs Required
DLI 9. Post-partum family planning services are improved	• Training guidelines developed, training-of-trainers implemented and training of providers done • Joint/individual instructive guidelines in the form of circulars sent out • Social and behavioral change communication conducted and micro plans at each district level prepared, with appropriate culturally sensitive messaging and communication channels • Improve the logistics coordination of ensuring the supply of contraceptives • Focus on Sylhet and Chittagong divisions	Revenue Budget • Staff salaries Development Budget • Staff salaries • Trainings • Social and Behavioral Change communication campaign
DLI 10. Utilization of maternal health care services is increased	• Train staff • Deploy trained medical staff • Undertake effective communication campaign, outreach • Procure the necessary medicines and equipment • Focus on Sylhet and Chittagong divisions	Revenue Budget • Staff salaries Development Budget • Staff salaries • Communication activities •
DLI 11. Emergency obstetric care services are improved	• Rapid assessment done to determine the baseline values for CEmONC capacities at the DHs	Revenue Budget • Staff salaries Development Budget • Staff salaries

DLI	Activities Needed for Achieving the Results	Inputs Required
	• MOHFW disseminates minimum standards and criteria to all 15 DHs in Sylhet and Chittagong divisions • Develop quality Improvement action plan in DHs for compliance with national standards • Train staff on the standards • Minor investments to address gaps • Monitor the progress towards the improvement, particularly involving the district health officers and representatives from the targeted facilities • Focus on Sylhet and Chittagong divisions	• Medical supplies • Surgical instruments • Equipment • Training • Consultant services to prepare the baseline assessment
DLI 12. Immunization coverage and equity are enhanced	• Develop district-specific measles-rubella (MR) vaccination micro-plans for access to hard to reach and urban areas • Through the routine Expanded Program on Immunization, children under 12 months will be immunized against MR • Procure MR vaccines • Create awareness through Intensive communication campaign • Outreach to remote areas • Focus on Sylhet and Chittagong divisions	Revenue Budget • Staff salaries Development Budget • Staff salaries • Operating costs • Vaccines procured through UNICEF
DLI 13. Maternal nutrition services are expanded	• Develop manual, training guideline, reporting tools and training materials • Orientation completed • Undertake quality survey • Undertake awareness-raising campaigns • Monitor and measure improvements in delivery • Implement individual records and case management for registered pregnant mothers • Focus on Sylhet and Chittagong divisions	Revenue Budget • Staff salaries Development Budget • Staff salaries • Technical assistance (off-budget) • Workshops/training • Communication activities
DLI 14. Infant and child nutrition services are expanded	• National Nutrition Services (NNS) develops guidelines on growth monitoring and infant and young child feeding practices • Implement individual records and case management for registered infants and children • NNS develops quality assessment methodology • Train staff • Collect baseline data • Undertake quality assessment • Undertake awareness-raising campaigns • Focus on Sylhet and Chittagong divisions	Revenue Budget • Staff salaries Development Budget • Staff salaries • Operating costs • Technical assistance (off-budget) • Training • Communication materials • Consultant services for quality assessment
DLI 15. School-based adolescent HNP program is developed and implemented	• Plan on school-focused adolescent health program • The DGHS develops a monitoring and evaluation framework with support from DGFP, partner NGOs and secondary education sector • Train trainers	Revenue Budget • Staff salaries Development Budget • Staff salaries • Operating costs

DLI	Activities Needed for Achieving the Results	Inputs Required
	• Develop district-specific action plans • Orient teachers and peer girl students • Coordination with the education sector at the national and local level • Focus on Sylhet and Chittagong divisions	• Workshops/training
DLI 16. Emerging challenges are addressed	• Undertake the Coordination Meetings on urban health, including national and local city corporation stakeholders • Develop detailed guidelines/manuals/reporting tool and training materials for screening and referral of hypertension • Train staff • Undertake awareness-raising campaign • Screen patients for hypertension • Assess hypertension screening and management services for further roll-out	Revenue Budget • Staff salaries Development Budget • Staff salaries • Operating costs • Workshops/training • Communication materials • Consultant services

C. Project Expenditure

34. The government's Fourth Health, Population, and Nutrition Sector Program, covering 2017-2022, is estimated to cost US$14.7 billion. The slice of the government's program defined as the project as described in the tables above, is estimated to cost US$1.1 billion at a minimum based on an analysis of related expenditures under the previous sector program (including relevant expenditures from the development budget of the relevant OPs and the recurrent cost of operating the MOHFW facilities to achieve the objectives). The project will reimburse defined eligible expenditures totaling US$515 million (or US$715 million depending on pooled co-financing from DPs), subject to the achievement of the DLIs.

35. Following the precedent of the World Bank's additional financing to the previous project (HSDP) supporting the third sector program, and in accordance with the costs defined for the project, the defined Eligible Expenditure Program consists of MOHFW expenditures for the economic classification of Pay of Officers (4500) and Pay of Establishment (non-gazetted staff) (4600) under the non-development or revenue budget for the MOHFW and its units as well as the service delivery units at the district level and below (functional codes of those units defined in Table 14).

36. Toward the achievement of the project objective, the government will support investments, operating costs, information and education activities such as media production; repair and maintenance; research and surveys; salaries and allowances; technical assistance; training, seminars, and conferences; vaccines and medicines specific to the Maternal, Neonatal, and Child and Adolescent Health Operational Plan. These refer to economic classifications of 4500, 4600 and some selected investments under 4800 for 13 out of the 29 OPs. More specifically, the translation of the above expenditures into specific economic classifications is shown in Table 13.

Table 13. Expenditure Type Defined by Economic Codes

Expenditure Type	Economic Codes Included in Definition
Staff salaries	4500 and 4600
Contractual staff or Consultant Services	4874, 4886
Operating Cost	4801-4819, 4821-6, 4828, 4831, 4833, 4836, 4845-4851, 4857,

	4869, 4871, 4874, 4875, 4881-82, 4884-87, 4890-91, 4893, 4895-98
Workshops/training	4840-44
Communication materials	4827, 4833
Logistics and Supplies	4868
Vaccines	4862 (specific to 5-2711-5018)

37. Based on the above information, Table 14 provides the detailed definition the total project cost broken down by the two components: (a) the Eligible Expenditure Program; and (b) the expenditures entirely financed by the MOHFW.

Table 14. Summary of the Total Project Cost by Functional and Economic Code

	Functional Codes for Institutions and Operational Plans linked to achieving Project Objective	Economic Codes for Inputs linked to Tables 9, 10, and 12	Estimated Value (US$, millions)
Eligible Expenditure Program to be reimbursed by Bank and other co-financiers from the revenue budget	Institutions: 2701, 2711, 2712, 2713, 2714, 2716, 2742, 2743, 2744, 2771, 2772, 7481, 7483, and 7485	4500 and 4600	780
Expenditures by the MOHFW from the development budget	Operational Plans: 5-2711-5009, 5-2711-5014, 5-2711-5018, 5-2711-5019, 5-2711-5026, 5-2711-5029, 5-2701-5002, 5-2701-5005, 5-2701-5006, 5-7481-5003, 5-7481-5004, 5-7481-5005, 5-7401-5001	4500, 4600, 4801–4819, 4821–4828, 4833, 4836, 4840–4851, 4857, 4868, 4869, 4871, 4874, 4875, 4878, 4881–4887, 4890–4891, 4893, 4895–4898, and 4862 (specific to 5-2711-5018)	320
Total			1,100

38. These expenditures reflect a similar pattern under the third HNP sector program where recurrent expenditures constituted about 82 percent of the total health sector expenditures. The Eligible Expenditure Program with an estimated cost of US$780 million exceeds the estimated World Bank and development partner pooled co-financing (up to US$715 million, subject to the achievement of the DLIs and subject to the final agreement with development partners on co-financing). The government budget is expected to finance the difference between the actual expenditures and that which is reimbursed by the World Bank. The US$320 million estimated project costs from the government's development budget will be entirely financed by the government.

D. Economic Analysis

39. Bangladesh is a lower-middle-income country with a per capita income of US$1,466. The population living below the poverty line has been estimated at about 25 percent and a large share (73 percent) of the population continues to live in rural areas. The macroeconomic environment in recent years has been strong. GDP growth in FY2016, estimated at 7.1 percent, has been healthy despite slowing private investment and remittances. The overall fiscal framework underpinning the FY2017 budget is prudent, with sustainable deficit and debt levels and an improved composition of spending. However, the revenue targets are aspirational, while the size of its annual development program is large in relation to the government's ability to spend and implement. The inflation rate (5.9 percent in FY2016) has slowed, but it remains high relative to comparators. While Bangladesh has already achieved its ambition to reach middle-income status by 2021, the 50th anniversary of its independence, the challenge will be to further accelerate growth.

Budgetary Implications

40. The percentage contribution of GDP to health is still very low. Public health spending is 0.8 percent of GDP (or US$6.20 per capita in 2012) and total health expenditure is 3.5 percent of GDP. Increasing the budget share allocated to health will be challenging, given the many other competing claims on Bangladesh's relatively small government budget. The total estimated cost of the government's Fourth Health, Population, and Nutrition Sector Program is US$14.7 billion, which covers the sector budget over a 5.5-year period (or about US$2.7 billion per year). The budget for the government program comes through two channels: (a) the revenue (non-development) budget that covers recurrent costs and some capital costs allocated directly to different institutions and (b) the development budget that largely covers capital costs and some recurrent costs allocated to different OPs, each implemented by a Line Director (LD) in the MOHFW. The government expects to mobilize US$12.3 billion from general revenue and up to US$2.4 billion from international sources of financing. In brief, the budgetary implications of recurrent costs are relatively large given the small government resource envelope for health. However, it is also expected that Bangladesh's robust economic growth outlook will provide a conductive environment for sustaining the program's investments. Like previous programs under the SWAp, it is expected that a significant proportion of DP support will be channeled through on-budget financing, including through co-financing of World Bank operation.

Development Impact

41. The government's fourth sector program, covering the period January 2017 to June 2022, is described by its approved SIP (Government of Bangladesh 2016a). It builds on a successful history of the previous sector programs, with well-established planning and consultation processes as well as monitoring and coordination mechanisms. The government's fourth sector program encompasses three components: (a) Governance and Stewardship, (b) HNP Systems Strengthening, and (c) Provision of Quality HNP Services.

42. In general terms, improving access to primary health care can boost economic growth by promoting human capital formation as well as increasing labor supply and productivity. Primary health care interventions and health systems strengthening to support these interventions have been shown to produce health benefits as well as reduced costs of poor health. Better health outcomes also have a very high intrinsic value, which highlights the economic significance of improved health in addition to its

potential to raise household and national income levels. The research literature estimates very high rates of return in this regard.

43. The program is expected to reduce morbidity and mortality in Bangladesh through utilization of cost-effective basic health interventions at the primary level and equitably increase access to health care services. The Global Investment Framework for Women's and Children's Health demonstrates how investment in women's and children's health will secure high health, social, and economic returns. Health systems strengthening and six investment packages (for maternal and newborn health, child health, immunization, family planning, HIV/AIDS, and malaria) were costed. Nutrition is a cross-cutting theme. The framework estimates that investments in reproductive, maternal, newborn, and child health in lower-middle-income countries like Bangladesh would yield high rates of return, producing up to 11.3 times the economic and social benefit. These returns include greater GDP growth through improved productivity and prevention of deaths. (Stenberg *et al*. 2014)

44. Based on analysis by the Institute for Health Metrics and Evaluation, the health conditions addressed by program interventions account for about 35.1 percent of the disease burden in Bangladesh. Neonatal encephalopathy, neonatal preterm birth, lower respiratory infections, and iron deficiency anemia are four of the ten leading causes of DALYs lost in 2013 in Bangladesh. (IHME 2015)

45. The cost-effectiveness of interventions has been established in the research literature. The program prioritizes services that are highly cost-effective with regard to the estimated cost per DALY averted. Table 15 presents cost per DALY averted by interventions supported by the program. Given Bangladesh's GDP per capita, targeted interventions were cost-effective. An intervention is considered cost-effective if the cost per DALY averted is less than three times the annual GDP per capita and highly cost-effective if it is less than the annual GDP per capita (WHO 2001).

46. A recent costing of the Essential Service Package (ESP) at the *Upazila* level in Bangladesh estimated current per capita expenditure at US$2.90, while needs based on revised ESP are projected at US$8.50 per capita. The figure is quite modest compared to international estimates of US$44–80 per capita to deliver a basic package of health services (Government of Bangladesh 2016b).

Table 15. Cost-Effectiveness of HNP Interventions Delivered under the Government's Fourth Sector Program

HNP Interventions	US$ per DALY Averted
Standard maternal and child health package	24–585
Package of prenatal and delivery care	92–148
Expanded program on immunization	8
Tetanus toxoid vaccine	14
Treatment of acute respiratory infections (facility based)	24–424
Treatment of diarrhea (oral rehydration therapy)	132
Integrated management of childhood illness	9–218
Breastfeeding support program	3–11
Growth monitoring and counseling	8–11
Vitamin A supplementation	6–12
Prevention of unwanted pregnancy (family-planning program)	117

Source: Laxminarayan *et al*. 2006.

47. In addition to the high intrinsic value of better health and favorable rates of return to investing in early childhood, the economic impact of the project may derive from (a) prevented health care costs incurred by patients/households; (b) prevented individual income loss, through lost labor resulting from morbidity; and (c) prevented costs to the health system for care/treatment of patients. Healthier people have the energy to work more productively and thus earn a higher return in the labor market. The project will contribute to human capital and increase productivity directly by reducing incapacity.

48. A cost-benefit analysis of the proposed project, with a total estimated cost of US$1.1 billion over 5.5 years, models the benefits of anticipated improvements in service delivery and HNP outcomes, with assumptions based on the literature on the economic impact of such improved outcomes. Cost of the project accounts for 7.5 percent of the total cost of Fourth Health, Population and Nutrition Sector Program (US$14.7 billion). Conservative estimates of direct benefits are confined to anticipated reduced household out-of-pocket (OOP) expenditures on medicines, while indirect benefits are estimated as increased labor productivity due to fewer days lost from illness, premature death, and caring for the sick. With benefits accruing over a 20-year period, the model estimates a net present value of the proposed project of US$2.0 billion and an internal rate of return of 22 percent.

49. **Direct benefit**. This was computed as reduced OOP expenditure on medicines. Per capita OOP expenditure data from the Bangladesh National Health Accounts (NHA) 1997–2012 were used. The savings in expenditures were calculated as the total number of cases of treatment averted multiplied by the cost of treatment. Unit cost was taken from the Millennium Development Goals Needs Assessment and Costing 2009–2015 Bangladesh (Government of Bangladesh 2009).

50. **Indirect benefit**. This benefit was calculated as the increase in productivity due to fewer days lost from illness, premature death, and caring for the sick. The gains were calculated as the reduction in the total days of morbidity and/or mortality multiplied by the average daily per capita GDP.

Table 16. Parameters of Cost-Benefit Analysis

Key Parameters and Assumptions	Value	Source
Discount rate for life	3%	WHO Guide to Cost-Effectiveness Analysis *http://www.who.int/choice/publications/p_2003_generalised_cea.pdf*
Discount rate for monetary value	3%	World Bank Disease Control Priorities Study and the Global Burden of Diseases Project both used a 3% discount rate. World Development Report 1993 also used a 3% discount rate.
GDP per capita growth (annual %)	5.28% (2015) increased to 6.76% (2037)	GDP and GDP per capita were taken from World Development Indicators for earlier years. GDP was projected based on the assumed 7.2% growth rate. Per capita GDP was estimated dividing the projected GDP by the projected population figure taken from world population estimates. Per capita GDP growth was calculated based on that.
Annual GDP growth over 20 years	7.20%	GDP growth rate was taken from World Development Indicators 2015 for available years and then assumed to be 7.2% based on the current trends.
Value of Statistical Life in US$	US$65,000	Consultancy Services for "Technical Feasibility Studies and Detailed Design for Coastal Embankment Improvement Programme (CEIP)" Contract Package No. BWDB/D2.2/S-3 (IDA CR. No. 4507). Final Report Volume I.

Key Parameters and Assumptions	Value	Source
		June 2013 Coastal Embankment Improvement Project, Phase-I (CEIP-I) Bangladesh Water Development Board, Ministry of Water Resources, Government of the People's Republic of Bangladesh
MOHFW Budget Growth	5% (2016) increased to 10% (2037)	Assumption
Efficiency gain from DLI[a]	0.50%	Assumption
Average length of stay in hospitals at the district level and below[b]	4 days to reduce by 1 day	Health Bulletin DGHS for actual admission figures. Projected admission figures are based on assumed annual growth rate at 2%.
Increased productivity from each outpatient visit	0.5 day	Assumption
Public sector contribution to infants' lives saved	80%	Assumption
Public sector contribution to reduced maternal mortality	60%	Assumption
GDP per capita (2016–2037)	1,031 (2016) increased to 3,766 (2037)	Per capita GDP was estimated by dividing the projected GDP by projected population figure taken from World Population estimates. Per capita GDP growth was calculated based on that.
Of people ill, % seeking treatment	90.30% (2016) increased to 92% (2037)	Based on trends from Household Income and Expenditure Survey (HIES) 2000, 2005, and 2010
Of people seeking treatment, % going to public facilities	12.1% (2016) increased to 45% (2037)	Based on HIES 2010 and assumed
Per capita OOP spending on health	US$17 (2012)	Bangladesh NHA figures up to 2012 and WHO (2013–2014); estimated based on past trends
Per capita OOP spending on medicine	US$11 (2012)	Bangladesh NHA up to 2012, estimated keeping OOP spending on medicine as constant at 65%
Morbidity reduction among children due to vaccination	30%	Assumption
Percentage of	10%	Chandrasiri, J., C. Anuranga, R. Wickramasinghe, R. P. Rannan-Eliya.

Key Parameters and Assumptions	Value	Source
OOP spending for children		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 Household Income and Expenditure Surveys 2000–2010*. Country Brief. Mandaluyong City, Philippines: Asian Development Bank.
Maternal mortality ratio per 100,000 live births	176 (2015) reduced to 121 by 2021(fourth sector program target) and then to 70 by 2030 (SDG target) and then 50 by 2037	Bangladesh Maternal Mortality and Health Care Survey 2010 and Maternal Mortality Estimation Inter-Agency Group for actual figures.
Infant mortality rate per 1,000 live births	38 (2014) reduced to 15 (2037)	Figures are based on Bangladesh Demographic and Health Survey 2014 (figures between the years are interpolated) and projections taken from United Nations 2015 estimates.

Notes: a. Government health budget that is assumed to be US$2.7 billion per year and 5 percent growth rate for budget. Efficiency gain 0.5 percent for first five years from 2017, then 1 percent for the next five years, and then 1.5 percent till 2032 and 2 percent for the remaining years.
b. Saved productivity loss through reducing hospital stay by one day for the patient and for one attendant.
c. 95 percent reduction over the next 20 years (2017–2037).

ANNEX 4: IMPLEMENTATION ARRANGEMENTS

Project Institutional and Implementation Arrangements

1. As part of the government's Fourth Health, Population, and Nutrition Sector Program, the proposed HSSP will be implemented by the MOHFW through existing institutional structures similar to the previous sector programs. There are 29 Line Directors, responsible for detailing activities, their implementation, and disbursements under the Operational Plans (OPs). Each Line Director is responsible for carrying out certain actions under the government's sector program. A summary of OPs and budgets is prepared for a period of five years, and these OPs along with the budgets, taken together, constitute the five-year PIP. In March 2017, the PIP was approved by the Executive Committee of National Economic Council, the highest approval authority of the government for development projects, chaired by the Prime Minister. Following approval of the PIP, the Line Directors prepared detailed OPs for five years with detailed budgets for the first three years and block allocations for the last two years. The OPs have been approved by a Steering Committee in each division, which comprises inter-ministerial representatives and is headed by the Secretary of each division of the Minister of Health and Family Welfare.

2. The MOF allocates the annual budget to the health sector according to the approved national budget. The MOF is responsible for channeling funds to the MOHFW on time for the smooth implementation of activities.

3. The MOHFW is responsible for the overall implementation of the government's sector program and development partner coordination. Key entities within the MOHFW involved in implementation include the Health Services Division, the Medical Education and Family Welfare Division, National Institute of Population Research and Training, Directorate General of Drug Administration, Directorate General of Health Economics Unit, and the Directorate of Nursing. Most of the OPs of the government's sector program are implemented by these six entities. Additionally, there are five regulatory bodies under the MOHFW. These existing structures will be used for implementing the project activities.

4. The MOHFW, in collaboration with the DPs, will jointly review the implementation progress of the government's sector program in the third quarter of every CY. This Annual Program Review will be led by the MOHFW and guided by the Annual Program Review Steering Committee as has been the practice in the last three sector programs. Thematic task groups, comprising representatives of the government and development partners, will meet every periodically to review implementation progress and decide on the way forward. In addition, a DLI Monitoring Committee will monitor the achievement of the DLIs and provide supervisory support to the Line Directors in consultation with the DPs and other MOHFW agencies.

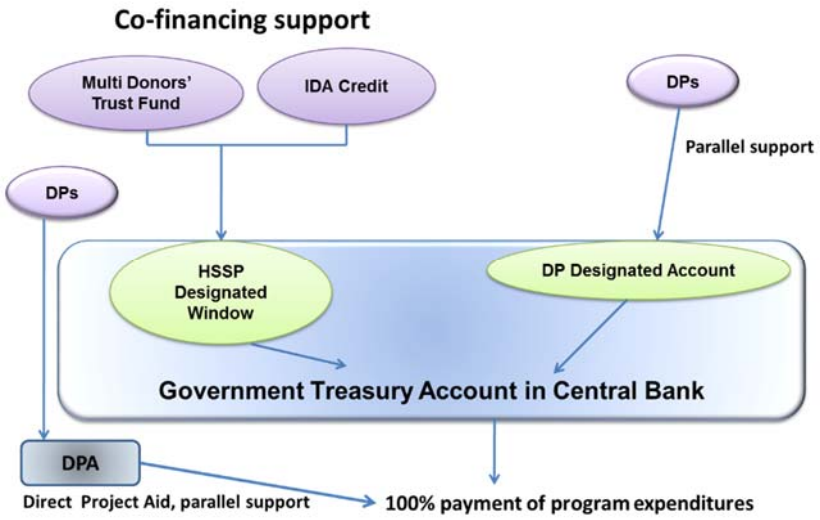
5. There will be a multiyear consolidated technical assistance plan for the government's sector program to support the MOHFW in strengthening its institutional capacity at different levels and focus on achieving results. This consolidated technical assistance will be supported, in parallel, by the development partners.

Financial Management

6. An IFA was carried out for the proposed health sector program with a view to determine the strengths and weaknesses of the government's public financial management and procurement systems and identify appropriate arrangements for the next sector program. The assessment further drew from the IFA that was conducted in 2015 for the additional financing of the ongoing HSDP and the lessons from the implementation of the IFA Action Plan that was agreed to by all key stakeholders.

7. **Fund flow and treasury management.** The World Bank-administered resources (IDA Credit and trust funds) will directly flow to the government's Treasury Account, through a designated 'window', which will be created by the MOF, to receive disbursement based on the achievement of agreed DLIs (Figure 1). This will not be a specific sub-account, but a device to measure and track the deposits into the treasury from the multiple financing agreements for the purposes of the project to facilitate the transparency to the MOHFW and the co-financing partners. The currency of the Treasury Account will be Bangladesh Taka (BDT). Either the Minister, the Secretaries, or the Planning Wing of the HS Division or the Planning Branch of the ME&FW Branch of the MOHFW will be responsible for communication of information on achievement of DLIs to the World Bank along with necessary supporting documents. The FMAU of the HS Division and the FMAU of the ME&FW Division will coordinate to prepare and submit the joint interim unaudited financial report (IUFR) to the World Bank, reporting eligible expenditures, under the economic codes 4500 and 4600 equal to or more than the allocations to achieved DLIs. The IUFR would include separate columns for IDA and GFF expenditures (and any other grant agreement which may be signed subsequently), following a pre-determined ratio, which would document sufficient eligible expenditures to cover the expenditures per agreement. The IUFR will be submitted to the World Bank within 45 days after the end of each quarter. The MOHFW will obtain the relevant Treasury Account details from the MOF and will provide these to the World Bank.

Figure 1. Fund Flow Arrangements for the Program



8. **Internal control.** The existing policies and procedures as laid out in the General Financial Rules, Treasury Rules, Delegation of Financial Authority, will be followed. The Secretaries of the HS Division and the ME&FW of the MOHFW, who are the principal accounting officers of their respective divisions, will be

responsible for ensuring overall accountability in expenditure management is duly adhered to. To prevent fraud and error and ensure checks and balances, proper segregation of duties across the LDs will be ensured. Segregation of duties refer to assigning different levels of authority to the staff members, in an organization, to complete one particular task. The shared responsibility of the staff to complete a particular task ensures necessary controls to deter errors and fraud in the performance of their respective obligations.

9. **AMS.** The computerized AMS, which has been piloted in Moulvibazar DH, will be rolled out to the health facilities (DLI 5) to ensure safeguarding of assets as well as to provide optimum services to the beneficiaries. A comprehensive training manual will be developed to impart training on the use of the AMS. The internal audit will review the effectiveness of the AMS and physical verification according to system specification.

10. **Internal audit.** The outsourcing of a private audit firm to conduct annual internal audit of the sector program will continue until the in-house capacity to carry out internal audit is developed. The terms of reference of the internal audit will be periodically revisited for revision, if deemed necessary. Action plans will be prepared, based on the recommendations of the internal audit report, by the FMAUs of the respective divisions. Implementation of the audit action plan will be followed up, and progress in implementation will be communicated to the World Bank periodically. With the bifurcation of the MOHFW into two divisions, a new FMAU has been established under the ME&FW Division. An assessment may be conducted to determine if any further strengthening of the unit is required, similar to that of the HSD FMAU, to enable it to provide adequate fiduciary oversight.

11. **External audit.** The MOHFW is current on its external audit obligations under the closing HSDP.[3] The Comptroller and Auditor General (CAG) of Bangladesh is accepted as the independent auditor and it will carry out audit of the annual financial statements of the government's sector program. The audit of the project, covering all costs regardless of financing source, will be carried out following these overall country systems with a particular agreed statement of audit needs. The definition of the project costs is defined in Annex 3, Table 14 and will not be repeated here. As per recent agreement, the Office of the CAG will authorize the respective audit directorate to conduct the audit of the entire program. There will be one audit certification of the program financial statement, including the project, which will be submitted to the Bank within 9 months after the end of each FY. The audit report will be monitored by the World Bank's internal system (PRIMA) periodically. It was agreed that the Bank will share the statement of audit needs specifying the audit coverage within three months of project effectiveness. Following usual practice, the statement of audit needs will be discussed during an entry meeting between the CAG, MOHFW and the World Bank to ensure that the specific audit needs of the project are understood. Also following usual practice, the audit report finalization process will include a discussion of the draft audit report at an exit meeting which the concerned audit directorate about 5 days prior to final submission. Once received, the World Bank will review the final audit report and communicate its comments to Office of the CAG and MOHFW. MOHFW will take corrective measures to address any material issues within an agreed time frame. In case of serious audit findings requiring further investigation, MOHFW as per country practice will set up an enquiry committee to substantiate the

[3] During the life of the HSDP from FY2012 to FY2016, 153 material audit observations, equivalent to US$49.3 million were identified by IDA. Out of these, 78 audit observations, amounting to US$26.52 million has been resolved. There are 75 audit observations, equivalent to US$22.7 million which remain unsettled. It may be noted that out these 75 audit observations, 34 observations, equivalent to US$4.07 million are related to the last year (FY2016) and were recently communicated to the MOHFW and the remaining unsettled observations are not older than FY2014. Active discussions are underway to address those remaining observations.

allegations and take necessary actions. It was agreed that MOHFW will communicate with the World Bank the findings of the enquiry and actions taken. The MOHFW, including both the FMAU of the HS Division and the FMAU of the ME&FW Division, will be responsible for following up of audit observations and resolution of World Bank-identified audit findings as soon as feasible with the majority of observations to be resolved before the receipt of the subsequent year's audit report. The legal remedial measures of the Bank with respect to the audit observations will be applicable to the Eligible Expenditure Program, although all the observations relating to the boundary of the total project costs would be monitored by the Bank and followed up with the government for resolution.

Table 17. Audit Reports, Type, and Due Dates

Responsible Agency	Audit Type	Auditor	Deadline for Receipt
MOHFW	Certification of program financial statements including Management Letter containing observation on program expenditure	Government audit by the CAG	Nine months after the end of each FY

Disbursements

12. The FMAU of the HS Division of the MOHFW will prepare the Withdrawal Applications in coordination with the ME&FW Division which will be electronically signed by the single authorized signatory and submitted to the World Bank through Client Connection for requesting disbursements. The Withdrawal Application will accompany a set of the IUFRs, the preparation of which will be coordinated by both the HS Division and the ME&FW Division, along with a copy of the World Bank's 'Confirmation of Results Achievement Notification - Authorization to Disburse', signed by the Country Director or a representative designated by the Country Director.

Procurement

13. The project will not finance any procurable items as the eligible expenditures include non-procurable categories. Any goods, works, non-consulting services, and consulting services, if required to be financed out of the project proceeds, shall be procured in accordance with the requirements set forth or referred to in the World Bank's 'Procurement Regulations for Borrowers under Investment Project Financing', dated July 1, 2016 (Procurement Regulations).

Fraud and Corruption

14. The World Bank "Guidelines on Preventing and Combating Fraud and Corruption in Projects Financed by IBRD Loans and IDA Credits and Grants, Dated October 15, 2006 and Revised in January 2011 and as of July 1, 2016" will be applied to the Eligible Expenditure Program reimbursed by the World Bank Credit, GFF Grant and any other co-financing.

Environmental and Social (including safeguards)

15. **Environment.** Consistent with the World Bank's Operational Policy 4.01, the MOHFW has prepared an Environment Management Framework (EMF) to control risks to the environment posed by medical waste generated at the health facilities. At the *Upazila* level, the low amount of waste generated by health services does not necessitate the need for outsourced waste management infrastructure to be developed because it is not financially viable. Activities needed to achieve the service delivery-related DLIs

are likely to increase sharp wastes, recyclable wastes, and infectious wastes, as well as increase the risk of infection and contamination. In general, there is weak monitoring of MWM related activities and enforcement of policies and regulations due to weak capacity in the MOHFW. Through effective implementation of MWM activities as highlighted in the EMF and keeping in line with the government's MWM Act 2008, the risks can be adequately mitigated. Specific activities will include capacity building of relevant personnel, proper segregation of waste, disposal of sharps, and introducing of deep burial pits for sharps and infectious wastes/body parts.

16. An MWM monitoring cell will be constituted at the DGHS to ensure proper monitoring and supervision of MWM-related activities. The MOHFW will appoint national consultants for developing required documentation, assisting in inter-ministerial coordination and cooperation, and supervising and monitoring the actions.

17. **Safeguards.** Consistent with the World Bank's Operational Policy 4.10, the MOHFW has developed a Social Management Framework (SMF) and a Framework for Tribal People's Plan (FTPP) to deal with issues that may concern tribal peoples and social and gender-related issues. The SMF and FTPP contain principles, policies, guidelines, and procedure to identify and address impact issues and preparation and implementation arrangements for Tribal People's Plans (TPPs). If any safeguards policy is triggered, the MOHFW will prepare site-specific plans (as applicable), which will be approved by the World Bank, and implemented before commencement of the activity. The SMF and FTPP provide the social screening formats to determine the requirement of developing TPPs. Furthermore, the FTPP documents the improvements and lessons learnt from the implementation of previous tribal health plans prepared in 2011 and also identifies existing gaps and mitigation measures required to be implemented under the project.

18. **Contents of Social Safeguard Frameworks.** The two frameworks, SMF and FTPP, include social screening formats for the subcomponents; consultation; communication, information dissemination, and feedback framework; grievance redress mechanisms; gender considerations; institutional arrangement and capacity building; and framework for monitoring and mitigation of adverse impacts. The FTPP is a stand-alone document that includes guidance on consultation strategies and participatory processes to gather feedback effectively and efficiently in a culturally appropriate and gender-sensitive manner so that appropriate mitigation measures can be designed. The FTPP also provides the social screening format to be administered by *Upazila* health officials to decide if a TPP needs to be developed. Grievance mechanism and institutional arrangements are also discussed. Based on the FTPP and the screening procedure as discussed above, site-specific TPPs have to be prepared, approved, disclosed, and implemented before interventions can occur. The World Bank has reviewed the SMF and FTPP and ensured compliance with the safeguard policies.

19. The SMF and FTPP prepared for the project address the potential social risks and concerns. The Planning Wing of HS Division and Planning Branch of ME&FW Division will monitor and follow up on the SMF as well as FTPP with the concerned line directorates. The Health Economics Unit of the MOHFW will take a lead on issues relating to gender, equity, voice, and accountability.

20. **Disclosure.** The SMF, FTPP, and EMF have been publicly disclosed at the MOHFW website as well as on the World Bank's website. Hard copies of the documents are available in the MOHFW. The disclosure notification was published in one Bangla and one English daily newspaper.

Monitoring and Evaluation

21. Data for tracking progress of the project's outcome and intermediate results indicators will be generated from the MOHFW's routine MISs. In addition, Bangladesh regularly carries out a variety of surveys in the HNP sector, at the household, facility, and community levels, which will provide supplementary information on quality of care, service utilization and coverage, and system functioning.

22. Progress of the project will be reported through the Annual Program Implementation Review report prepared within 90 days following the conclusion of each FY. The report will cover the larger sector program including the project and will be valid for the IDA credit, GFF grant and any other trust fund that may be established for the development partners. A mid-term review of the sector program, including the project, will be conducted around the first semester of the FY2020.

23. The PMMU of the MOHFW will be equipped with adequate skilled professionals and logistics. The PMMU will be instrumental for management, coordination, monitoring, and evaluation to track progress of the government's sector program.

Role of Partners

24. The HNP DP Consortium will provide for inter-DP coordination and strategic agreements among DPs active in the sector. The Chair and the Co-chair of the DP Consortium are elected every two years. To facilitate coordination between the MOHFW and the DPs during implementation, the Local Consultative Sub-Group for Health meets every six months. These meetings had been jointly chaired by the Secretary of the MOHFW and Chair of the DP Consortium. The arrangement following the bifurcation of the Ministry into two divisions is still to be determined.

25. A number of DPs are expected to pool their financial contributions through a Multi-Donor Trust Fund, administered by the World Bank. The pooled funds will be channeled through the same foreign exchange account at the Treasury. An Administration Agreement between the World Bank and each of these DPs will outline the terms and conditions of co-financing arrangements. There will be Grant Agreements between the government and World Bank outlining the terms and conditions applicable to resources under the co-financing arrangement.

26. For the purposes of the project, the co-financiers of the project are defined as the World Bank and those DPs that channel at least part of their financial support to the same designated foreign exchange account in the Central Bank for the purpose of financing defined eligible expenditures under the project. All other funding mechanisms used by DPs, whether through an agency-specific account held by the Central Bank or by MOHFW, or through commodity support, will be considered outside of the remit of the project.

27. Significant efforts are being undertaken to provide a harmonized and comprehensive package of consolidated technical cooperation and technical assistance, to support the implementation of the government's sector program and further the policy dialogue for the HNP sector. Both co-financing DPs and those that provide other support are engaged in developing such a coherent and consolidated technical support program, focusing on areas that include, but are not necessarily limited to financial management; procurement and logistics management; monitoring and evaluation; health care financing; human resource management; and governance and stewardship. These focus areas are in line with the

intention to increasingly rely on government systems and put in place a concerted effort to strengthen these systems.

ANNEX 5: FIDUCIARY ACTION PLAN

1. The HSSP provides a continuation in the priority focus and effort on strengthening the fiduciary systems and control functions of the MOHFW. The critical agreement, laying out the agenda in this area, was the 2015 Integrated Fiduciary Assessment and the related action plan, agreed by the MOHFW, the Bank and the other co-financing partners. The additional financing phase of the HSDP provides the first initial steps towards the realization on this action plan. The HSSP provides the next phase, carrying forward the earlier agreements to what should be achieved until June 2022 or the completion of the fourth sector program. Table 18 below shows this link, identifying the fiduciary issues highlighted by the assessment, the immediate steps supported by the HSDP and the follow-up actions to be supported by the HSSP. The HSSP will not be the only avenue of support. Additionally, areas of policy and technical engagement to be undertaken in the Bank's analytical and advisory work and collaboration with other development partners are noted.

Table 18. IFA Action Plan linked with the HSDP and HSSP

Fiduciary Issue	Short-Term Actions Supported by the HSDP (through June 2017)	Follow-Up Actions to be supported by the HSSP (through June 2022)	Other (TA, Working other DPs)
1. Strengthen system for identifying, investigating and reporting fraud and corruption.	- Bank has undertaken integrated Fiduciary Review for Project-supported expenditures.	- Support the strengthening and roll out of e-GP (DLI) and public GRS (DLI).	- Have policy and technical dialogue with the Office of the CAG on strengthening the capacity of the audit directorate, including possible investigative audit techniques. - Have policy and technical dialogue with the CMSD and central procurement authorities on identification of integrity risk flags.
2. Improve contract management through guidelines and technical skills.	- Contract Management Guidelines drafted, but not yet adopted (linked to the HSDP AF DLI)	- Adopt and train on guidelines for contract management in the health sector. (FAP)	
3. Reduce the risk of collusion resulting in unfair competition, fraud and waste.	- Implement project-specific remedial actions such as appointing independent consultants to be part of bid evaluation committees and excluding local agents from eligibility. (linked to HSDP AF DLI)	- Support the completion of the CMSD restructuring (DLI). - Support the evidence on the availability of essential drugs through expansion of information measuring stock-outs at Community Clinic level.	- In preparation of restructuring, benchmark of performance of the CMSD and plan for areas of improvement.

	- Proposal for CMSD restructuring prepared. (linked to the HSDP AF DLI) - Bank reviewed Bangladesh pharmaceutical market and the competitiveness of national Essential Drug Company.	(DLI) - Support the development, adoption and transparency of standard technical specifications for the common medical equipment at DH level. (FAP)	
4. Increase the capacity at the FMAU to comply with applicable financial procedures and controls.	- A restructuring proposal of the FMAU to improve its fiduciary oversight capacity approved by the MOPA. (linked to the HSDP AF DLI) - Strengthened FM capacity of the Line Directors through training - Validated expenditure data prior to submission of IUFR. - Continued to outsource internal audit reviews with external audit firm. (linked to the HSDP AF DLI)	- Support the completion of the FMAU restructuring and its undertaking of internal audit function for the DGHS (DLI). - Continue to outsource internal audit reviews with external audit firm until the FMAU capacity for internal audit established (FAP).	- Support the performance reviews of specific programs or sub-programs, including cost-effectiveness in collaboration with the FMAU.
5. Strengthen the AMS to reduce misuse of assets, underutilization, and waste of funds.	Accounting needs assessment completed to pilot an Financial Management Information System - Piloted an AMS (linked to the HSDP AF DLI)	- Support the MOF to roll-out of iBAS++ to all cost centers under the MOHFW. (FAP) - Support the institutionalization and roll-out of the AMS to selected DHs. (DLI)	- TA support for the roll-out of the AMS.
6. Improve the timeliness and effectiveness in resolving external audit findings to improve accountability.	- Bank identified material audit findings for response by the MOHFW. - Progress against audit findings regularly reported. No outstanding audit observations greater than 3 FYs.	- Bank will continue to identify material audit findings that need to be responded pertaining to the Project. (FAP) - Progress against the audit findings will be regularly followed up and reported. (FAP)	
7. Strengthening of an effective complaint handling system.	- Maintained a web and SMS-based GRS. (linked to the HSDP AF DLI)	Support the institutionalization, strengthening and transparency of the GRS system. (DLI)	- Have policy and technical dialogue with the DGHS.

2. Given the priority of strengthening the country systems and to address some of the issues identified as part of the World Bank's fiduciary systems assessment, a FAP has been agreed that would further complement the DLIs on systems strengthening under the HSSP Component 2. Besides highlighting these priority actions, the purpose of the Action Plan is to make measurable progress, in the areas agreed upon, over the project implementation period through monitoring and reporting on the progress. The World Bank, as well as other development partners, will also contribute to the progress of the actions through technical and other support. The FAP may need to be revised from time to time. Any changes will be mutually agreed between the MOHFW, the World Bank and any co-financing partners. As of now, the FAP including indicative timeline, responsibility and measurement is as follows:

Table 19. The HSSP FAP

Action Description	***Target Dates***	***Responsibility***	***Measurement***
1. Preparation of detailed (code wise) Annual Development Plan (ADP) budgets for submission to the Planning Wing, HS Division, and Planning Branch, ME&FW Division	July 22 each year starting from July 22, 2017	Line Directors, Planning Wing and Planning Branch	Detailed budgets/ Implementation progress report submitted to the Bank annually
2. Capacity building of MOHFW financial management staff and Line Directorates (LDs) based on the financial management course module prepared by the FMAU	Module developed by June 2018; training throughout the implementation period starting from July 2018 as per the new module	FMAU	Implementation progress report submitted to the World Bank
3. Develop an Asset Management Guideline	June 2018	Hospital Wing of the HSD in collaboration with LDs of IFM, HSM, PSSM-HS, PSSM-FP	Asset management guideline/ Implementation progress report submitted to the World Bank
4. Training manual developed for asset management and training implemented	Manual developed by December 2017; training throughout the implementation period starting from January 2018	Hospital Wing, MOHFW in collaboration with LD- HSM.	Implementation progress report submitted to the World Bank
5. Outsource annual internal audit to an external audit firm until such time as the FMAU is able to conduct internal audit and roll-out of internal audit manual of the MOF and train the MOHFW staff	Auditor(s) hired by June 2018 and continued annually; training of MOHFW staff in 2018 and continually	FMAU	Implementation progress report submitted to the World Bank annually
6. Develop and follow-up on implementation of an action plan based on the recommendations of the annual internal audit report	Action Plan developed based on Internal Audit report for FY2019 and implementation followed-up	FMAU	Implementation progress report submitted to the World Bank annually

Action Description	*Target Dates*	*Responsibility*	*Measurement*
7. Follow-up resolution of material audit observations from the external audit report	Annually, with majority of audit observations resolved on the previous year's audit before the next audit report is due	FMAU and all Line Directors	Implementation progress report submitted to the World Bank annually
8. Work with the MOF to roll out iBAS++ to the required cost-centers of the MOHFW	By December 2019	FMA Wing, HSD of the MOHFW	Implementation progress report submitted to the World Bank annually
9. Contract management guidelines are adopted and the CMSD and DGFP staff are trained	Guidelines adopted by December 2018; training will be throughout the implementation period	Dev. & ME Wing, MOHFW in collaboration with LDs of PSSM-HS, PSSM-FP	Implementation progress report submitted to the World Bank annually
10. Develop generic technical specifications, targeted for major medical equipment required at the DH according to the list of equipment at the health facility	Starting by June 2018, expanded and updated through the implementation period	Dev. & ME Wing, MOHFW in collaboration with LD-HSM, PSSM-HS	Implementation progress report submitted to the Bank annually

Note: Dev. & ME = Development and Medical Education; FMA = Financial Management and Audit; IFM = Improved Financial Management; HSM = Hospital Services Management; LD = Line Director; PSSM-FP = Procurement, Storage, and Supply Management - Family Planning; and PSSM = Procurement, Storage, and Supply Management - Health Services

ANNEX 6: REFERENCES

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ANNEX 7: MAP


BANGLADESH
HEALTH SECTOR SUPPORT PROJECT
DIVISIONS OF SPECIAL FOCUS
DISTRICT CAPITALS
DIVISION CAPITALS
NATIONAL CAPITAL
DISTRICT (ZILA) BOUNDARIES
DIVISION BOUNDARIES
INTERNATIONAL BOUNDARIES
BHUTAN
INDIA
INDIA
INDIA
MYANMAR
BANGLADESH
Panchagar
Thakurgaon
Nilphamari
Lalmonirhat
Kurigram
Rangpur
Dinajpur
Gaibandha
Joypurhat
Naogaon
Bogra
Sherpur
Jamalpur
Netrokona
Mymensingh
Sunamganj
Sylhet
Moulvi Bazar
Habiganj
Kishorganj
Nowabganj
Rajshahi
Natore
Sirajganj
Tangail
Pabna
Kushtia
Meherpur
Chuadanga
Jhenaidah
Magura
Rajbari
Faridpur
Gazipur
Narsingdi
Brahmanbaria
Manikganj
DHAKA
Narayanganj
Munshiganj
Comilla
Chandpur
Sariatpur
Madaripur
Gopalganj
Jessore
Narail
Khulna
Satkhira
Bagerhat
Jhalukathi
Perojpur
Barisal
Bhola
Patuakhali
Barguna
Lakhimpur
Noakhali
Feni
Khagrachhari
Rangamati
Kaptai Lake
Chittagong
Bandarban
Cox's Bazar
RAJSHAHI
KHULNA
BARISAL
DHAKA
CHITTAGONG
SYLHET
Ganges
Jamuna
Meghna
Mouths of the Ganges
Bay of Bengal
0 25 50 Kilometers
0 25 50 Miles
IBRD 43006 | JUNE 2017
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90°E
91°E
92°E
89°E
26°N
25°N
24°N
23°N
22°N
21°N