Report and Recommendation of the President to the Board of Directors

Project Number: 42177-024
Loan Number: 2878-BAN
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August 2018

Proposed Loan and Administration of Grant for Additional Financing
People's Republic of Bangladesh: Urban Primary Health Care Services Delivery Project

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Asian Development Bank

CURRENCY EQUIVALENTS
(as of 1 August 2018)

Currency unit	–	taka (Tk)
Tk1.00	=	$0.01183
$1.00	=	Tk84.52470

ABBREVIATIONS

ADB	–	Asian Development Bank
LGD	–	Local Government Division
MOHFW	–	Ministry of Health and Family Welfare
MOLGRDC	–	Ministry of Local Government, Rural Development and Cooperatives
NGO	–	nongovernment organization
NUHS	–	National Urban Health Strategy
PAM	–	project administration manual
PHC	–	primary health care
PMU	–	project management unit
PPP	–	public–private partnership
UHCC	–	urban health coordination committee
ULB	–	urban local body

NOTES

(i) The fiscal year (FY) of the Government of Bangladesh ends on 30 June. “FY” before a calendar year denotes the year in which the fiscal year ends, e.g., FY2018 ends on 30 June 2018.

(ii) In this report, “$” refers to United States dollars.

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PROJECT AT A GLANCE

1. Basic Data			**Project Number:** 42177-024
Project Name	Urban Primary Health Care Services Delivery Project - Additional Financing	**Department /Division**	SARD/SAHS
Country	Bangladesh	**Executing Agency**	Local Govt Div,Min of Local Govt Rural Devt & Coop
Borrower	People's Republic of Bangladesh		

2. Sector	**Subsector(s)**		**ADB Financing ($ million)**
✓ **Health**	Health system development		110.00
		Total	**110.00**

3. Strategic Agenda	**Subcomponents**	**Climate Change Information**	
Inclusive economic growth (IEG)	Pillar 2: Access to economic opportunities, including jobs, made more inclusive	CO_2 reduction (tons per annum)	836
Environmentally sustainable growth (ESG)	Global and regional transboundary environmental concerns	Climate Change impact on the Project	Medium
		ADB Financing	
		Adaptation ($ million)	5.62
		Mitigation ($ million)	1.71
		Cofinancing	
		Adaptation ($ million)	0.80
		Mitigation ($ million)	0.79

4. Drivers of Change	**Components**	**Gender Equity and Mainstreaming**	
Governance and capacity development (GCD)	Civil society participation Institutional development Organizational development	Gender equity (GEN)	✓
Knowledge solutions (KNS)	Knowledge sharing activities Pilot-testing innovation and learning		
Partnerships (PAR)	Civil society organizations Implementation Official cofinancing United Nations organization		
Private sector development (PSD)	Public sector goods and services essential for private sector development		

5. Poverty and SDG Targeting		**Location Impact**	
Geographic Targeting	No	Urban	High
Household Targeting	No		
SDG Targeting	Yes		
SDG Goals	SDG3, SDG11		

6. Risk Categorization: Low

7. Safeguard Categorization **Environment:** B **Involuntary Resettlement:** C **Indigenous Peoples:** C

8. Financing

Modality and Sources	Amount ($ million)
ADB	**110.00**
Sovereign Project (Concessional Loan): Ordinary capital resources	110.00
Cofinancing	**2.00**
Urban Climate Change Resilience Trust Fund under the Urban Financing Partnership Facility - Project grant (Full ADB Administration)	2.00
Counterpart	**30.00**
Government	30.00
Total	**142.00**

Source: Asian Development Bank

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on a proposed loan to the People's Republic of Bangladesh for the additional financing of the Urban Primary Health Care Services Delivery Project. The report also describes the proposed administration of a grant to be provided by the Urban Climate Change Resilience Trust Fund[1] under the Urban Financing Partnership Facility, for the additional financing of the Urban Primary Health Care Services Delivery Project, and if the Board approves the proposed loan, I, acting under the authority delegated to me by the Board, approve the administration of the grant.

2. The project supports improving the accessibility, quality, and use of urban primary health care (PHC) services through public–private partnership (PPP).[2] The proposed additional financing will (i) strengthen institutions and capacity for sustainable delivery of urban PHC; (ii) scale up successful provision of PHC services, especially for the poor, vulnerable, women, and children; and (iii) provide effective support to decentralized project management.

II. THE PROJECT

A. Rationale

3. On 18 July 2012, Asian Development Bank (ADB) approved the project in the amount of $50 million loan and cofinancing of $20 million equivalent, which covers 10 cities and four municipalities (9.5 million population), representing about 17% of the total 57 million urban population. The project is one of the largest PPP projects in the delivery of PHC in South Asia and is recognized for its longstanding innovative model of partnership between the government contracting out health service delivery and service providers (mainly nongovernment organizations [NGOs]).[3] Although ADB has supported PHC in urban areas through the first and second Urban Primary Health Care Projects, significant investment is still needed to enhance service delivery, reduce health inequalities, and strengthen institutional sustainability.[4]

4. The project has been filling a vacuum created by the lack of urban public primary health infrastructure and limited primary health services by (i) increasing the access of target beneficiaries, especially from poor households, to the essential service package[5] provided by service providers; (ii) providing 25.5 million services to some 23.5 million client contacts, of which 74% were female and 26% male at midterm review in November 2015; (iii) constructing a network of over 180 health facilities and 224 satellite clinics nationwide run by about 3,000 health workers; (iv) building experience in the management and contracting of health service delivery by service

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[1] Financing partners: The Rockefeller Foundation and the governments of Switzerland and the United Kingdom.

[2] Asian Development Bank (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.

[3] PPP exists where the urban local government enters into a long-term contract with a service provider selected after a competitive bidding process, for providing a specified set of health services in a public health facility and achieving a specified income generation target, in which the service provider bears significant risk and management responsibility.

[4] ADB. 1996. *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.

[5] The health package is described in Annex 10 of the Project Administration Manual (PAM, accessible from the list of linked documents in Appendix 2).

providers; and (v) strengthening procurement, financial management, and monitoring and evaluation systems.

5. **Experience and lessons learned from the current project**. The project is demonstrating good results. The independent midterm review in November 2015 observed that through the project, the Local Government Division (LGD), the executing agency, effectively provides leadership to the country's efforts in finding scalable models for urban PHC delivery through urban local bodies (ULBs). The review also stated that the project merits continuation and expansion to (i) meet growing demand for health care in urban areas and (ii) contribute significantly to continue providing leadership to support the country's plans to deliver urban PHC sustainably. A study has shown that the project's modality of contracting service delivery is an effective and efficient means to extend service coverage.[6] An impact evaluation analysis identified positive effects of the second phase project on key health outcomes such as antenatal care, skilled birth attendance, and diarrhea and acute respiratory infection in children.[7] Apart from the partnership model, the current project has incorporated several innovative features such as (i) pilot testing of green clinics with solar panel renewable energy; (ii) establishing a health and demographic surveillance system to improve health information on the urban poor;[8] (iii) being highly inclusive, where 80% of curative services are for women and girls, and 30% of services are provided free for the poor; and (iv) communities actively leading urban health coordination committees (UHCCs).

6. Despite this progress, further measures are needed to enhance the existing setup by harnessing the project's momentum. The proposed additional financing will cover the cost of the 5-year extension to assist the government to (i) strengthen local health systems and capacities with an integrated and long-term perspective toward a sustainable urban primary health sector, (ii) continue and scale up the PPP modality of contracting service providers, and (iii) provide effective support to decentralized project management. It will also expand on previous efforts in climate change mitigation through solar panels for "green clinics" to include both climate change mitigation and adaptation measures such as (i) conducting climate risk and vulnerability assessments; (ii) adopting climate-resilient infrastructure including solar panels, rain-water harvesting system, and flood protection drain system; (iii) training on medical waste management and disposal; and (iv) building capacity on climate change resilience (water and electricity conservation, disaster and emergency response, disease surveillance, and outbreak response).[9]

7. **Sustainability**. The sustainability of health services will be ensured by strengthening the LGD's Urban Development Wing into a functional, fully staffed permanent institutional body; and establishing a dedicated revenue budget head for urban primary health under the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC) from which government budget allocations will supplement city and municipal health financing. The ULBs will also ensure financing, staff, and institutional arrangements to be sustained accordingly. After project completion, health services will mainly continue to be contracted out, and where the capacity exists, selected local governments may deliver services by themselves. Government commitment and prioritization at all levels is required to ensure that adequate financing and institutions will be in place.

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[6] A. Heard, D.K. Nath, and B. Loevinsohn. 2013. Contracting urban primary health care services in Bangladesh – effect on use, efficiency, equity, and quality of care. *Tropical Medicine and International Health*. 18 (7). pp. 861–70.

[7] M.L. Albis, S.K. Bhadra, and B. Chin. Forthcoming. Impact evaluation of contracting primary health care services in urban Bangladesh.

[8] The Health and Demographic Surveillance System covers selected slums of Dhaka (North & South) and Gazipur City Corporations and provides information on the urban poor related to migration, noncommunicable disease, and its risk factors, gender, and health care costs.

[9] Climate risks include flooding, salt water intrusion, rising temperature, and spread of infectious diseases.

8. **Government priorities.** The additional financing will support the sector framework, the National Urban Health Strategy (NUHS), and its forthcoming action plan.[10] The continued assistance of ADB reflects the priorities of the government's Seventh Five-Year Plan, FY2016–FY2020, which emphasizes the need for PHC of urban residents, including slum and street dwellers.[11] The plan highlights the need to manage urban health and build a coalition of interests around one harmonized approach for greater coordination between the MOLGRDC and the Ministry of Health and Family Welfare (MOHFW). City and municipal ward level committees and the development partners' forum are progressively improving coordination. Local government health officials will play a larger stewardship role for all actors in the health space (public, private, NGOs, charitable providers, and development partners).

9. **Alignment with ADB priorities**. The project will contribute to Sustainable Development Goals 3 and 11;[12] and is aligned with ADB's Operational Plan for Health, 2015–2020 and country partnership strategy for Bangladesh, 2016–2020, which identify urban health as a specific priority.[13] The proposed ADB support is also aligned with Strategy 2030, which emphasizes the need for ADB to expand health operations to support developing member countries to achieve universal health coverage as well as facilitate PPPs and engagement with the NGOs and civil society organizations to leverage and improve results.[14]

10. **Additional financing eligibility criteria.** The additional financing meets ADB's eligibility criteria. The overall project (i) remains technically feasible, economically viable, and financially sound; (ii) is accorded high priority by the government; and (iii) is consistent with the current project's development objectives, the government's priorities, and ADB's country partnership strategy, which prioritizes urban PHC, governance improvement, and climate- and disaster-resilient infrastructure and services. The current project has been rated *on track* since it started, and implementation progress and results are satisfactory. As of 6 July 2018, cumulative contract awards are $64.1 million (96% achieved) and disbursements are $60.2 million (90% achieved) against the net loan and grant amount of $66.9 million. Overall physical progress is 95%. The current project has complied with all safeguard requirements and adequately managed risks. Project readiness for additional financing is high.

B. Impact and Outcome

11. The project is aligned with the following impact: improved health, nutrition, and family planning status of the urban population, particularly the poor, women, and children, aligned with the government's NUHS. The project will have the following outcome: sustainable good quality urban PHC services are provided in the project areas and target the poor and the needs of women and children.[15]

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[10] Government of Bangladesh, MOLGRDC, Local Government Division (LGD). 2014. *National Urban Health Strategy*. Dhaka; Government of Bangladesh, MOLGRDC, LGD. Forthcoming. *Action Plan for Implementation of the National Urban Health Strategy*. Dhaka.

[11] Government of Bangladesh, Ministry of Planning, Planning Commission. 2015. *Seventh Five-Year Plan, FY2016–FY2020*. Dhaka.

[12] Sustainable Development Goals 3 on health and 11 on inclusive, safe, resilient, and sustainable cities.

[13] ADB. 2015. *Operational Plan for Health, 2015–2020*. Manila; and ADB. 2016. *Country Partnership Strategy: Bangladesh, 2016–2020.* Manila.

[14] ADB. 2018. *Strategy 2030: Achieving a Prosperous, Inclusive, Resilient, and Sustainable Asia and the Pacific*. Manila.

[15] The current and overall (current project including additional financing) outcome targets are in the revised design and monitoring framework in Appendix 1.

C. Outputs

12. The project outcome will be supported through the following outputs: (i) institutional governance and local government capacity to deliver urban PHC services sustainably strengthened; (ii) accessibility, quality, and utilization of urban PHC services (with a focus on the poor, women, and children) improved through PPP; and (iii) effective support for decentralized project management provided.

13. **Output 1: Institutional governance and local government capacity to deliver urban primary health care services sustainably strengthened**. The additional financing will (i) strengthen the LGD's Urban Development Wing to effectively coordinate urban health; (ii) establish a revenue budget head in the MOLGRDC to manage PHC and operate and maintain PHC facilities sustainably; (iii) facilitate revenue budget allocations to supplement city and municipal health financing; (iv) facilitate coordination among the LGD, MOHFW, and development partners under one harmonized approach as detailed in the NUHS; and (v) support city and municipality health departments to develop organograms and reorganization plans and integrate with other determinants of health and related climate-sensitive subsectors (e.g., water, sanitation, and waste management) in a holistic manner to improve public health. Improved coordination will enhance the governance and stewardship roles of the LGD and MOHFW in key strategic areas (quality assurance, referral linkages, human resources, and information systems). The additional financing will continue to support mapping of all health facilities in the project areas, including those under the MOHFW and private service providers, to help develop effective referral systems and identify gaps in coverage, particularly for the poor, slum, and floating populations. Information systems will be improved by developing a real-time patient management system that will be linked to the national health management information system and automatically generate routine reports to support performance monitoring and management.

14. **Output 2: Accessibility, quality, and utilization of urban primary health care services (with a focus on the poor, women, and children) improved through public–private partnership**. The additional financing will (i) expand coverage to additional one city and 10 municipalities;[16] (ii) continue provision of PHC through contracting out to service providers; and (iii) construct additional eight comprehensive reproductive health care centers and 24 PHC centers where such facilities do not exist in the project areas, and modernize existing facilities. Partnership agreements will be further refined to give greater emphasis on the quality of the service provider compared to the cost proposed. The service providers will deliver essential health services in the partnership areas where females use about 80% of the services.[17] New medical equipment and in-service training for health care personnel will be provided to enhance the quality of services. The additional financing will continue to support semiannual independent monitoring of service providers' performance and quality improvement, using an Integrated Supervisory Instrument covering health service delivery and quality, coverage of the poor, as well as management and accounting practices. A behavior change communication and marketing program aligned with an updated behavior change communication strategy will engage audiences through an innovative, interactive, multi-platform campaign;[18] empower and build capacity of service providers, through participatory approaches, to develop and implement local media plans;

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[16] As well as the existing 10 city corporations and four municipalities covering about 9.5 million people, the additional financing will include Chattogram City Corporation and 10 selected municipalities that have a large poor and vulnerable population and no medical colleges or 300 bed hospitals. In total, 11 city corporations and 14 municipalities (16.7 million people) will be covered by the project. These are listed in Annex 4 of the PAM.

[17] Additional focus on child and maternal nutrition, neonatal health, adolescent health, and noncommunicable diseases.

[18] Television, radio, newspaper, mobile, social media, website, and interpersonal communication through door-to-door, clinic, community theater, and community events.

and sustain the project by strengthening transition advocacy with the LGD and ULBs. To assess the effectiveness and efficiency of the project, including across various geographical areas, communities, and interventions, baseline and end line surveys will be conducted.

15. **Output 3: Effective support for decentralized project management provided**. The additional financing will provide (i) policy support (planning and coordination) for institutional strengthening actions at central and ULB levels; (ii) technical support to the project management unit (PMU) and ULBs in procurement, monitoring, financial management, implementing the gender action plan, and monitoring environmental and social safeguards; and (iii) training and capacity development for the LGD, city and municipal health departments, and service providers. To empower the ULBs and ensure more ownership and sustainability of urban PHC, the project will further devolve the management and implementation responsibilities of the PMU in the LGD to project implementing units in the health departments of selected ULBs, which will receive focused guidance and technical support.

D. Investment and Financing Plans

16. The project is estimated to cost $142 million, including additional financing of $110 million from ADB (Table 1). Detailed cost estimates by expenditure category and detailed cost estimates by financier are in the project administration manual (PAM).[19]

Table 1: Project Investment Plan
($ million)

Item	Current Amount[a]	Additional Financing[b]	Total
A. Base Cost[c]			
1. Institutional governance and capacity to deliver urban primary health care services sustainably strengthened	3.82	5.70	9.52
2. Accessibility, quality, and utilization of urban primary health care services delivery system improved	62.43	112.50	174.93
3. Effective support for decentralized project management provided	8.00	11.00	19.00
Subtotal (A)	**74.25**	**129.20**	**203.45**
B. Contingencies[d]	**5.45**	**7.10**	**12.55**
C. Financing Charges During Implementation[e]	**1.30**	**5.70**	**7.00**
Total (A+B+C)	**81.00**	**142.00**	**223.00**

[a] Refers to the original amount. Includes taxes and duties of $6.85 million financed from government resources.
[b] Includes taxes and duties of $23.26 million to be financed from government resources.
[c] In June 2018 prices; exchange rate of $1 = Tk80 is used.
[d] Physical contingencies computed at 6.43% for civil works and equipment. Price contingencies computed at 1.5% on foreign exchange costs and 6.3% on local currency costs; includes provision for potential exchange rate fluctuation under the assumption of a purchasing power parity exchange rate.
[e] Includes interest during construction for a concessional ordinary capital resources loan computed at 2% per year.
Source: Asian Development Bank.

17. The government has requested a concessional loan of $110 million from ADB's ordinary capital resources to help finance the project. The loan will have a 25-year term, including a grace period of 5 years; an interest rate of 2% per year during the grace period and thereafter; and such other terms and conditions set forth in the draft loan and project agreements. The Urban Climate Change Resilience Trust Fund under the Urban Financing Partnership Facility will provide grant

[19] PAM (accessible from the list of linked documents in Appendix 2).

cofinancing of $2 million, to be administered by ADB.[20] The United Nations Population Fund will provide in-kind support of $1.5 million for complementary activities.[21]

18. The financing plan is in Table 2. ADB will finance $110 million loan (77.5% of the financing), the Urban Climate Change Resilience Trust Fund will provide $2 million grant (1.4%), and the Government of Bangladesh will provide the equivalent of $30 million (21.1%).

Table 2: Financing Plan

Source	Current[a]		Additional Financing		Total	
	Amount ($ million)	**Share of Total** (%)	**Amount** ($ million)	**Share of Total** (%)	**Amount** ($ million)	**Share of Total** (%)
ADB	50.0	61.7	110.0	77.5	160.0	71.7
UCCRTF[b]	0.0	0.0	2.0	1.4	2.0	0.9
Government of Sweden[c]	20.0	24.7	0.0	0.0	20.0	9.0
Government of Bangladesh	11.0	13.6	30.0	21.1	41.0	18.4
Total	**81.0**	**100.0**	**142.0**	**100.0**	**223.0**	**100.0**

ADB = Asian Development Bank, UCCRTF = Urban Climate Change Resilience Trust Fund.
[a] Refers to the original amount of the project.
[b] Financing partners: the Rockefeller Foundation and the governments of Switzerland and the United Kingdom. Administered by ADB.
[c] Administered by ADB. This amount also includes ADB's administration fee, audit costs, bank charges, and a provision for foreign exchange fluctuations (if any), to the extent that these items are not covered by the interest and investment income earned on this grant, or any additional grant from the Government of Sweden.
Source: Asian Development Bank estimates.

19. Climate change mitigation is estimated to cost $2.50 million and climate change adaptation is estimated to cost $6.42 million. ADB will finance 68.4% and 87.5% of mitigation and adaptation costs, respectively, excluding taxes and duties. Changes in rainfall and temperature may result in wetter or drier conditions that could contribute to flooding or droughts. Details are described in the PAM (footnote 19).

E. Implementation Arrangements

20. The LGD of the MOLGRDC will continue to be the executing agency. City corporations and municipal governments will likewise continue to be the implementing agencies in their project areas. A PMU headed by a full-time project director in the LGD will provide the technical, administrative, and logistical support required for implementation. An interministerial national project steering committee, chaired by the secretary of the LGD, will continue to oversee the overall project implementation. In addition to the existing 14 project implementing units in ULB health departments, 11 additional units will be created to oversee implementation in project cities and municipalities. The UHCCs will be set up in each project city or municipality to coordinate field activities and stakeholder participation, and will be chaired by ULB chief executive officers. Cities and municipalities are divided into wards for administrative purposes, so ward UHCCs co-chaired by ward commissioners and zonal health officers will be created and include representation from local stakeholders. Where standing committees with similar responsibilities already exist—dealing with health and water and sanitation, for example—the role envisaged for the UHCCs may be assigned to these committees so that parallel structures are not established.

[20] Financing partners: the Rockefeller Foundation and the governments of Switzerland and the United Kingdom. Grant activities are described in the PAM.
[21] The United Nations Population Fund will provide support in family planning and adolescent sexual reproductive health.

21. Procurement of civil works, goods, and related services will be in accordance with ADB's Procurement Guidelines (2015, as amended from time to time). Packages using national competitive bidding may follow the government's Public Procurement Act, 2006 and Public Procurement Rules, 2008, with modifications agreed between the government and ADB, as set out in the procurement plan. Consulting services will be engaged in accordance with ADB's Guidelines on the Use of Consultants (2013, as amended from time to time). The implementation arrangements are summarized in Table 3 and described in detail in the PAM, which includes an indicative procurement plan (footnote 19).

Table 3: Implementation Arrangements

Aspects	**Arrangements**		
Implementation period	1 April 2018–31 March 2023		
Estimated completion date	31 March 2023 (closing date for concessional loan: 30 September 2023; UCCRTF grant closing date: 31 December 2021; loan and grant closing date for original financing: 30 September 2018)		
Management			
(i) Oversight body	National Project Steering Committee Secretary, LGD (chair) Representatives of MOHFW, project ULBs, MOF, and Planning Commission (members)		
(ii) Executing agency	LGD, MOLGRDC		
(iii) Key implementing agencies	City corporations, municipal governments		
(iv) Implementation unit	PMU under the LGD		
Procurement[a]	ICB	45 contracts	$80.44 million
	NCB	40 contracts	$27.69 million
	Shopping	4 contracts	$0.62 million
Consulting services	QCBS	240 person-months	$7.99 million
	CQS	99 person-months	$0.82 million
	SSS	36 person-months	$0.32 million
	ICS	296 person-months	$2.00 million
Retroactive financing and/or advance contracting	ADB may, subject to its policies and procedures, allow on request advance contracting of procurement and consulting services, and may finance up to 20% of the loan and the grant amounts for eligible expenditures for operational costs incurred in the 12-month period before signing of the loan and grant agreements. Any approval of advance contracting or retroactive financing will not constitute a commitment by ADB to finance the project.		
Disbursement	The loan and grant proceeds will be disbursed in accordance with ADB's *Loan Disbursement Handbook* (2017, as amended from time to time) and detailed arrangements agreed between the government and ADB.		

ADB = Asian Development Bank; CQS = consultants qualification selection; ICB = international competitive bidding; ICS = individual consultants selection; LGD = Local Government Division; MOF = Ministry of Finance; MOHFW = Ministry of Health and Family Welfare; MOLGRDC = Ministry of Local Government, Rural Development and Cooperatives; NCB = national competitive bidding; PMU = project management unit; QCBS = quality- and cost-based selection; SSS = single-source selection; UCCRTF = Urban Climate Change Resilience Trust Fund; ULB = urban local body.
[a] Universal procurement applies.
Source: Asian Development Bank.

III. DUE DILIGENCE

A. Economic and Financial

22. **Economic viability.** The economic rationale for investing in the additional financing lies in improved health outcomes through improved access to effective, efficient, and sustainable PHC services. The project is pro-poor in its focus on addressing the health care needs of the urban poor. The economic benefits accrue from (i) savings from reduced household out-of-pocket

expenditures and (ii) benefits from disability-adjusted life years averted. The economic internal rate of return on the project investment is estimated to be 9.5%, with a net present value of $8.5 million over a 20-year (2018–2037) benefit stream. The economic internal rate of return was tested through sensitivity analysis, which showed that even under adverse changes to assumptions, the additional financing remains economically viable.

23. **Financial sustainability.** The government needs to allocate additional funds after the project to sustain the current level of service coverage. A total of Tk1.3 billion per year will be required as recurrent expenditure from 2023. The financial sustainability of the project and the sector will be ensured through specific interventions, including the implementation of the NUHS and revitalizing the Urban Primary Health Care Sustainability Fund.[22] The LGD is committed to sustaining urban PHC activities. In this regard, the LGD will develop a revenue (nondevelopment) budget line for urban PHC and provide supplementary financing for PHC (salaries, administration, overhead, and service delivery) from block grant allocations of its budget to the ULBs. This will strengthen the financial capacity of the ULBs and encourage the ULBs to improve the provision of PHC services. The ULBs are encouraged to raise revenue to match block grants, which will enable them to continue PHC services after the end of the project as well as create an incentive for them to enhance PHC services.

B. Governance

24. Project-related governance risks have been assessed as part of the midterm review and additional financing processing in accordance with ADB's procurement and financial management requirements. The assessments found that an adequate management system and staff capacity were established in the PMU under the Urban Primary Health Care Services Delivery Project.[23] In terms of procurement rules and procedures, the proposed additional financing is rated *low* risk since the PMU has extensive experience in procuring goods, works, and consulting services in accordance with ADB procedures and requirements. On procurement capacity and implementation, the risk rating is *moderate* due to the volume of procurement. The financial management risk rating is *moderate* and remains manageable because of the measures provided in the financial management manual, the proposed engagement of additional staff in the PMU, and conducting independent biennial fiduciary reviews, supported by targeted technical assistance to provide capacity development and to enhance financial monitoring and reporting using accounting software.

25. Since the additional financing will expand geographic coverage and aims to develop sustainable capacity in ULBs for delivering basic health services, the risk assessment and risk management plan makes several recommendations to strengthen capacity both in the executing and implementing agencies and to improve procedures for efficient management and effective control in financial management and procurement.[24]

26. ADB's Anticorruption Policy (1998, as amended to date) was explained to and discussed with the government and the LGD, MOLGRDC. The specific policy requirements and supplementary measures are described in the PAM (footnote 19).

[22] Government of Bangladesh, MOLGRDC, LGD. Forthcoming. *Action Plan for Implementation of the National Urban Health Strategy*. Dhaka.

[23] Financial Management Assessment, and Procurement Capacity Assessment (accessible from the list of linked documents in Appendix 2).

[24] Risk Assessment and Risk Management Plan (accessible from the list of linked documents in Appendix 2).

C. Poverty and Social

27. The project will continue to ensure that all urban citizens have access to quality and equitable health care in a healthy and safe environment. In addition to the essential services provided, the additional financing will focus more on strengthening the present service delivery system, building on the good results of the current project, meeting unmet demands, and developing institutional self-reliance. Counseling for women, adolescents, and couples—as well as pre-marriage counseling, addressing noncommunicable diseases, reducing climate-induced ailments, and building and promoting gender-friendly structures—will receive special attention. The capacity building, behavior change, and outreach project components will focus on strengthening the abilities of government and partner service providers to improve access to quality health services in slums and impoverished areas with a focus on the poor, women, and children. The gender action plan of this gender equity-categorized project has been enhanced to promote gender equity and respond effectively to the needs voiced by women in underserved urban areas.[25]

D. Safeguards

28. **Environment, involuntary resettlement, and indigenous peoples.** The current project's compliance with the safeguard requirements has been satisfactory and risks have been well-managed. The project remains category B for environment, and will continue to construct new health care centers, improve existing facilities, and enhance climate change resilience and medical waste management. It is not expected to have significant or irreversible negative environmental impacts during construction or operation. Any environmental risks will be effectively addressed through proper mitigation measures with the updated environmental assessment and review framework that has been prepared and disclosed because land and sites for project civil works will be identified by the time implementation begins. The project remains category C for both involuntary resettlement and tribes, minor races, ethnic sects, and community peoples.[26] No land acquisition will be involved because land required will be either government-owned or donated voluntarily. Existing project areas do not overlap with any areas inhabited by tribes, minor races, ethnic sects, and community peoples. The project will screen new health care center sites to ensure social safeguard impacts do not occur.[27]

E. Risks and Mitigating Measures

29. The overall risk assessment is *moderate* without mitigation and *low* with mitigation. Significant risks and mitigating measures are summarized in Table 4 and described in detail in the risk assessment and risk management plan (footnote 24). The integrated benefits and impacts are expected to outweigh the costs.

Table 4: Summary of Risks and Mitigating Measures

Risks	Mitigating Measures
Some city corporations and municipalities have insufficient funds, human resources, and leadership to implement programs and strategies for strengthening pro-poor urban primary health care delivery services.	The project will sensitize the importance of urban health and provide guidance and capacity building to enhance ownership by the ULBs and their commitments to increase resources for urban health.

[25] Gender Action Plan (accessible from the list of linked documents in Appendix 2).

[26] Groups or population identified as indigenous peoples within the context of ADB's Safeguard Policy Statement (2009) will be referred to in this document as tribes, minor races, ethnic sects, and community peoples (following the request of the Government of Bangladesh).

[27] Resettlement, Tribes, Minor Races, Ethnic Sects, and Community Peoples Planning Framework set out in the PAM.

Risks	Mitigating Measures
Competing needs and politically driven interests in allocating resources to the ULBs.	Implementation of the NUHS Action Plan and the establishment of a dedicated revenue budget will create fiscal space for urban health.
High turnover of service providers' management, clinical, and counterpart staff.	(i) The PMU will have additional staff and technical specialists to responsively administer service providers' contracts. (ii) A web-based financial management system will be launched for real-time monitoring of cash flow and to avoid payment delays. (iii) Authority to make quarterly payments for contracts of service providers will be delegated to well-performing implementing agencies, with post-audit done by the PMU.

NUHS = National Urban Health Strategy, PMU = project management unit, ULB = urban local body.
Source: Asian Development Bank.

IV. ASSURANCES AND CONDITIONS

30. The government and the LGD, MOLGRDC have assured ADB that implementation of the project shall conform to all applicable ADB policies including those concerning anticorruption measures, safeguards, gender, procurement, consulting services, and disbursement as described in detail in the PAM and loan documents.

31. The government and the LGD, MOLGRDC have agreed with ADB on certain covenants for the project, which are set forth in the loan agreement, grant agreement, and project agreement. To ensure institutional and financial sustainability for urban PHC, disbursement of a total of $20,000,000 of the concessional loan (approximately 18% of the loan amount) allocated for works for constructing or upgrading of health care centers under output 2 will be subject to disbursement conditions with respect to the completion of six institutional actions.[28]

V. RECOMMENDATION

32. I am satisfied that the proposed loan would comply with the Articles of Agreement of the Asian Development Bank (ADB) and recommend that the Board approve the loan of $110,000,000 to the People's Republic of Bangladesh for the additional financing of the Urban Primary Health Care Services Delivery Project, from ADB's ordinary capital resources, in concessional terms, with an interest charge at the rate of 2% per year during the grace period and thereafter; for a term of 25 years, including a grace period of 5 years; and such other terms and conditions as are substantially in accordance with those set forth in the draft loan and project agreements presented to the Board.

Takehiko Nakao
President

27 August 2018

[28] Verification protocols for the completion of the institutional actions are set out in the PAM.

REVISED DESIGN AND MONITORING FRAMEWORK[a]

Impact the Project is Aligned with
Current project Health of the urban population, particularly the poor, women, and children improved **Overall project** Health, nutrition, and family planning status of the urban population, particularly the poor, women, and children improved (National Urban Health Strategy, 2014)[b]

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
Outcome **Current project** Sustainable good quality urban PHC services are provided in the project areas and target the poor and the needs of women and children **Overall project** Sustainable good quality urban PHC services in the project areas (particularly to the poor, women, and children) provided	**a. Current project (2012–2018)** By 2017, in project areas: 60% of births are attended by skilled health personnel (2012 baseline: 26.5% [BMMS, 2010]) **Overall project** By 2024, for all indicators: 70% of births are attended by skilled health personnel (2018 baseline: urban 63.4% [UESD, 2016]) **b. Current project (2012–2018)** At least 80% of growth monitoring and promotion performed on under-five children (2012 baseline: 43.3% [UPHCP-II, 2008]) **Overall project** 80% of children under five who visited health centers received nutritional screening and measured on anthropometry (MUAC, height, and weight) (2018 baseline: 64% of children under five, excluding neonates [2017 rapid assessment of 19 partnership areas]) **c. Current project (2012–2018)** At least 60% of eligible couples use modern contraceptives (2012 baseline: 53% [UHS, 2006]) **Overall project** 65% of currently married women of reproductive age (15–49 years old) use modern contraceptives (2018 baseline: urban 56.2% [BDHS, 2014]; urban 55.6% [UESD, 2016]) **d. Current project (2012–2018)** At least 80% of poor households are properly identified as eligible for free health care (2012 baseline: 67% [UPHCP-II, 2008]) **Overall project** 99% of poor households identified as eligible for free health care (2018 baseline: 98% [Annual Red Card Verification, 2017]) **e. Current project (2012–2018)** At least 80% of the poor access project health services when needed (2012 baseline: 64.7% [UPHCP-II, 2008]) **Overall project** 90% of urban population have access to public health service (2018 baseline: urban 88% [BDHS, 2014])[c] **f. Current project (2012–2018)** At least 90% of project clients express satisfaction with project services (2012 baseline: 76% [UPHCP-II, 2009])	Project baseline and end line surveys (household) ISI results Urban health surveys; UESD survey (every non-DHS years), BDHS (every 3 years)	Some city corporations and municipalities have insufficient funds, human resources, and leadership to implement programs and strategies for strengthening pro-poor urban PHC delivery services Competing needs and politically driven interests in allocating resources to the ULBs

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
	Overall project Unchanged (2018 baseline: 74% [end line household survey 2018])		
Outputs **Output 1** **Current project** Strengthened institutional governance and local government capacity to sustainably deliver urban PHC services **Overall project** Institutional governance and local government capacity to deliver urban PHC services sustainably strengthened	**Governance and capacity** **1a. Current project** Permanent and functional interagency coordination structure for urban health is established by December 2013 (2012 baseline: NA) **Overall project** Central level permanent structure for administrating and coordinating urban health and nutrition established by April 2020 (2018 baseline: NA) **1b. Current project (2012–2018)** All project ULBs have a functioning health department with at least one staff in each department trained in PPP contract management and core project management skills by 31 December 2013 (2012 baseline: 0) **Overall project** All project ULBs have a fully staffed and functioning health department, including a gender focal person or team with at least one staff in each department trained in PPP contract management and core project management skills to implement and monitor PHC, urban HMIS, and public health functions by April 2021 (2018 baseline: 0) **1c. Current project (2012–2018)** Gender-responsive data collection and analysis are computerized through HMIS in 80% of partnership areas by 31 December 2014 (2012 baseline: NA) **Overall project** Gender-responsive data collection and analysis in 80% of project ULBs use computerized HMIS by December 2018 (2018 baseline: 0) **Sustainability and commitment** **1d. Current project (2012–2018)** At least 50% increase in overall allocation to the urban PHC sustainability fund compared with the second project (2011 baseline: Tk38.5 million) **Overall project** Urban PHC budget line in LGD's nondevelopment revenue budget established by July 2020 (2018 baseline: NA) **1e. Current project (2012–2018)** At least 5% per annum increase of ULB annual development program and block grants allocated for PHC and public health-related services (2011 baseline: 0) **Overall project** Financing for urban PHC provided through LGD's revenue budget for FY2020–2021 and each subsequent year (2018 baseline: NA) **Additional indicators** 1f. All project ULBs' organograms and reorganization plans submitted to LGD for approval by December 2020 (2018 baseline: NA)	1a.–h. Project joint review missions, QPRs 1e.–f. MOLGRDC sector budgets; PIU sector budgets and urban annual development plans	High turnover of service providers' management, clinical, and counterpart staff

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
	1g. Functional health emergencies preparedness and response plan finalized by July 2020 (2018 baseline: NA) 1h. At least four model ULBs selected for a pilot on direct management of urban PHC by July 2019 (2018 baseline: 0)		
Output 2 **Current project** Improved accessibility, quality, and utilization of urban PHC services, with a focus on the poor, women, and children, through PPP **Overall project** Accessibility, quality, and utilization of urban PHC services (with a focus on the poor, women, and children) improved through PPP	**By midterm review and sustained until project completion:** **Accessibility and utilization** **2a. Current project (2012–2018)** At least 30% of each of the major project health care services (including caesarian section, and treatment of children with acute malnutrition) is provided free of charge to holders of government-issued red cards that identify them as poor (2012 baseline: 0) **Overall project** 30% of urban health care services, including sexual and reproductive health and treatment of acute malnutrition, provided free to identified poor (2017 data: 34% [Q1 2017 QPR]) **2b. Current project (2012–2018)** At least 80% of facilities planned for construction and upgrading function normally within 3 years of loan effectiveness (12 CRHCCs and 26 PHCCs) (2012 baseline: 0) **Overall project** Additional eight CRHCCs and 24 PHCCs (2018 baseline: 10 CRHCCs and 19 PHCCs) **Quality** **2c. Current project (2012–2018)** At least 80% of children consulting project PHC services for acute respiratory infection receive correct treatment (2012 baseline: NA) **Overall project** At least 80% of women in labor monitored using partograph (2018 baseline: NA) **2d. Current project (2012–2018)** At least 80% of children consulting project PHC services for diarrhea receive correct treatment (2012 baseline: NA) **Overall project** At least 80% of children under five consulting project PHC services for diarrhea in the last 2 weeks received oral rehydration therapy and zinc (2018 baseline: NA) **PPP performance and accountability** **2e. Current project (2012–2018)** 100% of partnership area service providers achieved internal quality compliance (financial management, updated clinical registers, clinical waste management, and inventory management (2012 baseline: NA) **Overall project** Unchanged	2a., c.–e. ISI results 2b. QPR 2a., c., d. HMIS 2c., d. Project baseline, midline, and end line surveys (household, facility-based, and qualitative)	

Results Chain	Performance Indicators with Targets and Baselines	Data Sources and Reporting Mechanisms	Risks
Output 3 **Current project** Effective support for decentralized project management **Overall project** Effective support for decentralized project management provided	**3a. Current project (2012–2018)** A fully functional PMU with at least 20% of the staff female is established by loan effectiveness and PIUs are established in ULBs within 3 months of loan effectiveness (2012 baseline: NA) **Overall project** Unchanged **3b. Current project (2012–2018)** Computerized FMIS is functioning fully in partnership areas by 31 December 2014, streamlining accounting procedures and processes at all levels of project implementation (PMU, PIUs, and partner service providers) (2012 baseline: 0) **Overall project** Computerized FMIS is functioning fully in partnership areas by December 2018, streamlining accounting procedures and processes at all levels of project implementation (PMU, PIUs, and partner service providers) (2018 data: partial use of FMIS) **3c. Current project (2012–2018)** Project monitoring and evaluation surveys, follow-ups on findings, data collection, and quarterly progress reporting are implemented on schedule (2012 baseline: NA) **Overall project** Unchanged **Additional indicators** 3d. At least two persons from each project ULB trained on computerized financial management by June 2019 (2018 baseline: 0) 3e. At least two persons from PMU and each project ULB trained on using HMIS (DHIS2) for project monitoring and evaluation, and gender-responsive urban PHC by June 2019 (2018 baseline: 0) 3f. Climate-resilient health care infrastructure and services in at least 12 PHCCs by October 2020 (2018 baseline: 0)	3a.–f. Project joint review missions, QPRs, HMIS 3d., e. Project training evaluations	

Key Activities with Milestones (Overall project)

1. **Institutional governance and local government capacity to deliver urban PHC services sustainably strengthened**

1.1 Prepare action plan of National Urban Health Strategy to implement in collaboration with MOHFW and in consultation with development partners, by additional financing loan effectiveness (updated).
1.2 Develop draft implementation guidelines for urban PHC service in ULBs (PPP contract management; revenue raising for urban health; Urban Primary Health Care Sustainability Fund), and fully implement training program on urban PHC services for LGD and ULB staff, by additional financing loan effectiveness (updated).
1.3 Complete ULB perception survey for all project ULBs and develop and implement a marketing and advocacy program by additional financing loan effectiveness (completed and updated).
1.4 Complete rollout of fully functional web-based HMIS (DHIS2) with sex-disaggregation in all partnership areas by 31 December 2021; initiate all operations research studies by July 2019 for completion by March 2023 (updated).
1.5 Provide additional technical assistance to the model ULBs to fulfill their expanded roles and responsibilities by July 2019 (added).
1.6 Strengthen the Urban Development Wing with a designated PHC unit, permanent staff, equipment, and supplies by April 2020 (added).
1.7 Establish working level arrangements for coordinating urban health between LGD and MOHFW identified and in place within 12 months of loan effectiveness (added).

2. Accessibility, quality, and utilization of urban PHC services improved, with a focus on the poor, women, and children, through PPP

2.1 Sign partnership agreements with service providers in partnership areas—advance contracting for existing partnership areas, and within 6 months of additional financing loan effectiveness for new partnership areas (completed and updated).
2.2 Establish a list of the poor in every partnership area, within 6 months of loan effectiveness, and distribute red cards to those identified as poor within 6 months of the signing of the partnership agreement, with proper annual updating (completed and updated).
2.3 Conduct ISI surveys every 6 months through project performance monitoring and evaluation firm and regular follow-up and feedback of ISI findings through PMU quality assurance team (completed and updated).
2.4 Provide and monitor regular ongoing training and retraining to health care service providers (added).

3. Effective support for decentralized project management provided

3.1 Establish a fully functional PMU with at least 20% of the staff female and PIUs in ULBs within 3 months of loan effectiveness (completed and updated).
3.2 Recruit consultants to provide technical support to PMU within 3 months of loan effectiveness (completed and updated).
3.3 Complete rollout of fully functional web-based FMIS in place by January 2019 (updated).
3.4 Ensure that training activities are timely, gender representation is balanced, and at least 80% of scheduled participants attend the training sessions (updated).
3.5 Conduct regular training for health service providers on gender-sensitive and newborn and child-friendly health services (added).

Inputs

Asian Development Bank

Loan	Technical Assistance Grant	Urban Climate Change Resilience Trust Fund Investment Grant
$50 million (current)	$0.4 million (current)	$0.0 million (current)
$110 million (additional)	$0.0 million (additional)	$2.0 million (additional)
$160 million (overall)	$0.4 million (overall)	$2.0 million (overall)

Government of Sweden Grant
$20 million (current)
$0 million (additional)
$20 million (overall)

Government of Bangladesh
$11 million (current)
$30 million (additional)
$41 million (overall)

Assumptions for Partner Financing

Current project

Not applicable

Overall project

Unchanged

BDHS = Bangladesh Demographic and Health Survey; BMMS = Bangladesh Maternal Mortality and Health Care Survey; CRHCC = comprehensive reproductive health care center; DHIS2 = District Health Information System Version 2; DHS = Demographic and Health Survey; FMIS = financial management information system; HMIS = health management information system; ISI = integrated supervisory instrument; LGD = Local Government Division; MOHFW = Ministry of Health and Family Welfare; MOLGRDC = Ministry of Local Government, Rural Development and Cooperatives; MUAC = mid-upper arm circumference; NA = not applicable; PHC = primary health care; PHCC = primary health care center; PIU = project implementation unit; PMU = project management unit; PPP = public–private partnership; Q = quarter; QPR = quarterly progress report; UESD = Utilization of Essential Service Delivery; UHS = Urban Health Survey; ULB = urban local body, UPHCP-II = Second Urban Primary Health Care Project.

[a] Baseline and targets at impact and outcome level will be updated following the availability of the BDHS, 2017; BMMS, 2016; and Urban Primary Health Care Services Delivery Project end line survey, 2017–2018.

[b] Government of Bangladesh, MOLGRDC, LGD. 2014. *National Urban Health Strategy*. Dhaka.

[c] Defined in the BDHS, 2014 as the percentage of sample clusters with a health facility within 1 kilometer. The percentage is almost the same in rural (87%) and urban areas (88%).

Source: Asian Development Bank.

LIST OF LINKED DOCUMENTS

http://www.adb.org/Documents/RRPs/?id=42177-024-3

1. Loan Agreement
2. Grant Agreement
3. Project Agreement
4. Sector Assessment (Summary): Health
5. Project Administration Manual
6. Summary of Project Performance
7. Contribution to the ADB Results Framework
8. Development Coordination
9. Financial Analysis
10. Economic Analysis
11. Country Economic Indicators
12. Summary Poverty Reduction and Social Strategy
13. Gender Action Plan
14. Environmental Assessment and Review Framework
15. Risk Assessment and Risk Management Plan

Supplementary Documents

16. Financial Management Assessment
17. Procurement Capacity Assessment
18. Local Government Institutional Assessment
19. Project Evaluation, Lessons Learned, and Project Design Features