SUMMARY OF PROJECT PERFORMANCE

A. Background

1. On 18 July 2012, the Asian Development Bank (ADB) approved a loan of $50 million from its Special Funds resources for the Urban Primary Health Care Services Delivery Project, which became effective on 3 December 2012.[1] The Swedish International Development Agency provides grant cofinancing equivalent to $20 million, which ADB administers. The Government of Bangladesh is financing $11 million for the project. The United Nations Population Fund provides about $3 million parallel grant cofinancing for complementary services. The project closing date is 31 March 2018. The project provides urban primary health care (PHC) services to the urban population, particularly the poor, vulnerable women, and children, through public–private partnership (PPP) including nongovernment organizations (NGOs), civil society organizations, charitable missions, and non-state actors. The project was also designed to strengthen urban governance and the capacities of urban local governments in institutional arrangement and financial sustainability for the management and delivery of urban PHC.

2. The first phase of the project started in 1998 through the Urban Primary Health Care Project (1998–2005), followed by the Second Urban Primary Health Care Project (2005–2012) and the ongoing phase project (2012–present).[2] The project is one of the largest PPP interventions for urban PHC services in South Asia and applies an innovative contracting model of health care delivery that has proven to be efficient and effective.[3] At present, the project covers an urban population of 9.5 million across 10 cities and four municipalities and has a network of 138 health facilities and 226 satellite clinics at the community level. The Local Government Division (LGD) in the Ministry of Local Government, Rural Development and Cooperatives is the executing agency; and the respective city corporations and municipalities are implementing agencies.

3. The impact of the project is improved health of the urban population in Bangladesh, particularly the poor, women, and children. The outcome is sustainable good quality urban PHC services provided in project areas that target the poor and the needs of women and children. The project outcome is supported through the following outputs: (i) strengthened institutional governance and local government capacity to sustainably deliver urban PHC services; (ii) improved accessibility, quality, and utilization of the urban PHC services delivery system, with a focus on the poor, women, and children, through PPP; and (iii) effective support for decentralized project management.

B. Performance of the Project

4. **Status of project implementation.** The independent midterm review notes that the vacuum created by the lack of urban public primary health infrastructure and limited primary health services by the government is being partially balanced by fragmented services provided by

[1] ADB. 2012. *Report and Recommendation of the President to the Board of Directors: Proposed Loan, Technical Assistance Grant, and Administration of Grant to the People's Republic of Bangladesh for the Urban Primary Health Care Services Delivery Project.* Manila.

[2] ADB. 1997. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Asian Development Fund Grant to the People's Republic of Bangladesh for the Urban Primary Health Care Project.* Manila; and ADB. 2005. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Asian Development Fund Grant to the People's Republic of Bangladesh for the Second Urban Primary Health Care Project.* Manila.

[3] A. Heard, D.K. Nath, B. Loevinsohn. 2013. Contracting urban primary healthcare services in Bangladesh - effect on use, efficiency, equity and quality of care. *Tropical Medicine and International Health.* 18 (7). pp. 861–870.

different NGOs, including those working on implementing the Urban Primary Health Care Services Delivery Project. Several challenges remain, and lessons learned need time to be internalized in the institutional structures of the national and local levels. However, the project and the model of urban PHC service delivery that has been established merits extension and expansion to continue providing leadership to support the country's plans to deliver urban PHC services in a programmatic mode.

(i) **Delivery of expected outputs.**

(a) **Sustainability.** The Urban Primary Health Care Services Delivery Project has strengthened the mandate of the LGD to provide urban PHC services in the country through (i) establishing PHC infrastructure and a services network; (ii) involving urban local bodies (ULBs) in project areas to monitor the performance of service providers; (iii) supporting the creation of national, local, and donor institutions to deliver urban PHC services; and (iv) supporting the LGD to operationalize the National Urban Health Strategy. ADB has been involved since 1998 in project modality. The central and local government urban health system needs to be strengthened in terms of the financial, management, and technical capacity of the LGD and ULBs. The current phase has incorporated some of the activities but has not been able to gain much traction. The intended purpose of the Urban Primary Health Care Sustainability Fund in contributing to the sustainability of urban PHC was undermined by uneven contributions from city corporations and municipalities and lack of practical guidelines on the use of the fund. Because of the limited city corporations and municipality budgets, sustainability can only be assured through the establishment of a budget line at the LGD level, which has been strongly communicated to the LGD and was acknowledged as critical.

(b) **Service coverage and equity.** The project coverage at loan effectiveness was 7.7 million people and it presently covers a population of 9.5 million. At least 30% of each major category of health services is accessed by the poor. At midterm review, the Urban Primary Health Care Services Delivery Project provided 25.5 million services to some 23.5 million contacts, of which 74% were women and 26% men. Red card distribution was consistently around 85% and at least three rounds of household poverty checklist surveys were conducted for the identification of target beneficiaries for fee exempt services.

(c) **Utilization of services.** Analysis of service data shows that antenatal and postnatal service contacts per facility delivery reported were higher than the findings from project and national surveys. The high service contact–delivery ratio, especially for antenatal care, suggests many maternity clients deliver elsewhere and/or a data quality issue. The proportion of caesarean sections to total facility deliveries was about 37% from 2013 to 2016 and warrants further examination through operations research.

(d) **Quality of services.** Using data from semiannual integrated supervisory instrument surveys, the achievement of service quality indicators—such as antenatal care visits, availability and completeness of postpartum hemorrhage kits, emergency kits and eclamptic kits, infection prevention protocols, clinical waste management, medical staff knowledge of newborn danger signs and maternal danger signs, and community satisfaction—has been high, with 96% of the service providers scoring above 80 (out of 100).

(e) **Human resource capacity and development**. Project management unit (PMU) staffing has been satisfactory and the gender action plan was

implemented. While project implementing units in ULBs were established, the capacity and retention of counterpart human resources in the health departments of ULBs need to be strengthened by (i) increasing position levels, (ii) implementing a career development plan, and (iii) using project technical assistance and material support for capacity development.

(f) **Financial management information system.** Financial management was enhanced and the flow of funds improved compared with previous phases through the adoption of Tally software and consultancy support in the PMU. The proposed expanded PMU includes additional financial and accountancy staff.

(g) **Project monitoring and data reporting.** The project has developed an online unified record-keeping system for monthly service delivery data reporting and the data are compiled in quarterly progress reports. However, a delay in adapting a real-time, patient-centered health management information system has affected the effectiveness of the steering and management functions of urban PHC at the ULB level. Consequently, the service data are not included in the national health statistics. Most importantly, data analysis and use are not evidenced; and the quality of data is affected.

(ii) **Satisfactory implementation progress.** As of 7 May 2018, cumulative contract awards are $63.95 million (95% achieved) and disbursements are $56.76 million (85% achieved) against the net loan and grant amount of $67.02 million. Overall physical progress stands at 95% overall.

(iii) **Satisfactory compliance with safeguard policy requirements.** Safeguard consultants have assisted the government to update the (a) environmental assessment and review framework and (b) resettlement and indigenous peoples planning framework as a precautionary approach. If any impact occurs on safeguards during the project phase, the executing agency has agreed to use the frameworks. The consultants have also prepared an initial environmental examination for the ongoing project and in advance of site selection under the additional financing.

(iv) **Successful management of risks.** During project design, several risks were identified: (a) priorities and programs of the Government of Bangladesh change; (b) governance and corruption risks are not minimized; (c) citizen demands for greater participation, transparency, and accountability are not met; (d) ULBs lack sufficient funds to implement programs and strategies for strengthening pro-poor urban PHC services; (e) political pressures at the ULB level divert resources and efforts away from the delivery of PHC services; (f) recurrent expenditures are inadequate to sustain the services of partnership area NGOs after the project ends; (g) procedural problems arise in the contracting process because relations between ULBs and contracted NGOs do not remain smooth or NGO partners are not supervised effectively; and (h) turnover of counterpart technical staff is high because of resignations, promotions, or assignments to other government or private offices.

(v) Numerous risks were identified but the project mitigated them successfully, so major risks did not threaten the successful implementation of the project. While no major risks exist, a few overarching risks relate to the ULBs having sufficient funds to implement and sustain service delivery after the project ends. The ongoing

project is the first phase that attempted to address sustainability issues, which the additional financing is a good way to reinforce by using the existing setup and have an opportunity to enhance the setup further.

(vi) **On track rating.** The project has been rated *on track* since January 2013.

(vii) **Rationale and scope of additional financing.** Given the successful performance of the current project and the government's request to continue the momentum by scaling up coverage and strengthening institutional and financial sustainability, additional financing is warranted and was included in the latest country operations business plan.[4] The proposed additional financing will (a) strengthen both central and local government institutional governance and capacity for the sustainable delivery of primary health services, including applying climate change adaptation and resilience approaches for infrastructure and capacity development; (b) scale up the provision of primary health services especially for the poor, women, and children to an additional 12 ULBs (from a total of 14 to 26); and (c) provide effective support for decentralized project management.

[4] ADB. 2017. *Country Operations Business Plan: Bangladesh, 2018–2020.* Manila.