SUMMARY POVERTY REDUCTION AND SOCIAL STRATEGY

<table>
<thead>
<tr>
<th>Country:</th>
<th>Bangladesh</th>
<th>Project Title:</th>
<th>Urban Primary Health Care Services Delivery Project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lending/Financing Modality:</td>
<td>Sector Project Loan</td>
<td>Department/ Division:</td>
<td>South Asia Regional Department/ Human and Social Development Division</td>
</tr>
</tbody>
</table>

I. POVERTY ANALYSIS AND STRATEGY

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

Bangladesh has a population of about 143 million people, 1 of which 28% 2 dwell in urban areas within CCs and municipalities. Over the last few decades, the country's urban population has grown at four times the national population growth rate. By the year 2015, it is projected that nearly one-third of the population of Bangladesh will be living in urban areas. Due to rural-urban migration, this figure is expected to reach between 40%–60% of the country's total population by 2030. A study conducted in 2005 3 found that the total slum population in the six major cities was 5.4 million, or 35% of their combined overall population, with minimal access to basic facilities and services, especially primary health care.

Currently, Bangladesh's urban poverty incidence stands at 21.3%. 4 Though their contribution to the national GDP is estimated to be around 60%, nearly 80% of the households have incomes below the upper poverty line. They have a small asset base, and many depend on informal day-to-day jobs. Their biggest asset is health, and poor health results in loss in productivity or setbacks in poverty gains from catastrophic spending. Hence, the improvement in the lives of the urban poor/slum dwellers through access to basic health services has critical links to the country’s economic growth.

The urban poor in Bangladesh are especially vulnerable to out of pocket catastrophic health expenditures which can lead this population into further impoverishment. The urban poor pay a larger share of their income for health care, yet their health status is substantially lower than the national average and their access to health services is marginal. The women of poor urban community face high maternal mortality, and health problems due to unhygienic living conditions. The proposed project was designed with full consideration of the provisions of Bangladesh’s National Strategy for Accelerated Poverty Reduction-II 6 and the Sixth Five Year Plan (2011-2015) 7, together with ADB’s Country Partnership Strategy. 8 These strategies identify reduction of poverty, including improving access and quality to health care services to the poor, as priorities for poverty reduction. Moreover, the project is also aligned with Bangladesh’s National Health Policy (2011), draft national urban sector policy, and draft urban health strategy. It will support the Government of Bangladesh (GOB) in implementing its Health, Nutrition, and Population Sector Development Plan (HNPSDP) (2011-2016) and will build on the ongoing second phase of the Urban Primary Health Care Project (UPHCP II) toward poverty reduction among the urban poor in Bangladesh by improving their health status, especially those constituting the slum and floating populations. This is expected to have a positive economic return in terms of fewer days lost to illness, fewer days of lower productivity, reduced health care expenditures, and other positive externalities for the larger urbanized Bangladesh.

B. Poverty Analysis

Targeting Classification: General Intervention

1. Key Issues

Though the country has achieved impressive progress in some health indicators and related MDGs, inequities in the health conditions between the rich and the poor and between the urban poor and rural poor still exists due to the absence of accessible health services for the poor. Some examples are: 63.1 and 18.8 per 1,000 for infant and child mortality rates, respectively, in slum areas, and 29.8 and 1.3, respectively, for non-slum areas. More than half (56%) of under-five children in the slums are stunted, including 28% who are severely stunted, compared with non-slums with 36% of under-five children stunted. TFR is 2.5 and 1.9 births per woman for slum and non-slum areas, respectively. 9 Maternal health status is very poor, even for women living in proximity to facilities with skilled medical care, 70% of whom give birth at home with the assistance of untrained traditional birth attendants. These high frequencies of home delivery with insufficient preparedness expose women to higher risks and complications, along with delays in reaching the facilities. Reduction in the number of maternal deaths requires timely access to effective, affordable, and appropriate emergency obstetric care (EmOC) services. The use of health services by the urban poor is characterized by limited

---

4. BBS Household Income and Expenditure Survey (HIES), 2010.
access to health facilities. Only 33.4% have access to services from such facilities, 29% access facilities operated by NGOs, 58.2% self-medicate through over the counter medicine, and 48.6% still use traditional forms of medicine because they are cheaper. One positive aspect is that almost all their children are immunized.10 The main problems related to access and utilization of services on the demand side are proximity to facilities, opportunity costs of seeking health care, ignorance of eligibility criteria and entitlements, and unavailability of free medicine. Supply-side obstacles include political interference, clinic timing, shortage of trained service providers and doctors, and fluidity of the target population.

2. Design Features
The proposed project targets the poor and aims to improve access to urban health infrastructure and services through the construction of primary health care centers and comprehensive reproductive health care centers and reactivating user forums. It will implement (i) strong outreach activities to ensure community participation in the process of selecting and targeting the poor and in all other stages of project implementation, assessment, and evaluation; (ii) concerted behavior change communication (BCC) to overcome underutilization of facilities; (iii) an improved system for pro-poor targeting and issuance of red cards to minimize the exclusion of beneficiaries.

It will improve the urban health infrastructure and service delivery methods by building on the lessons learned from UPHCP I and II and the ongoing UGIIP-I and by strengthening pro-poor focus and reproductive health (RH) services and expanding the reach of urban health service provision to wider underserved areas and populations of the city corporations and municipalities. By strengthening and mainstreaming the public-private partnership (PPP) model of service delivery with a major focus on poor women’s health, the proposed project will enhance accountability and increase efficiencies in providing pro-poor services.

II. SOCIAL ANALYSIS AND STRATEGY

A. Findings of Social Analysis

Key Issues. It has been estimated that in Dhaka alone, around 35% of the people live below the poverty line, out of whom around 20% were classified as “hard core poor” (with incomes of less than Tk2,500 per month).11 As expected, in the proposed project catchment areas, poor households have more family members, particularly children, are substantially less educated, and have lower school attendance rates. Only 40% of household heads among the poor have achieved more than 5 years of schooling, and only 6% have had more than 10 years of schooling (HIES). They spend a higher proportion of their earnings on housing (24%), other non-food items (17%), transport (10%), and health and education (11%). Nutrition and food intake fall short of the requirements for a decent human life in urban areas. Both household assets and savings appear to be minimal. In the labor market, they face the challenges of low wages, underemployment, unemployment, and low skills levels. More than two-thirds of male workers from these households are involved either in production work, including transport laborers, such as rickshaw pullers, or trade workers like street vendors and those engaged in the retail trade. Employment options for poor female workers are even more limited. Given gender norms and lower education levels, they are excluded from a large range of sectors and occupations. Living conditions are extremely poor, and access to health services is minimal.

B. Consultation and Participation

1. Provide a summary of the consultation and participation (C&P) process during project preparation.
During project design, workshops were held and attended by stakeholder representatives from the Ministry of Local Government, Rural Development, and Cooperatives (MOLGRDC), Ministry of Health and Family Welfare (MOHFW), development partners (DPs), officials and staff of the CCs and municipalities, other health/community projects, PMU, and PA-NGOs. During these workshops, numerous issues were discussed and have been incorporated into the project design. Target beneficiaries were also consulted during field visits. During project implementation, participatory processes will be incorporated in the mapping of target beneficiaries and the monitoring of health services through the ward health committees in the community.

2. What level of C&P is envisaged during the project implementation and monitoring?
- Information sharing
- Consultation
- Collaborative decision making
- Empowerment

3. Was a C&P plan prepared for project implementation? Yes  No
Participation strategies are integrated into the BCC and M&E activities, which include (i) formation of a community-based health service monitoring committee in each CC/municipality; (ii) capacity building of the poor to effectively voice their needs and claim their entitlements; (iii) strengthening of the voice of the poor in decision making; and (iv) empowering the poor to assist CCs/municipalities to prepare community-based, primary health care services.

C. Gender and Development

Gender Mainstreaming Category: Gender Equity

1. Key Issues
The key gender issues in the project area are the following: (i) social and economic barriers towards institution-based

---

delivery, which lead to high maternal and infant mortality; (ii) unmet reproductive health (RH) and FP needs of women, including adolescents, leading to unwanted pregnancies; (iii) women’s inability and inadequate access to PHC services; (iv) absence of basic health care services at close proximity to the poor; (v) exploitation of, and violence against, women and adolescent girls, which have significant effects on women’s health; (vi) unequal food distribution and insufficient resource allocation for women’s health in poor households; and (vii) insufficient privacy for female patients posing as a barrier to services at the health care centers.

2. Key Actions

Measures included in the design to promote gender equality and women’s empowerment—access to and use of relevant services, resources, assets, or opportunities and participation in decision-making process:

- Gender action plan
- Other actions or measures
- No action or measure

The project plans to address the above gender issues by focusing on gender equity and equitable access to services and providing PHC and comprehensive reproductive health care services, viz., basic and comprehensive emergency obstetric care (EmOC) facilities, delivering an ESD+ package including intensive supply of family planning (FP) logistics, supplementary nutritional support, serving the underserved pockets by expanding horizontally through mobile and mini clinics in workplaces, and adjusting project timing with the community people’s timing. Observing the huge health need of the community and their limited resources, the proposed project will initiate community-based services delivered by the community volunteers who will be trained on counseling, motivation, and awareness raising skills. This will help empower the women to raise their voices to demand services in solving their problems. As part of its multidimensional approach, the project will engage community people in maintaining environmental hygiene and solid and medical waste management, to some extent. To address the gender equity issues, a Gender Action (GAP) has been prepared. The GAP will support the purpose and overall outputs of UPHCSDP by the explicit integration of gender concerns in the program outputs and outcome areas. Through its large focus on women’s health and by implementing the GAP, the project will enhance greater gender equity.

III. SOCIAL SAFEGUARD ISSUES AND OTHER SOCIAL RISKS

<table>
<thead>
<tr>
<th>Issue</th>
<th>Significant/ Limited/ No Impact</th>
<th>Strategy to Address Issue</th>
<th>Plan or Other Measures Included in Design</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involuntary Resettlement</td>
<td>No Impact</td>
<td>Category C project. There are no negative impacts on land, businesses, or structures. No involuntary resettlement effects are foreseen. A resettlement framework has been prepared as a prudent measure for civil works that involve construction of new facilities to support any potential need for land acquisition and compensation.</td>
<td>Resettlement Framework</td>
</tr>
<tr>
<td>Indigenous Peoples</td>
<td>No Impact</td>
<td>Category C project. None of the six city corporations or the five municipalities has a large indigenous population.</td>
<td>No Action</td>
</tr>
<tr>
<td>Labor</td>
<td></td>
<td>Employment opportunities will be provided by the civil works at fair wages that are equal for men and women for the same type of work. Contractor bidding documents will include core labor standards.</td>
<td>No Action</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Project design includes pro-poor targeting and demand-side financing. The project aims at making primary health services available and accessible to the urban population, and has special features to support demand-side financing for the poor.</td>
<td>No Action</td>
</tr>
<tr>
<td>Other Risks and/or Vulnerabilities</td>
<td>Limited</td>
<td>Category B project. An environment framework has been prepared that shows the potential adverse impacts are not significant, localized, and can be mitigated. The project will improve medical waste practices and will pilot new green initiatives including solar panels, solar water heaters, and rainwater collection.</td>
<td>Environment Framework</td>
</tr>
</tbody>
</table>

IV. MONITORING AND EVALUATION

Are social indicators included in the design and monitoring framework to facilitate monitoring of gender and social development activities and/or social impacts during project implementation? Yes No