Project Administration Manual

Project Number: BAN 42177-024
Loan and Grant Numbers: 2878-BAN, 8118-BAN, and 0298-BAN
August 2018

People's Republic of Bangladesh: Urban Primary Health Care Services Delivery Project (Additional Financing)

ABBREVIATIONS

ADB	–	Asian Development Bank
ARI	–	acute respiratory infection
BCCM	–	behavior change communication and marketing
BRAC	–	Bangladesh Rural Advancement Committee
CEO	–	chief executive officer
CRHCC	–	comprehensive reproductive health care center
DGHS	–	Directorate General of Health Services
DHIS2	–	District Health Information System Version 2
DMF	–	design and monitoring framework
DPP	–	development project proposal
EOC	–	emergency obstetric care
ESD	–	essential service delivery
FMIS	–	financial management information system
GAP	–	gender action plan
GIS	–	geographic information system
HMIS	–	health management information system
HRD	–	human resources development
ICB	–	international competitive bidding
ICT	–	information and communication technology
IEC	–	information, education, and communication
ISI	–	integrated supervisory instrument
LGD	–	Local Government Division
LGED	–	Local Government Engineering Department
MCH	–	maternal and child health
MMR	–	maternal mortality ratio
MNCH	–	maternal, neonatal, and child health
MOHFW	–	Ministry of Health and Family Welfare
MOLGRDC	–	Ministry of Local Government, Rural Development, and Cooperatives
MOU	–	memorandum of understanding
MTR	–	midterm review
NCB	–	national competitive bidding
NGO	–	non-government organization
NPSC	–	National Project Steering Committee
NUHS	–	National Urban Health Strategy
PAM	–	project administration manual
PHC	–	primary health care
PHCC	–	primary health care center
PIU	–	project implementation unit
PMU	–	project management unit
PPME	–	project performance monitoring and evaluation
PPP	–	public–private partnership
QBS	–	quality-based selection
QCBS	–	quality- and cost-based selection
QPR	–	quarterly progress report
SES	–	solar energy system
SFYP	–	Sixth Five-Year Plan
SOE	–	statement of expenditure
SPS	–	Safeguard Policy Statement

SSPF	–	Social Safeguards Planning Framework
STI	–	sexually transmitted infection
TCU	–	training coordination unit
TNA	–	training needs assessment
TOR	–	terms of reference
ULB	–	urban local body
UNFPA	–	United Nations Population Fund
UPHCP	–	Urban Primary Health Care Project
UPHCP-II	–	Second Urban Primary Health Care Project
UPHCSDP	–	Urban Primary Health Care Services Delivery Project
UPHCSDP-AF	–	Urban Primary Health Care Services Delivery Project–Additional Financing
URKS	–	Unified Record Keeping System
VAW	–	violence against women

CONTENTS

Project Administration Manual Purpose and Process

The project administration manual (PAM) describes the essential administrative and management requirements to implement the project on time, within budget, and in accordance with government and Asian Development Bank (ADB) policies and procedures. The PAM should include references to all available templates and instructions either through linkages to relevant URLs or directly incorporated in the PAM.

The Local Government Division of the Ministry of Local Government, Rural Development and Cooperatives as executing agency and the city corporations and municipalities as implementing agencies are wholly responsible for the implementation of the Urban Primary Health Care Services Delivery Project, as agreed jointly between the borrower and ADB, and in accordance with government and ADB's policies and procedures. ADB staff will be responsible for supporting implementation, including compliance by the Ministry of Local Government, Rural Development and Cooperatives and city corporations and municipalities of their obligations and responsibilities for project implementation in accordance with ADB's policies and procedures.

At loan negotiations, the borrower and ADB shall agree to the PAM and ensure consistency with the loan agreement and the government's Development Project Proposal. Such agreement shall be reflected in the minutes of the loan negotiations. In the event of any discrepancy or contradiction between the PAM, the loan agreement, and the Development Project Proposal, the provisions of the loan agreement shall prevail.

After ADB Board approval of the project's Report and Recommendation of the President, changes in implementation arrangements are subject to agreement and approval pursuant to relevant government and ADB administrative procedures (including the Project Administration Instructions) and upon such approval, they will be subsequently incorporated in the PAM.

I. PROJECT DESCRIPTION

1. The additional financing of Urban Primary Health Care Services Delivery Project builds upon three previous phases of the urban primary health care (PHC) projects—Urban Primary Health Care Project-I (1998–2005), Urban Primary Health Care Project-II (2005–2012), and Urban Primary Health Care Services Delivery Project (2012–2018)—financed by the Government of Bangladesh and Asian Development Bank (ADB) to further develop and strengthen institutional capacity for sustainable delivery of pro-poor PHC services in urban areas through public–private partnership (PPP). The Urban Primary Health Care Services Delivery Project ended on 31 March 2018 (loan closing date of 30 September 2018). The proposed additional financing, over a 5-year period (1 April 2018 to 31 March 2023), will see an expansion of additional physical network of partnership areas in existing city corporations and municipalities, as well as new municipalities. To ensure the continuity of crucial PHC services in urban areas, the additional financing will be processed in a time-bound manner, which will build on the ongoing momentum for institutional and financial sustainability in urban health care service delivery by the Local Government Division (LGD), such as the National Urban Health Strategy (NUHS) (2014) and finalization of its action plan. The project will cover a physical network of 45 partnership areas in 11 city corporations and 15 selected municipalities.[1]

2. **Impact and outcome.** The impact of the project will be the improved health, nutrition, and family planning status of the urban population, particularly the poor, women, and children (NUHS, 2014).[2] The outcome will be sustainable good quality urban PHC services provided in project areas that target the poor and the needs of women and children.[3]

3. **Outputs.** 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 improved, with a focus on the poor, women, and children through PPP; and (iii) effective support for decentralized project management provided. The outputs are described in detail in **Annex 1**.[4]

4. **Output 1: Institutional governance and local government capacity to deliver urban primary health care services sustainably strengthened.** The project will support the establishment of a revenue budget line with the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC) to deliver PHC including infrastructure operations and maintenance sustainably. The project will facilitate sufficient government budget allocations to ensure that cities and municipals will continue urban PHC at the end of the project. Coordination among LGD, Ministry of Health and Family Welfare (MOHFW), and development partners will be under one harmonized approach as detailed in the NUHS and specified in the action plan. The project will strengthen the governance and stewardship role of MOHFW and LGD in key strategic areas (quality assurance, referral linkages, human resources, and information systems). Local government human resources and capacity will be strengthened through arrangement with MOHFW for deputation of medical officers to urban local bodies (ULBs). The ULBs' health departments will be supported to integrate with other determinants of health and related climate

[1] Refer to Annex 13 in the Project Administration Manual on project's criteria for selection of municipalities and project locations.

[2] Government of Bangladesh, Local Government Division, Ministry of Local Government, Rural Development and Cooperatives. 2014. *National Urban Health Strategy*. Dhaka.

[3] Outcome level performance targets and indicators encompass the broad range of major, comparable child and maternal health outcomes, and conditions related to reproductive health and malnutrition, as well as covering efficiency of pro-poor targeting and commitment towards sustaining the project.

[4] Also see Annex 16 for map of the project areas.

sensitive sub-sectors. Furthermore, the ULBs should establish linkage with quality control cell of MOHFW to harmonize approach in quality assurance. Special support will be provided to selected ULBs which have the potential to undertake direct management of PHC services delivery. Over the project period, participating ULBs will continue to contribute to the urban PHC sustainability fund which shall be utilized to strengthen the capability of ULBs and to improve services delivery. The utilization of fund will be based on annual plans prepared by ULBs and approved by LGD. Sustainability in medium- and long-term will be ensured through establishment of a dedicated revenue (nondevelopment) budget line specifically for urban PHC.

5. **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 project will expand coverage to include 20 additional partnership areas for a total of 45 partnership areas across 11 cities and 14 municipalities. The project will continue provision of PHC through contracting-out to nongovernment organizations (NGOs), civil society organizations (CSOs), private sector, etc. It will further improve the partnership agreements pioneered during the first three project phases. The partner service providers will provide essential health services through comprehensive reproductive health care centers (CRHCCs), PHC centers (PHCCs), and satellite clinics. The project will continue to construct health care facilities where such facilities do not exist in the project area, as well as upgrade existing facilities established in previous phase as needed. At least 30% of all services, including drugs, will be given free to the poor, with specific emphasis on women, and the project will allocate additional resources to identifying and targeting the urban poor.

6. **Output 3: Effective support for decentralized project management provided.** The project will support the current five-year plan's priorities of capacity development in public administration and devolution of responsibilities to local governments by progressively devolving the management and implementation responsibilities of its project management unit (PMU) to the LGD, and the project implementation units (PIUs) into the health departments of each project city corporations or municipalities. This will ultimately strengthen the sustainability of PHC services delivery. Considering the expanded coverage of the project, the PMU will be substantially strengthened to address enhanced focus on nutrition mainstreaming and neonatal care. It has also been considered that monitoring of services delivery through PPP service providers will be critical in providing quality PHC services.

7. The components/outputs are described in detail in **Annex 1**.[5]

II. IMPLEMENTATION PLANS

A. Project Readiness Activities

8. The project readiness activities, responsibilities, and estimated timeframe are:

[5] Also see Annex 16 for a map of project areas.

Table 1: Project Readiness Activities, Responsibilities, and Estimated Timeframe

Indicative Activities	Month (2017–2018)																Responsible Individual/ Unit/Agency/ Government
	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	
Advance contracting actions	X	X	X	X	X	X											PMU/LGD
Establish project implementation arrangements	X																PMU and ADB
Fact-finding mission	X																ADB
ADB staff review meeting						X											ADB
EA approves DPP								X									LGD
PEC recommends DPP										X							PEC
ECNEC considers DPP											X						ECNEC
Send RRP and loan agreements to ERD												X					ADB
Loan negotiations													X				ADB/ERD/LGD
ECNEC approves recast DPP															X		ECNEC
ADB Board approval															X		ADB
Loan signing																X	ADB/ERD/LGD
Loan effectiveness/government legal opinion provided																X	ADB/ERD/LGD

ADB = Asian Development Bank, DPP = development project proforma, EA = executing agency, ECNEC = Executive Committee of the National Economic Council, ERD = Economic Relations Division, LGD = Local Government Division, PEC = project evaluation committee, PMU= project management unit, RRP = Report and Recommendation of the President.
Source: Asian Development Bank.

B. Project Implementation Plan

Table 2: Project Implementation Plan

Activities	Adv. Action 2017				Year 1 2018				Year 2 2019				Year 3 2020				Year 4 2021				Year 5 2022				Year 6 2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Output 1: Institutional governance and local government capacity to deliver urban PHC services sustainably strengthened																												
Sub-component 1.1: Strengthen LGD capacity to support ULBs in delivering urban PHC																												
Activity 1.1.1: Prepare action plan to implement National Urban Health Strategy																												
Activity 1.1.2: Develop guidelines for ULBs (GOB budget line items, sustainability fund)																												
Activity 1.1.3: Strengthen UDW with designated and fully-staffed PHC unit																												
Activity 1.1.4: Establish revenue budget line for urban PHC in MOLGRDC																												
Activity 1.1.5: Disburse revenue budget line allocations for UDW and ULBs for PHC																												
Activity 1.1.6: Establish working level arrangement between LGD and MOHFW																												
Sub-component 1.2: Strengthen ULB capacity to ensure delivery of urban PHC																												
Activity 1.2.1: Organize national workshop for ULBs orientation and advocacy																												
Activity 1.2.2: Recruit consulting firm for pilot initiative to support selected ULBs																												
Activity 1.2.3: Strengthen model ULBs through focused technical support																												
Activity 1.2.4: Capacity building of ULB staff in key management areas																												
Activity 1.2.5: Support/improve awareness and advocacy program for ULBs																												
Activity 1.2.6: Monitor progress related to urban PHC sustainability fund																												
Sub-component 1.3: Management systems, learning, and innovations in urban PHC																												
Activity 1.3.1: Roll-out of fully functional electronic patient management/HMIS																												
Activity 1.3.2: Update mapping of PHC facilities																												
Activity 1.3.3: Implement operations research																												

Activities	Adv. Action 2017	Year 1 2018	Year 2 2019	Year 3 2020	Year 4 2021	Year 5 2022	Year 6 2023
Output 2: Accessibility, quality, and utilization of urban PHC services (with a focus on the poor, women, and children) improved through PPP							
Sub-component 2.1: Urban PHC services delivery, including health education and behavior change communication							
Activity 2.1.1: Tender PPP contracts for existing PA areas							
Activity 2.1.2: Sign partnership agreement for existing PA areas							
Activity 2.1.3: Tender PPP contracts for new PA areas							
Activity 2.1.4: Sign partnership agreement for new PA areas							
Activity 2.1.5: Recruit BCCM firm							
Activity 2.1.6: Develop and implement BCCM							
Sub-component 2.2: Effective reaching of the urban poor							
Activity 2.2.1: Establish/update list of poor							
Activity 2.2.2: Provide technical support to service providers related to red-card system							
Activity 2.2.3: Expand mobile outreach services for poor not reached by red cards							
Sub-component 2.3: Ensuring quality of PHC services							
Activity 2.3.1: Provide and monitor regular in-service training for health care personnel							
Activity 2.3.2: Conduct semiannual independent monitoring of PAs (ISI)							
Activity 2.3.3: Implement quality assurance system by PMU and service providers							
Activity 2.3.4: Procure medical equipment							
Activity 2.3.5: Procure vehicles							
Activity 2.3.6: Establish shortlisting of drugs suppliers							
Sub-component 2.4: Access to PHC services through improved infrastructure network							
Activity 2.4.1: Tender Package WD1-15 (expansion and renovation)							
Activity 2.4.2: Tender Package WD16-49 (new construction)							

Activities	Adv. Action 2017	Year 1 2018	Year 2 2019	Year 3 2020	Year 4 2021	Year 5 2022	Year 6 2023
Output 3: Effective support for decentralized project management provided							
Sub-component 3.1: Core project management							
Activity 3.1.1: Establish fully functional PMU							
Activity 3.1.2: Procure vehicles and office equipment for PMU/PIUs							
Sub-component 3.2: Technical support for project management							
Activity 3.2.1: Recruit consultants to assist in project implementation							
Activity 3.2.2: Engage consultants to assist PMU/PIUs in midterm review and PCR							
Sub-component 3.3: Project Financial Management System							
Activity 3.3.1: Roll-out fully functional FMIS							
Sub-component 3.4: Training Coordination Unit							
Activity 3.4.1: Finalize training plan							
Activity 3.4.2: Implement training program							
Sub-component 3.5: Monitoring and Evaluation							
Activity 3.5.1: Recruit PPME firm							
Management Activities							
Environment Management Plan key activities							
Gender Action Plan key activities							
Midterm review							
Biennial fiduciary review							
Project completion report							

BCCM = behavior change, communication and marketing, DMF = design and monitoring framework, FMIS = financial management information system, GOB = Government of Bangladesh, HMIS = health management information system, ISI = integrated supervisory instrument survey; LGD = Local Government Division, MOHFW = Ministry of Health and Family Welfare, MOLGRDC = Ministry of Local Government, Rural Development and Cooperatives, PA = partnership agreement, PCR = project completion report, PHC = primary health care, PIU = project implementing unit, PMU = project management unit, PPME = project performance monitoring and evaluation, PPP = public–private partnership, UDW = Urban Development Wing, ULB = urban local body.
Source: Asian Development Bank.

III. PROJECT MANAGEMENT ARRANGEMENTS

A. Project Implementation Organizations: Roles and Responsibilities

Table 3: Project Implementation Organizations and Roles and Responsibilities

Project Implementation Organizations	Management Roles and Responsibilities
Executing agency	LGD of MOLGRDC
Project-specific management body (either stand-alone or within the executing agency)	PMU, headed by a full-time project director, will be established in LGD to provide the required technical, administrative, and logistical support for project implementation.
Project steering committee	Interministerial NPSC established in the project, chaired by the secretary of LGD, will oversee project implementation.
Implementing agencies	City corporations and municipal governments (ULBs)
ADB	Funding agency

ADB = Asian Development Bank, LGD = Local Government Division, MOLGRDC = Ministry of Local Government, Rural Development and Cooperatives, NPSC = National Project Steering Committee, PMU = project management unit, ULB = urban local body.
Source: Asian Development Bank.

9. LGD of MOLGRDC will be the executing agency of the proposed project. The city corporations and municipalities (ULBs) will be the implementing agencies in their respective project areas. A PMU, headed by a full-time project director, will be established in LGD to provide the required technical, administrative, and logistical support for project implementation. The project director will be at least a deputy secretary-level officer, preferably at the joint secretary-level, and have project management experience, preferably related to the health sector. An interministerial national project steering committee, established in the previous project chaired by the secretary of LGD, will oversee project implementation. The national project steering committee will meet no less than twice a year. A project coordination committee in LGD chaired by the director general of the Monitoring, Inspection and Evaluation as chief project coordinator, and comprising chief health officers (CHOs) of ULBs, representatives from MOHFW (one from the Directorate General of Health Services and one from the Directorate General of Family Planning), project director and deputy project directors of Urban Primary Health Care Services Delivery Project, and PPP project managers will meet every quarter to review project progress and quarterly reports and implementation issues. The chief project coordinator will supervise the full-time project director. The Local Government Engineering Department (LGED) under the LGD will be responsible for implementing the construction program of the project. Accountability of LGED will be ensured through a memorandum of understanding (MOU) signed before the start of the civil works activities in the proposed additional financing between the project and LGED with result-based payment and delivery.

10. PIUs will be maintained for the existing project ULBs and will be established in the health departments for the new project ULBs to oversee project implementation in respective city corporations or municipalities. To ensure smooth and effective relations between public–private contracting parties, PIUs will also establish “partnership committees” in their respective localities with wide representation from local officials and private sector representatives. For general local-level coordination and public participation, at each city corporation or municipal level, urban health coordination committees (UHCCs) will be established. City corporation/municipality UHCCs will be chaired by the chief executive officers, and comprised of a district civil surgeon, CHOs, PPP service providers, and other stakeholders as relevant. At the ward level, a ward UHCC will be

established. The ward UHCC will be chaired by a ward commissioner, and co-chaired by zonal health officers, and comprise representation from PPP workers and local stakeholders (including representatives from poor communities and informal settlements, at least 40% representation must be female). The ward UHCC will also serve as a mechanism for grievance redress of any resettlement-related issues and coordinate 'user forums' to discuss communities' feedback on PPP health services provision. Where there are similar standing committees pre-existing (for example, dealing with health, water, and sanitation), the role of UHCCs may be subsumed under or combined with the standing committee to avoid creating parallel structures.

11. LGED, in coordination with the PMU, will undertake geo-technical survey and construction supervision responsibilities as defined in the MOU. LGED is responsible for survey and investigation, architectural drawings, structural design, assisting in tender document preparation and tendering for each site, as well construction monitoring. These activities will be supported under the service charge of 2% of the construction program as provided under the PMU.

12. Considering the expanded coverage of the project, the PMU will be substantially strengthened to address the additional partnership areas and enhanced focus on nutrition mainstreaming and neonatal care. It has also been considered that monitoring of service delivery through PPP will be critical in providing quality PHC services. Consequently, additional-related resources will be included in the PMU structure.

13. The detailed implementation arrangements are in **Annex 2**.

B. Key Persons Involved in Implementation

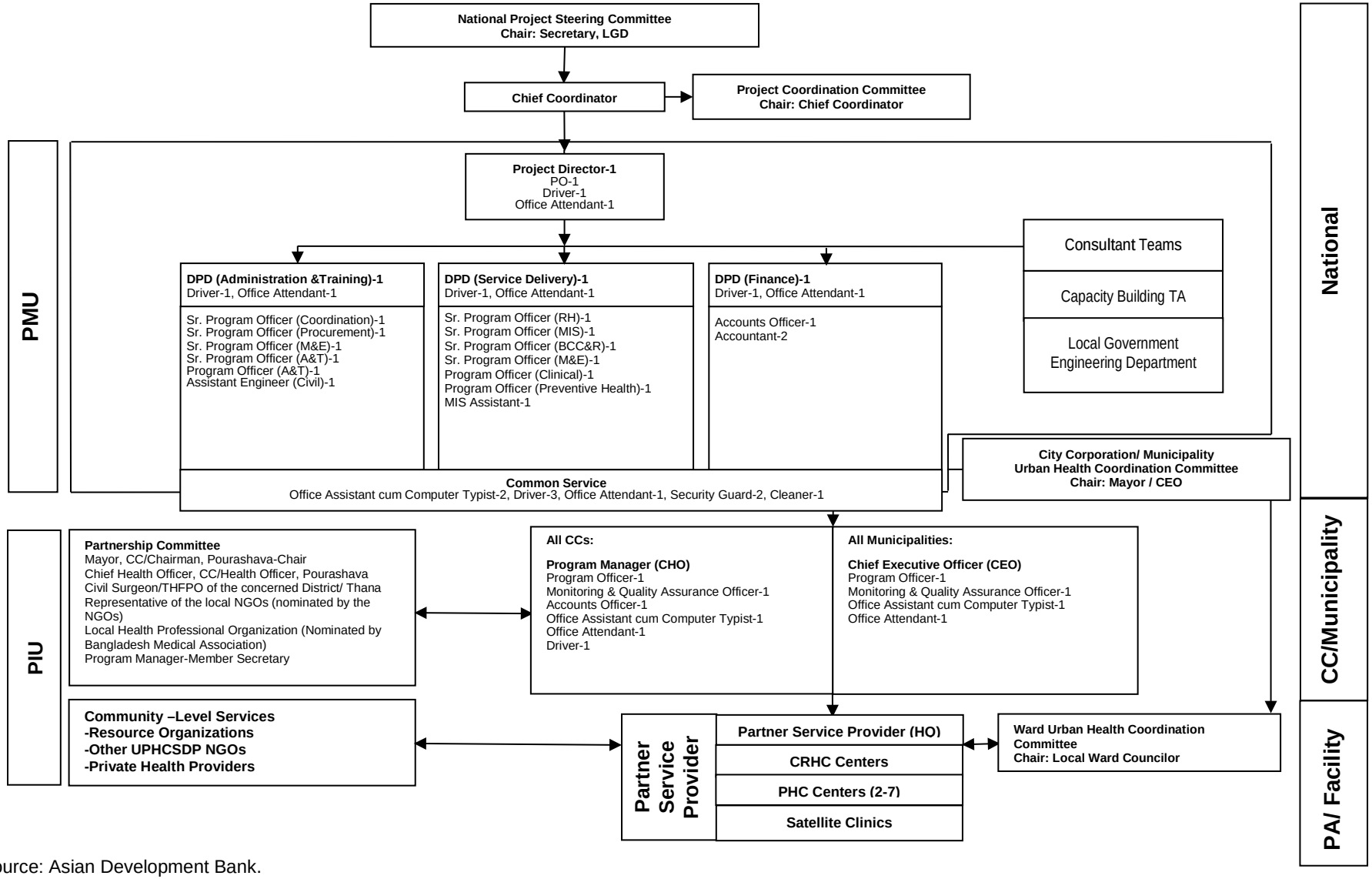
14. The executing agency officer, ADB division director and mission leader are presented in the table below.

Executing Agency	
Ministry of Local Government, Rural Development and Cooperatives	Dr. Zafar Ahmed Khan Senior Secretary Local Government Division Ministry of Local Government, Rural Development, and Cooperatives Dhaka, Bangladesh
Asian Development Bank	
South Asia Human and Social Development Division	Mr. Sungsup Ra Director, SAHS Tel: +63 2 632 4629 sungsupra@adb.org
Mission Leader	Mr. Brian Chin Social Sector Specialist Tel: +63 2 683 1650 bchin@adb.org

C. Project Organization Structure

15. The flow chart to show the reporting lines and essential internal structures of key organizations involved in implementation (including PIUs).

Figure 1: Project Management Structure



Source: Asian Development Bank.

IV. COSTS AND FINANCING

16. The additional financing is estimated to cost $142 million (Table 4). Detailed cost estimates by financier and by year are included in the later sections.

Table 4: 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 PHC 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 estimates.

17. The government 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.

18. The $110 million loan from ADB will finance (i) civil works for urban PHC infrastructure, (ii) equipment and furniture, (iii) vehicles, (iv) consulting services, (v) PPP contracts, and (vi) contingencies. ADB's Urban Climate Change Resilience Trust Fund[6] under the Urban Financing Partnership Facility will also provide a $2 million grant for (i) civil works, (ii) equipment, (iii) training and workshops, and (iv) consulting services. The government will provide $30 million equivalent for (i) human resources for PMU and PIUs, (ii) land registration, (iii) incremental recurrent costs, (iv) contingencies, and (v) taxes and duties. The United Nations Population Fund will provide in-kind support of $1.5 million for complementary activities (details in **Annex 17**).

19. The financing plan is in Table 5. The ADB loan will finance 77.5% of the additional financing cost. The government allocated counterpart financing for 21.1% of the cost and the Urban Climate Change Resilience Trust Fund for 1.4% of the cost.

[6] Financing partners: the Rockefeller Foundation and the Governments of Switzerland and the United Kingdom.

Table 5: Financing Plan

Source	Current[a] Amount ($ million)	Current[a] Share of Total (%)	Additional Financing Amount ($ million)	Additional Financing Share of Total (%)	Total Amount ($ million)	Total Share of Total (%)
ADB	50.0	61.7	110.0	77.5	160.0	71.7
UCCRTF (grant)[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.
Note: Numbers may not sum precisely because of rounding.
Source: Asian Development Bank estimates.

A. Key Assumptions

20. The following key assumptions underpin the cost estimates and financing plan:

(i) Exchange rate: Tk80.00 = $1.00;
(ii) Price contingencies based on expected cumulative inflation over the implementation period are as follows:

Table 6: Escalation Rates for Price Contingency Calculation

Item	2018	2019	2020	2021	2022	Average
Foreign rate of price inflation	1.13%	1.88%	3.41%	4.96%	7.09%	3.70%
Domestic rate of price inflation	4.58%	8.33%	14.66%	21.89%	29.57%	15.84%

Source: Cost Escalation Factors (https://lnadbg1.adb.org/erd0004p.nsf). Asian Development Bank estimates.

(iii) In-kind contributions cannot be easily measured and have not been quantified.

B. Detailed Cost Estimates by Expenditure Category

Table 7: Detailed Cost Estimates by Expenditure Category

Items	(Taka million)			($ million)			% of Base Cost
	Local	Foreign	Total	Local	Foreign	Total	
A. Investment Costs[a]							
1. Civil Works	1,880.0	-	1,880.0	23.5	-	23.5	18.2%
2. Equipment & Furniture	344.0	-	344.0	4.3	-	4.3	3.3%
3. Vehicles	40.0	-	40.0	0.5	-	0.5	0.4%
4. Training							
Local Training, Seminar and Workshop	184.0	-	184.0	2.3	-	2.3	1.8%
Overseas Training	-	104.0	104.0	-	1.3	1.3	1.0%
Subtotal	**184.0**	**104.0**	**288.0**	**2.3**	**1.3**	**3.6**	**2.8%**
5. Consultancy							
International Consultants (Firm)	-	672.0	672.0	-	8.4	8.4	6.5%
International Consultants (Individual)	-	40.0	40.0	-	0.5	0.5	0.4%
National Consultants (Firm)	48.0	-	48.0	0.6	-	0.6	0.5%
National Consultants (Individual)	96.0	-	96.0	1.2	-	1.2	0.9%
Subtotal	**144.0**	**712.0**	**856.0**	**1.8**	**8.9**	**10.7**	**8.3%**
6. Partnership Grants	6,432.0	-	6,432.0	80.4	-	80.4	62.2%
7. Human Resources for PMU and PIUs	360.0	-	360.0	4.5	-	4.5	3.5%
8. Operating Costs for PMU and PIUs	120.0	-	120.0	1.5	-	1.5	1.2%
9. LGED Service Charge	16.0	-	16.0	0.2	-	0.2	0.2%
Total Baseline Costs [A]	**9,520.0**	**816.0**	**10,336.0**	**119.0**	**10.2**	**129.2**	**100.0%**
B. Contingencies[b]							
Physical Contingencies	144.0	-	144.0	1.8	-	1.8	1.4%
Price Contingencies	424.0	-	424.0	**5.3**	**-**	5.3	4.1%
Total: Contingencies [B]	**568.0**	**-**	**568.0**	**7.1**	**-**	**7.1**	**5.5%**
C. Unallocated for Financing/Interest Charges[c]	-	456.0	456.0	-	5.7	5.7	4.4%
Total Project Cost [A+B+C]	**10,088.0**	**1,272.0**	**11,360.0**	**126.1**	**15.9**	**142.0**	**109.9%**

Note: Numbers may not sum precisely due to rounding.

[a] In June 2018 prices.

[b] Physical contingencies computed at 6.43% for civil works and equipment. Price contingencies are 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.

[c] Interest charges on the ADB loan at 2% per annum during implementation period will not be capitalized under ADB loan (will be treated as unallocated under ADB loan) and will be financed by GOB from its own resource as per loan negotiation decision on 11 July 2018.

Source: Government of Bangladesh and Asian Development Bank estimates.

C. Allocation and Withdrawal of Loan Proceeds

Table 8: Allocation and Withdrawal of Loan Proceeds

Number	Item	Total Amount Allocated for ADB Loan Financing ($)		Basis for Withdrawal from the Loan Account
		Category	Subcategory	
1	Civil Works	20,610,000		100% of total expenditure claimed*
1A	Works – 1A[a]		3,000,000	100% of total expenditure claimed*
1B	Works – 1B[b]		7,000,000	100% of total expenditure claimed*
1C	Works – 1C[c]		2,000,000	100% of total expenditure claimed*
1D	Works – 1D[d]		3,000,000	100% of total expenditure claimed*
1E	Works – 1E[e]		2,000,000	100% of total expenditure claimed*
1F	Works – 1F[f]		3,000,000	100% of total expenditure claimed*
1G	Works		610,000	100% of total expenditure claimed*
2	Equipment & Furniture	3,070,000		100% of total expenditure claimed*
3	Vehicle	450,000		100% of total expenditure claimed*
4	Training	2,900,000		
4A	Local Training, Seminar and Workshop		1,900,000	100% of total expenditure claimed*
4B	Overseas Training		1,000,000	100% of total expenditure claimed*
5	Consultancy	6,710,000		
5A	International Consultants		5,690,000	100% of total expenditure claimed*
5B	National Consultants		1,020,000	100% of total expenditure claimed*
6	Partnership Agreements	64,350,000		100% of total expenditure claimed*
7	Unallocated**	11,910,000		100% of total expenditure claimed*
	Total	**110,000,000**		

ADB = Asian Development Bank.
*Exclusive of all duties and taxes imposed within the territory of the borrower.
**Inclusive of financing/interest charges on the ADB loan at 2% per annum during implementation period which will not be capitalized under ADB loan (will be treated as unallocated under ADB loan) and will be financed by GOB from its own resource as per loan negotiation decision on 11 July 2018.
[a] Subject to the condition for withdrawal described in paragraph 6(a) of Schedule 3.
[b] Subject to the condition for withdrawal described in paragraph 6(b) of Schedule 3.
[c] Subject to the condition for withdrawal described in paragraph 6(c) of Schedule 3.
[d] Subject to the condition for withdrawal described in paragraph 6(d) of Schedule 3.
[e] Subject to the condition for withdrawal described in paragraph 6(e) of Schedule 3.
[f] Subject to the condition for withdrawal described in paragraph 6(f) of Schedule 3.
Source: Asian Development Bank.

D. Allocation and Withdrawal of Grant Proceeds (Urban Climate Change Resilience Trust Fund)

Table 9: Allocation and Withdrawal of Grant Proceeds

Number	Item	Total Amount Allocated for ADB UCCRTF Financing ($)		Basis for Withdrawal from the Grant Account
		Category	Subcategory	
1	Civil Works	85,000		100% of total expenditure claimed*
2	Equipment	835,000		100% of total expenditure claimed*
3	Training and Workshop	703,000		100% of total expenditure claimed*
4	Consultancy	377,000		100% of total expenditure claimed*
	Total	**2,000,000**		

ADB = Asian Development Bank, UCCRTF = Urban Climate Change Resilience Trust Fund.
*Exclusive of all duties and taxes imposed within the territory of the borrower.
Source: Asian Development Bank.

E. Detailed Cost Estimates by Financier

Table 10: Detailed Cost by Financier ($ million)

Items	Total Amount	ADB (OCR loan)		ADB (UCCRTF grant)		GOB			
		Amount	% of Cost Category	Amount	% of Cost Category	Non Tax	Tax	Total GoB	% of Cost Category
A. Investment Costs[a]									
1. Civil Works	23.5	20.6	87.7%	0.1	0.4%	-	2.8	2.8	11.9%
2. Equipment & Furniture	4.3	3.1	72.1%	0.8	18.6%	-	0.4	0.4	9.3%
3. Vehicles	0.5	0.4	80.0%	-	0.0%	-	0.1	0.1	20.0%
4. Training									
Local Training, Seminar and Workshop	2.3	1.9	82.6%	0.4	17.4%	-	-	-	0.0%
Overseas Training	1.3	1.0	76.9%	0.3	23.1%	-	-	-	0.0%
Subtotal	3.6	2.9	80.6%	0.7	19.4%	-	-	-	0.0%
5. Consultancy									
International Consultants (Firm)	8.4	5.4	64.3%	-	0.0%	-	3.0	3.0	35.7%
International Consultants (Individual)	0.5	0.3	60.0%	-	0.0%	-	0.2	0.2	40.0%
National Consultants (Firm)	0.6	0.4	66.7%	-	0.0%	-	0.2	0.2	33.3%
National Consultants (Individual)	1.2	0.6	50.0%	0.4	33.3%	-	0.2	0.2	16.7%
Subtotal	10.7	6.7	62.6%	0.4	3.7%	-	3.6	3.6	0.0%
6. Partnership Agreements	80.4	64.4	80.1%	-	0.0%	-	16.0	16.0	19.9%
7. Human Resources for PMU and PIUs	4.5	-	0.0%	-	0.0%	4.2	0.3	4.5	100.0%
8. Operating Costs for PMU and PIUs	1.5	-	0.0%	-	0.0%	1.4	0.1	1.5	100.0%
9. LGED Service Charge	0.2	-	0.0%	-	0.0%	0.2	-	0.2	100.0%
Total Baseline Costs [A]	**129.2**	**98.1**	75.9%	**2.0**	1.5%	**5.8**	**23.3**	**29.1**	22.5%
B. Contingencies[b]									
Physical Contingencies	1.8	1.6	88.9%	-	0.0%	0.2	-	0.2	11.1%
Price Contingencies	5.3	4.6	86.8%	-	0.0%	0.7	-	0.7	13.2%
Total: Contingencies [B]	7.1	**6.2**	**87.3%**	-	0.0%	**0.9**	**-**	**0.9**	**12.7%**
C. Unallocated for Financing/Interest Charges[c]	5.7	**5.7**	**100.0%**	-	0.0%	**-**	**-**	**-**	**0.0%**
Total Project Cost [A+B+C]	**142.0**	**110.0**	**77.5%**	**2.0**	**1.4%**	**6.7**	**23.3**	**30.0**	**21.1%**

Note: Numbers may not sum precisely due to rounding.

[a] In June 2018 prices.

[b] Physical contingencies computed at 6.43% for civil works and equipment. Price contingencies are computed at 1.5% on foreign exchange costs and 6.3% on local currency costs; includes provision for potential exchange rate fluctuation under the same assumption of a purchasing power parity exchange rate.

[c] Interest charges on the ADB loan at 2% per annum during implementation period will not be capitalized under ADB loan (will be treated as unallocated under ADB loan) and will be financed by GOB from its own resource as per loan negotiation decision on 11 July 2018.

Source: Government of Bangladesh and Asian Development Bank estimates.

F. Detailed Cost Estimates by Outputs and/or Components

Table 11: Detailed Cost Estimates by Outputs ($ million)

Items	Total Amount	Output-1		Output-2		Output-3	
		Amount	% of Cost Category	Amount	% of Cost Category	Amount	% of Cost Category
A. Investment Costs[a]							
1. Civil Works	23.5	-	0%	23.5	100%	-	0%
2. Equipment & Furniture	4.3	0.9	21%	2.3	53%	1.1	26%
3. Vehicles	0.5	-	0%	-	0%	0.5	100%
4. Training							
Local Training, Seminar and Workshop	2.3	0.4	17%	1.2	52%	0.7	30%
Overseas Training	1.3	-	0%	0.3	0%	1.0	77%
Subtotal	3.6	0.4	11%	1.5	42%	1.7	47%
5. Consultancy							
International Consultants (Firm)	8.4	3.8	45%	4.2	50%	0.4	5%
International Consultants (Individual)	0.5	-	0%	-	0%	0.5	100%
National Consultants (Firm)	0.6	0.6	100%	-	0%	-	0%
National Consultants (Individual)	1.2	-	0%	0.4	0%	0.8	67%
Subtotal	10.7	4.4	41%	4.6	43%	1.7	16%
6. Partnership Agreements	80.4	-	0%	80.4	100%	-	0%
7. Human Resources for PMU and PIUs	4.5	-	0%	-	0%	4.5	100%
8. Operating Costs for PMU and PIUs	1.5	-	0%	-	0%	1.5	100%
9. LGED Service Charge	0.2	-	0%	0.2	100%	-	0%
Total Baseline Costs [A]	**129.2**	**5.7**	4%	**112.5**	87%	**11.0**	9%
B. Contingencies[b]	-						
Physical Contingencies	1.8	-	0%	1.8	100%	-	0%
Price Contingencies	5.3	0.9	17%	4.2	79%	0.2	4%
Total: Contingencies [B]	7.1	**0.9**	13%	**6.0**	85%	**0.2**	3%
C. Unallocated for Financing/Interest Charges[c]	5.7	**1.2**	21%	**3.8**	67%	**0.7**	12%
Total Project Cost [A+B+C]	142.0	**7.8**	5%	**122.3**	86%	**11.9**	8%

Note: Numbers may not sum precisely due to rounding.

[a] In June 2018 prices.

[b] Physical contingencies computed at 6.43% for civil works and equipment. Price contingencies are computed at 1.5% on foreign exchange costs and 6.3% on local currency costs; includes provision for potential exchange rate fluctuation under the same assumption of a purchasing power parity exchange rate.

[c] Interest charges on the ADB loan at 2% per annum during implementation period will not be capitalized under ADB loan (will be treated as unallocated under ADB loan) and will be financed by GOB from its own resource as per loan negotiation decision on 11 July 2018.

Source: Government of Bangladesh and Asian Development Bank estimates.

G. Detailed Cost Estimates by Year

Table 12: Detailed Cost Estimates by Year ($ million)

Items	Total	2018	2019	2020	2021	2022
A. Investment Costs[a]						
1. Civil Works	23.5	2.0	6.0	9.0	4.0	2.5
2. Equipment & Furniture	4.3	1.0	1.3	1.2	0.5	0.3
3. Vehicles	0.5	0.1	-	-	-	-
4. Training						
Local Training, Seminar and Workshop	2.3	0.4	0.5	0.7	0.5	0.2
Overseas Training	1.3	0.1	0.8	0.2	0.2	-
Subtotal	**3.6**	**0.5**	**1.3**	**0.9**	**0.7**	**0.2**
5. Consultancy						
International Consultants (Firm)	8.4	0.5	1.0	2.5	2.6	1.8
International Consultants (Individual)	0.5	0.1	0.1	0.1	0.1	0.1
National Consultants (Firm)	0.6	0.1	0.1	0.1	0.1	0.2
National Consultants (Individual)	1.2	0.4	0.3	0.3	0.1	0.1
Subtotal	**10.7**	**1.1**	**1.5**	**3.0**	**2.9**	**2.2**
6. Partnership Agreements	80.4	9.0	16.8	17.0	17.8	19.8
7. Human Resources for PMU and PIUs	4.5	0.7	0.8	1.0	1.0	1.0
8. Operating Costs for PMU and PIUs	1.5	0.1	0.3	0.3	0.4	0.4
9. LGED Service Charge	0.2	0.1	0.1	0.1	0.1	-
Total baseline Costs including taxes and duties [A]	**129.2**	**14.6**	**28.1**	**32.5**	**27.4**	**26.4**
B. Contingencies[b]						
Physical Contingencies	1.8	0.1	0.6	0.6	0.3	0.2
Price Contingencies	5.3	0.3	0.9	1.0	1.5	1.6
Total: Contingencies [B]	**7.1**	**0.4**	**1.5**	**1.6**	**1.8**	**1.8**
C. Unallocated for Financing/Interest Charges[c]	**5.7**	**0.1**	**0.5**	**1.3**	**1.6**	**2.2**
Total Project Cost [A+B+C]	**142.0**	**15.1**	**30.1**	**35.4**	**30.8**	**30.4**
% of Total Project Cost	**100.0%**	**10.6%**	**21.2%**	**24.9%**	**21.7%**	**21.4%**

Note: Numbers may not sum precisely due to rounding.

[a] In June 2018 prices.

[b] Physical contingencies computed at 6.43% for civil works and equipment. Price contingencies are computed at 1.5% on foreign exchange costs and 6.3% on local currency costs; includes provision for potential exchange rate fluctuation under the same assumption of a purchasing power parity exchange rate.

[c] Interest charges on the ADB loan at 2% per annum during implementation period will not be capitalized under ADB loan (will be treated as unallocated under ADB loan) and will be financed by GOB from its own resource as per loan negotiation decision on 11 July 2018.

Source: Government of Bangladesh and Asian Development Bank estimates.

H. Contract Award and Disbursement S-Curve (Figure 2)

Figure 2.1: Contract Awards and Disbursement Projections (ADB Loan)
($ million)

Year	Contract Awards							Disbursements					
	Q1	Q2	Q3	Q4	Total	Cum.		Q1	Q2	Q3	Q4	Total	Cum.
2018	-	-	-	20	20	20	**2018**	-	-	-	-	0	0
2019	15	15	15	15	60	80	**2019**	5	12	8	10	35	35
2020	5	5	5	5	20	100	**2020**	5	7	6	12	30	65
2021	1	2	2	2	7	107	**2021**	5	5	5	5	20	85
2022	3	0	0	0	3	110	**2022**	5	5	5	5	20	105
2023	0	0	0	0	0	110	**2023**	5	0	0	0	5	110

Source: Asian Development Bank.

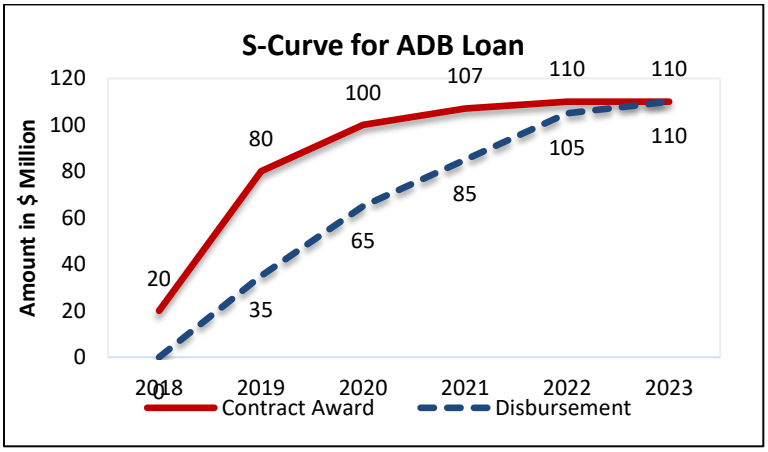
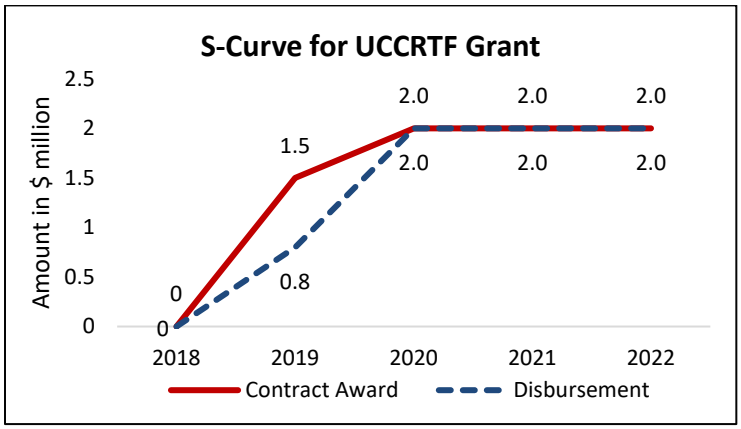


Figure 2.2: Contract Awards and Disbursement Projections (UCCRTF Grant)
($ million)

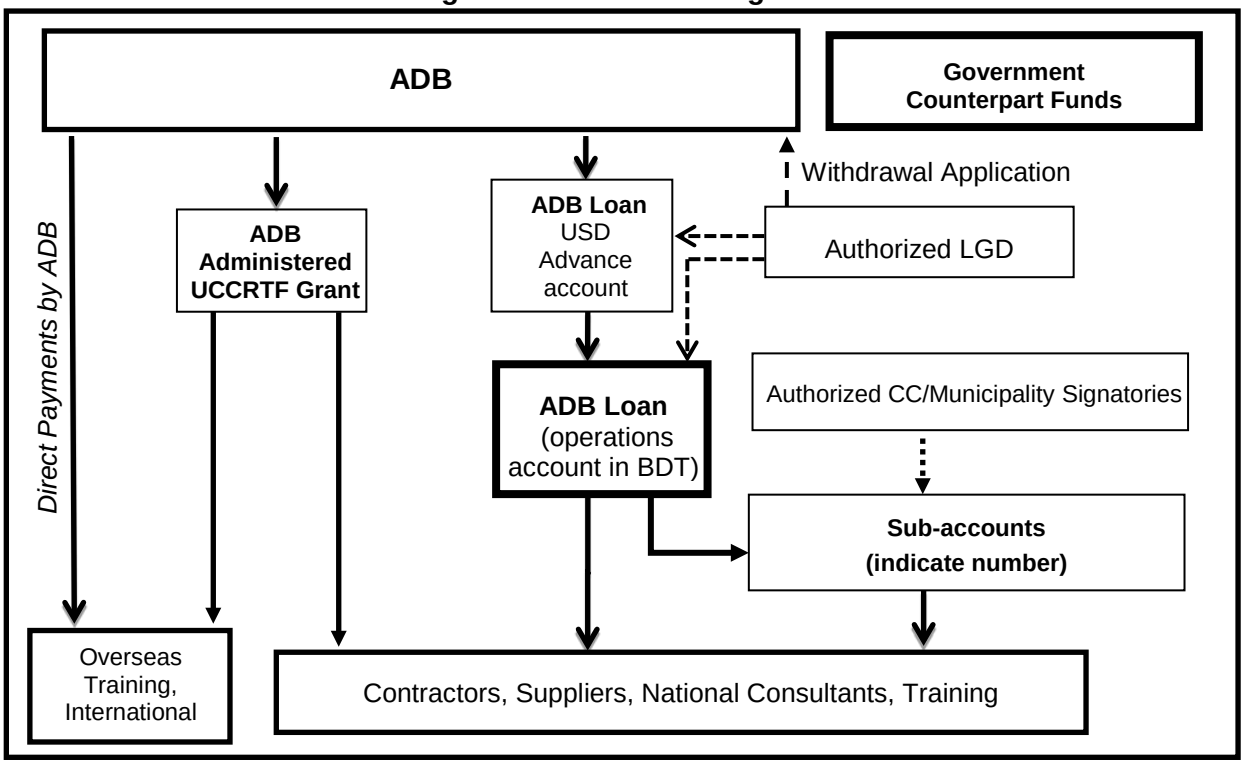
Year	Contract Awards							Disbursements					
	Q1	Q2	Q3	Q4	Total	Cum.		Q1	Q2	Q3	Q4	Total	Cum.
2018	-	-	-	-	0	0	**2018**	-	-	-	-	0	0
2019	0.4	0.4	0.4	0.3	1.5	1.5	**2019**	0.2	0.2	0.2	0.2	0.8	0.8
2020	0.25	0.25	0	0	0.5	2.0	**2020**	0.1	0.2	0.4	0.5	1.2	2.0
2021	-	-	-	-	0	2.0	**2021**	-	-	-	-	0	2.0
2022	-	-	-	-	0	2.0	**2022**	-	-	-	-	0	2.0

Source: Asian Development Bank.



I. Fund Flow Diagram

Figure 3: Fund Flow Diagram



Notes:

1. A United States dollar (USD) advance account for the ADB loan will be opened by the Local Government Division (LGD, the executing agency) at the Bangladesh Bank. The initial amount advanced to the advance account will be estimated expenditures to be funded through the respective advance accounts for the first 6 months of project implementation according to ADB *Loan Disbursement Handbook* (2017, as amended time to time).

2. A local currency (BDT) account, against the USD advance account for the ADB loan will be opened and operated by the project management unit (PMU) in LGD. Funds from the USD advance account will be converted and transferred into the corresponding BDT account (the "operation account") for utilization of project funds towards eligible expenditures.

3. Each project implementation unit at participating city corporations or municipalities may open a separate second-generation advance account that may be operated by the chief health officer, medical officer, or the mayors of respective city corporations or municipalities as the drawing and disbursement officer. The PMU will advance funds from the BDT account to the project implementation unit accounts for eligible project expenditures. The ceiling of the second-generation advance account for the loan shall not exceed 6 months estimated expenditures to be financed through the account according to ADB *Loan Disbursement Handbook* (2017, as amended time to time).

4. Financial reporting (monthly, quarterly, yearly, special) will be made based on the financial information assimilated from the cost centers (city corporations and municipalities) at the PMU (project director, LGD) following ADB and Government of Bangladesh's financial reporting guidelines. Financial reporting includes reporting to both government and ADB.

5. A financial management manual will be established stating in specific detail the modalities of fund operations, release, disbursement, etc. Additionally, the manual will also state specific books of accounts, ledgers, and registers to be maintained at each accounting location/cost center that receives/transfers the Urban Primary Health Care Services Delivery Project Funds.

6. A computerized financial reporting system will be implemented initially at the PMU and subsequently at the city corporations and municipalities.

7. Financial management staff/experts will be in place within the main PMU to oversee the overall accounting, budgeting, auditing, and financial reporting. Finance should be bifurcated from the administration in order to comply with government and ADB internal control regulations.

8. All the above will be implemented according to the existing Financial Rules and Regulations established by the Ministry of Finance for development projects and ADB *Loan Disbursement Handbook* (2017, as amended time to time).

Source: Asian Development Bank.

V. FINANCIAL MANAGEMENT

A. Financial Management Assessment

21. The financial management assessment (FMA) was conducted during March–June 2017 in accordance with ADB technical guidelines.[7] Updates were incorporated in August 2018 taking into consideration actions taken by PMU/LGD to address originally identified financial management risks, including updating Tally software service contract, updating the financial management manual, and settling major audit observations. The FMA considered the capacity of the LGD as the executing agency, including the existing PMU for the ongoing Urban Primary Health Care Services Delivery Project, and PIUs of ULBs as implementing agencies. Areas covered included funds flow arrangements, staffing, accounting and financial reporting systems, financial information systems, and internal and external auditing arrangements. PMU has the capacity to manage the advance fund and statement of expenditure (SOE).

22. Based on the assessment, the following are key financial management risks identified: (i) insufficient number of finance staff in the PMU; (ii) some gaps in the financial management skills of the existing finance staff in the PMU and PIUs; (iii) bank reconciliations are not carried out on a monthly basis by the PMU; (iv) weak internal audit; and (v) the PMU and PIUs face challenges in undertaking comprehensive monthly and quarterly financial reporting.

23. It is concluded that the overall pre-mitigation financial management risk of LGD, including the PMU, and the ULBs, including the PIUs, is *moderate*. LGD has agreed to implement an action plan as key measures to address the deficiencies. The financial management action plan is provided in Table 13.

Table 13: Financial Management Action Plan[8]

SL	Description	Timeline	Responsibility
1	Recruiting additional staff for the PMU's Finance Unit.	By loan effectiveness	PMU / LGD
2	Recruiting a FM consultant for the PMU.	By loan effectiveness	PMU / LGD
3	Recruiting additional FM support for new ULBs by consulting firm.	By loan effectiveness	PMU / LGD
4	Providing training on Tally accounting software and FM training to existing and new ULBs, the PMU and service providers.	Ongoing	PMU
5	Conducting training in ADB's procurement, FM and disbursement procedures and requirements.	Ongoing	PMU / ADB
6	Settling audit observations of the ongoing project and the previous phase project.	Ongoing (within six months of FAPAD report availability)	PMU / LGD
7	Ensuring that bank reconciliation is undertaken monthly for the project.	Monthly	PMU / PIUs / partner service providers
8	Carrying out Biennial Fiduciary Reviews.	Year 1 and Year 3	PMU / ADB

ADB = Asian Development Bank, FAPAD = Foreign Aided Project Audit Directorate, FM = financial management, LGD = Local Government Division, PIU = project implementation unit, PMU = project management unit, ULB = urban local body.
Source: Asian Development Bank.

[7] ADB. 2005. *Financial Management and Analysis of Projects*. Manila; ADB. 2009. *Financial Due Diligence: A Methodology Note*. Manila; ADB. 2015. *Financial Management Assessment – Financial Management Technical Guidance Note*. Manila.

[8] The action plan was reviewed and updated in August 2018.

24. The financial management risks and risk-mitigation measures will be reviewed and updated regularly throughout the life of the project.

B. Disbursement

1. Disbursement Arrangements for ADB

25. The loan proceeds will be disbursed in accordance with ADB's *Loan Disbursement Handbook* (2017, as amended from time to time), and detailed arrangements agreed upon between the government and ADB. Online training for project staff on disbursement policies and procedures is available.[9] Project staff are encouraged to avail of this training to help ensure efficient disbursement and fiduciary control.

26. The project team concluded that the executing and implementing agencies have adequate capacity to administer advance fund and SOE procedures because (i) adequate action plans are prepared, and most of them will be completed at the early stage of the project. The progress of the financial management action plans will be closely monitored, so that there will be no delay; and (ii) there was no significant disbursement issues in the original project.

27. In addition to the advance fund and SOE procedures, direct payment and reimbursement procedures will be used for disbursements under the project.[10]

28. **Advance fund procedure.** LGD will open and administer an advance account for the ADB loan at the Bangladesh Bank. The currency of the advance account is in United States dollar. The advance account is to be used exclusively for ADB's share of eligible expenditures. LGD is accountable and responsible for proper use of advances to the advance account.

29. The total outstanding advance to the advance account should not exceed the estimate of ADB's share of expenditures to be paid through the advance account for the forthcoming 6 months. LGD may request for initial and additional advances to the advance account based on an Estimate of Expenditure Sheet[11] setting out the estimated expenditures to be financed through the accounts for the forthcoming 6 months. Supporting documents should be submitted to ADB or retained by LGD in accordance with ADB's *Loan Disbursement Handbook* (2017, as amended from time to time) when liquidating or replenishing the advance account.

30. LGD will establish and maintain a local currency (BDT) sub-account, against the dollar advance account. Funds from the dollar advance account will be converted and transferred into the corresponding BDT account as project funds towards eligible expenditures. The sub-account is to be used exclusively for ADB's fund share of eligible expenditures. LGD will ensure that every liquidation and replenishment of the sub-account is supported by sufficient documentation in accordance with ADB's *Loan Disbursement Handbook* (2017, as amended from time to time).

31. Each participating ULB (PIU) will establish and maintain a separate local currency (BDT) sub-account for disbursement of funds to pay for eligible project costs. The account may be operated by the CHO, medical officer, or mayor of the respective ULB as the drawing and disbursement officer. The PMU will advance funds from its BDT account to the PIU account for eligible project expenditures. Disbursement of funds for partnership area service provider contract

[9] Disbursement eLearning. http://wpqr4.adb.org/disbursement_elearning.
[10] ADB. 2017. *Loan Disbursement Handbook*. Manila.
[11] ADB. 2017. *Loan Disbursement Handbook*. Manila.

payments may also be delegated to select PIUs,[12] as and when recommended by the project director and approved by the secretary of the LGD. The ceiling of each SGIA shall not exceed 6 months estimated expenditures to be financed through the account. The SGIA is to be used exclusively for ADB's share of eligible expenditures.

32. **Statement of expenditure procedure**.[13] The SOE procedure may be used for reimbursement of eligible expenditures or liquidation of advances to the advance account. The ceiling of the SOE procedure is the equivalent of $200,000 per individual payment. Supporting documents and records for the expenditures claimed under the SOE should be maintained and made readily available for review by ADB's disbursement and review missions, upon ADB's request for submission of supporting documents on a sampling basis, and for independent audit. Reimbursement and liquidation of individual payments in excess of the SOE ceiling should be supported by full documentation when submitting the withdrawal application to ADB.

33. Before the submission of the first withdrawal application, the borrower should submit to ADB sufficient evidence of the authority of the person(s) who will sign the withdrawal applications on behalf of the government, together with the authenticated specimen signatures of each authorized person. The minimum value per withdrawal application is $200,000 equivalent. Individual payments below this amount should be paid (i) by LGD and subsequently claimed to ADB through reimbursement, or (ii) through the advance fund procedure, unless otherwise accepted by ADB.

34. Loan proceeds of $20 million will have funding available as reimbursement to the government based on two conditions: (i) that LGD reports project-related eligible expenditures incurred for civil works; and, (ii) that LGD furnishes satisfactory evidence that it has achieved institutional action targets in accordance with the verification protocols (**Annex 19**). Should the agreed institutional actions targets not be met, the expenditures incurred by LGD will not be reimbursed to the government, and these expenditures will instead be treated as government expenditure for the project.

2. Disbursement Arrangements for Counterpart Funds

35. Disbursement and liquidation procedures for government funds will be based on disbursement projections prepared as part of the project design. For the 'ordinary' part of ADB's loan (approximately $90 million), the government will budget the source of funding as a reimbursable project aid (through advance accounts). The government allocates the budget in the specific year of the annual development program. LGD will be responsible for requesting budgetary allocations for counterpart funds. LGD will make allocations and payments of tax and value-added tax (VAT) under the project from counterpart funds as per government procedures.

36. The PIUs will affect government counterpart funds through a separate bank account.

37. As indicated above, the government will pre-finance project activities with corresponding eligible economic codes for civil works amounting to $20 million. The government will budget this funding source as a reimbursable project aid (through the government). Once the government

[12] To empower ULBs and ensure more ownership and sustainability of urban PHC, 10 partnership areas have been identified for more devolved role and responsibility in the management and provision of urban PHC. These 10 partnership areas will either have direct service provision by the respective ULB health department through an MOU with the executing agency, or contract out to service providers. The PMU will continue to provide oversight and technical support. (See Annex 2.C)

[13] SOE forms are available in ADB's *Loan Disbursement Handbook* (2017, as amended from time to time).

has met the agreed institutional action targets and incurred eligible expenditures, these will be reimbursed by ADB to the Government of Bangladesh.

C. Accounting

38. LGD should (i) maintain and cause ULBs to maintain, separate books and records by funding source for all expenditures incurred in accordance with the government's accounting laws and regulations which are consistent with international accounting principles and practices; and (ii) prepare consolidated project financial statements (ULBs' audited financial statements are to be consolidated) in accordance with the government's accounting laws and regulations which are consistent with international accounting principles and practices.

39. ULBs should (i) maintain separate books and records by funding source for all expenditures incurred for its portion of the project incurred in accordance with the government's accounting laws and regulations which are consistent with international accounting principles and practices; and (ii) prepare financial statements[14] for its portion of the project in accordance with the government's accounting laws and regulations which are consistent with international accounting principles and practices. Financial statements should be in the same format as the consolidated project financial statement prepared by LGD, with all notes and explanations.

D. Auditing and Public Disclosure

40. LGD will cause the detailed consolidated project financial statements to be audited in accordance with the government's audit regulations, which are based on International Standards on Auditing, by the Foreign Aided Project Audit Directorate (FAPAD). FAPAD will have the right to audit any or all of the ULBs accounts. Given the number of ULBs involved, FAPAD may opt for sampling. The audit report will be for the entire consolidated project financial statements, and FAPAD's opinion should cover everything. The consolidated audited project financial statements together with the auditor's opinion will be presented in the English language to ADB within 6 months from the end of the fiscal year by the project director/PMU/LGD.

41. The audit report for the project financial statements will include a management letter and auditor's opinions, which cover (i) whether the project financial statements present an accurate and fair view or are presented fairly, in all material respects, in accordance with the applicable financial reporting standards; (ii) whether the proceeds of the loan and grant were used only for the purpose(s) of the project; and (iii) whether the borrower or executing agency was in compliance with the financial covenants contained in the legal agreements (where applicable).

42. Compliance with financial reporting and auditing requirements will be monitored by review missions and during normal program supervision, and followed up regularly with all concerned, including the external auditor.

43. The government, LGD, and ULBs have been made aware of ADB's approach to delayed submission, and the requirements for satisfactory and acceptable quality of the audited project financial statements.[15] ADB reserves the right to require a change in the auditor (in a manner

[14] Following information needs to be provided: on the Sources side, the funding from each source (ULBs' own finance, federal subsidies, ADB loan, revenue collections from fees or similar charges from the health facilities), and on the expenditure side, 100% of project expenditures.

[15] ADB's approach and procedures regarding delayed submission of audited project financial statements:

(i) When audited project financial statements are not received by the due date, ADB will write to the executing agency advising that (a) the audit documents are overdue; and (b) if they are not received within the next 6

consistent with the constitution of the borrower), or for additional support to be provided to the auditor, if the audits required are not conducted in a manner satisfactory to ADB, or if the audits are substantially delayed. ADB reserves the right to verify the project's financial accounts to confirm that the share of ADB's financing is used in accordance with ADB's policies and procedures.

44. Public disclosure of the audited project financial statements, including the auditor's opinion on the project financial statements, will be guided by ADB's Public Communications Policy 2011.[16] After the review, ADB will disclose the audited project financial statements and the opinion of the auditors on the project financial statements no later than 14 days of ADB's confirmation of their acceptability by posting them on ADB's website. The management letter, additional auditor's opinions, and audited entity financial statements will not be disclosed.[17]

VI. PROCUREMENT AND CONSULTING SERVICES

A. Advance Contracting and Retroactive Financing

45. All advance contracting and retroactive financing will be undertaken in conformity with ADB's *Procurement Guidelines* (2015, as amended from time to time) and ADB's *Guidelines on the Use of Consultants* (2013, as amended from time to time). The issuance of invitations to bid under advance contracting and retroactive financing will be subject to ADB approval. The borrower, LGD of MOLGRDC as the executing agency, has been advised that approval of advance contracting and retroactive financing does not commit ADB to finance the project.

46. **Advance contracting.** The existing 25 partnership area NGOs (PANGOs) under the Urban Primary Health Care Services Delivery Project will be directly contracted under the additional financing for 3 months (from 1 April 2018 to 30 June 2018) to ensure continuity of health care services. It was also agreed that international competitive bidding will be conducted in advance for the 25 partnership areas that are covered by the existing project and will continue to be covered by the additional financing. The estimated schedule will be as follows:

(i) Invitation for bids – November 2017;
(ii) Bid submission – January 2018;
(iii) Evaluation of technical proposals and ADB concurrence – January 2018;
(iv) Evaluation of financial proposal and ADB concurrence – May 2018;
(v) Finalization of contracts with successful bidders – June 2018; and
(vi) Fielding of partner service providers – July 2018.

47. **Retroactive financing.** Withdrawals from the loan and grant accounts may be made for reimbursement of eligible expenditures for operational costs incurred under the project before

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months, requests for new contract awards and disbursement such as new replenishment of advance account, processing of new reimbursement, and issuance of new commitment letters will not be processed.

(ii) When audited project financial statements are not received within 6 months after the due date, ADB will withhold processing of requests for new contract awards and disbursement such as new replenishment of advance account, processing of new reimbursement, and issuance of new commitment letters. ADB will (a) inform the executing agency of ADB's actions; and (b) advise that the loan may be suspended if the audit documents are not received within the next 6 months.

(iii) When audited project financial statements are not received within 12 months after the due date, ADB may suspend the loan.

[16] Public Communications Policy: http://www.adb.org/documents/pcp-2011?ref=site/disclosure/publications.

[17] This type of information would generally fall under public communications policy exceptions to disclosure. ADB. 2011. *Public Communications Policy*. Paragraph 97(iv) and/or 97(v). Manila.

effective date, but not earlier than 12 months before the date of the loan and grant agreements, subject to a maximum amount equivalent to 20% of the loan amount.

B. Procurement of Goods, Works, and Consulting Services

48. All procurement of civil works, goods, and related services will be undertaken in accordance with the ADB's *Procurement Guidelines* (2015, as amended from time to time).

49. Before the start of any procurement, ADB and the government will review the public procurement laws of the central and state governments to ensure consistency with ADB's *Procurement Guidelines* (2015, as amended from time to time).

50. An 18-month procurement plan indicating threshold and review procedures, goods, works, and consulting service contract packages and national competitive bidding guidelines is in **Section C**.

51. All consultants will be recruited and administered according to ADB's *Guidelines on the Use of Consultants* (2013, as amended from time to time). The terms of reference for all consulting services are detailed in **Section D**.

52. An estimated 635 person-months (299 international, 336 national) of consulting services are required to (i) facilitate project management and implementation, and (ii) strengthen the institutional and operational capacity of the executing agency.

C. Procurement Plan

Basic Data

<table>
<tr><td colspan="2">Project Name: Urban Primary Health Care Services Delivery Project - Additional Financing</td></tr>
<tr><td>Project Number: 42177-024</td><td>Approval Number:</td></tr>
<tr><td>Country: Bangladesh</td><td>Executing Agency: Local Government Division, Ministry of Local Government, Rural Development, and Co-operatives</td></tr>
<tr><td>Project Procurement Classification: Category A</td><td rowspan="2">Implementing Agencies:
City corporations and municipal governments (urban local bodies)</td></tr>
<tr><td>Project Procurement Risk: Moderate</td></tr>
<tr><td>Project Financing Amount: US$ 142,000,000
ADB Financing: US$ 110,000,000
Cofinancing (ADB Administered): $2,000,000
Non-ADB Financing: US$ 30,000,000</td><td>Project Closing Date: 31 March 2023</td></tr>
<tr><td>Date of First Procurement Plan: 23 November 2017</td><td>Date of this Procurement Plan: 10 August 2018</td></tr>
</table>

A. Methods, Thresholds, Review and 18-Month Procurement Plan

1. Procurement and Consulting Methods and Thresholds

Except as the Asian Development Bank (ADB) may otherwise agree, the following process thresholds shall apply to procurement of goods and works.

Procurement of Goods and Works		
Method	**Threshold**	**Comments**
International Competitive Bidding for	US$ 2,000,000 and Above	-

Procurement of Goods and Works		
Method	**Threshold**	**Comments**
Goods		
National Competitive Bidding for Goods	Between US$ 100,000 and US$ 1,999,999	The first NCB is subject to prior review, thereafter post review.
Shopping for Goods	Up to US$ 99,999	-
National Competitive Bidding for Works	Between US$ 100,000 and US$ 14,999,999	The first NCB is subject to prior review, thereafter post review.
Shopping for Works	Up to US$ 99,999	-

Consulting Services	
Method	**Comments**
Consultant's Qualification Selection for Consulting Firm	Packages SD-1 to SD-4
Quality- and Cost-Based Selection for Consulting Firm	Packages SD-5 to SD-8
Individual Consultants Selection for Individual Consultant	Packages SD-9 to SD-24

2. Goods and Works Contracts Estimated to Cost $1 Million or More

The following table lists goods and works contracts for which the procurement activity is either ongoing or expected to commence within the next 18 months.

Package Number	**General Description**	**Estimated Value**	**Procurement Method**	**Review** (Prior/ Post)	**Bidding Procedure**	**Advertisement Date** (quarter/ year)	**Comments**
GD-00	3-months Continuation of Partnership Agreements in 25 Areas	2,800,000.00	Contract Variation	Prior	n/a	n/a	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-01	Dhaka South City Corporation PA-1	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-02	Dhaka South City Corporation PA-2	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-03	Dhaka South City Corporation PA-3	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-04	Dhaka South City Corporation PA-4	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-05	Dhaka South City Corporation PA-5	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents

Package Number	General Description	Estimated Value	Procurement Method	Review (Prior/ Post)	Bidding Procedure	Advertisement Date (quarter/ year)	Comments
GD-06	Dhaka North City Corporation PA-1	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-07	Dhaka North City Corporation PA-2	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-08	Dhaka North City Corporation PA-3	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-09	Dhaka North City Corporation PA-4	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-10	Dhaka North City Corporation PA-5	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-11	Rajshahi City Corporation PA-1	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-12	Rajshahi City Corporation PA-2	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-13	Khulna City Corporation PA-1	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-14	Khulna City Corporation PA-2	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-15	Sylhet City Corporation PA-1	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-16	Barishal City Corporation PA-1	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods

Package Number	General Description	Estimated Value	Procurement Method	Review (Prior/ Post)	Bidding Procedure	Advertisement Date (quarter/ year)	Comments
							documents
GD-17	Narayanganj City Corporation PA-1	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-18	Gazipur City Corporation PA-1	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-19	Gazipur City Corporation PA-2	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-20	Cumilla City Corporation PA-1	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-21	Rangpur City Corporation PA-1	1,880,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-22	Kishoreganj Municipality PA-1	1,560,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-23	Khustia Municipality PA-1	1,560,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-24	Sirajganj Municipality PA-1	1,560,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-25	Gopalganj Municipality PA-1	1,560,000.00	ICB	Prior	1S2E	Q4 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: Y Bidding Document: Goods Comments: Customized goods documents
GD-26	Dhaka South City Corporation PA-6	1,880,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-27	Dhaka South City Corporation PA-7	1,880,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods

Package Number	General Description	Estimated Value	Procurement Method	Review (Prior/ Post)	Bidding Procedure	Advertisement Date (quarter/ year)	Comments
							Comments: Customized goods documents
GD-28	Dhaka South City Corporation PA-8	1,880,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-29	Dhaka North City Corporation PA-6	1,880,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-30	Dhaka North City Corporation PA-7	1,880,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-31	Narayanganj City Corporation PA-2	1,880,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-32	Gazipur City Corporation PA-3	1,880,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-33	Chattogram City Corporation PA-1	1,880,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-34	Chattogram City Corporation PA-2	1,880,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-35	Chattogram City Corporation PA-3	1,880,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-36	Mymensingh Municipality PA-1	1,560,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-37	Faridpur Municipality PA-1	1,560,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-38	Shariatpur Municipality PA-1	1,560,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N

Package Number	General Description	Estimated Value	Procurement Method	Review (Prior/ Post)	Bidding Procedure	Advertisement Date (quarter/ year)	Comments
							Bidding Document: Goods Comments: Customized goods documents
GD-39	Gaibandha Municipality PA-1	1,560,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-40	Kurigram Municipality PA-1	1,560,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-41	Netrokona Municipality PA-1	1,560,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-42	Jagannathpur Municipality PA-1	1,560,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-43	Derai Municipality PA-1	1,560,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-44	Benapole Municipality PA-1	1,560,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-45	Tarabo Municipality PA-1	1,560,000.00	ICB	Prior	1S2E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods Comments: Customized goods documents
GD-51	IT hardware for old and new PAs	1,660,000.00	NCB	Prior	1S1E	Q3 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Goods
WD-18	CRHCC	1,225,000.00	NCB	Prior	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP customized documents
WD-19	CRHCC	1,225,000.00	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP customized documents
WD-20	CRHCC	1,225,000.00	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N

Package Number	General Description	Estimated Value	Procurement Method	Review (Prior/ Post)	Bidding Procedure	Advertisement Date (quarter/ year)	Comments
							Bidding Document: Others Comments: Delegated to LGED; eGP customized documents
WD-21	CRHCC	1,225,000.00	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP customized documents
WD-22	CRHCC	1,225,000.00	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP customized documents
WD-23	CRHCC	1,225,000.00	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP customized documents
WD-24	CRHCC	1,225,000.00	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP customized documents
WD-25	CRHCC	1,225,000.00	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advance Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP customized documents

3. Consulting Services Contracts Estimated to Cost $100,000 or More

The following table lists consulting services contracts for which the recruitment activity is either ongoing or expected to commence within the next 18 months.

Package Number	General Description	Estimated Value	Recruitment Method	Review (Prior/ Post)	Advertisement Date (quarter/year)	Type of Proposal	Comments
SD-01	TA firm for pilot initiative to support selected ULBs	1,800,000.00	QCBS	Prior	Q2 / 2018	FTP	Assignment: International Quality-Cost Ratio: 90:10 Advance Contracting: N Comments: -
SD-02	Monitoring and Evaluation	2,800,000.00	QCBS	Prior	Q1 / 2018	FTP	Assignment: International Quality-Cost Ratio: 90:10 Advance Contracting: Y Comments: -
SD-03	BCCM Program	2,500,000.00	QCBS	Prior	Q1 / 2018	FTP	Assignment: International Quality-Cost Ratio: 90:10 Advance Contracting: Y Comments: -
SD-04	ICT solutions and HMIS	890,000.00	QCBS	Prior	Q1 / 2018	STP	Assignment: International Quality-Cost Ratio: 90:10 Advance Contracting: Y Comments: -
SD-05	Biennial Fiduciary Review	200,000.00	CQS	Prior	Q2 / 2018	BTP	Assignment: International Advance Contracting: N Comments: -
SD-06	Operations Research	320,000.00	SSS	Prior	Q4 / 2018	BTP	Assignment: National Advance Contracting: N

Package Number	General Description	Estimated Value	Recruitment Method	Review (Prior/ Post)	Advertisement Date (quarter/year)	Type of Proposal	Comments
							Comments: icddr,b
SD-07	Operations Research	150,000.00	CQS	Prior	Q4 / 2018	BTP	Assignment: National Advance Contracting: N Comments: -
SD-08	Operations Research	150,000.00	CQS	Prior	Q4 / 2018	BTP	Assignment: National Advance Contracting: N Comments: -
SD-09	International consulting pool	440,000.00	ICS	Prior	Q1 / 2019		Assignment: International Expertise: various Advance Contracting: N Comments: 20 pm
SD-10	UPHC specialist	180,000.00	ICS	Prior	Q2 / 2018		Assignment: National Expertise: urban health Advance Contracting: N Comments: 36 pm
SD-11	Procurement Specialist	120,000.00	ICS	Prior	Q2 / 2018		Assignment: National Expertise: Procurement Advance Contracting: N Comments: 24 pm
SD-12	Quality Assurance/M&E Specialist	180,000.00	ICS	Prior	Q2 / 2018		Assignment: National Expertise: Quality Assurance/ Monitoring & Evaluation Advance Contracting: N Comments: 36 pm
SD-13	Financial Management Specialist	150,000.00	ICS	Prior	Q2 / 2018		Assignment: National Expertise: Financial Management Advance Contracting: N Comments: 30 pm
SD-14	National consulting pool	150,000.00	ICS	Prior	Q2 / 2018		Assignment: National Expertise: various Advance Contracting: N Comments: 30 pm

4. Goods and Works Contracts Estimated to Cost Less than $1 Million and Consulting Services Contracts Less than $100,000 (Smaller Value Contracts)

The following table lists smaller-value goods, works and consulting services contracts for which the activity is either ongoing or expected to commence within the next 18 months.

Goods and Works								
Package Number	**General Description**	**Estimated Value**	**Number of Contracts**	**Procurement Method**	**Review** (Prior/ Post)	**Bidding Procedure**	**Advertisement Date** (quarter/ year)	**Comments**
GD-46 to 50	Medical equipment for PAs	1,562,000.00	5	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Goods
GD-52	Office refurbishment for PMU & old PIUs	113,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Goods
GD-53 to 56	PMU & PIU Office equipment and furniture	340,000.00	4	SHOPPING	Post		Q2 / 2018	Advanced Contracting: N
GD-57	4 Jeeps (replacement)	368,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Goods Comments: including registration and CNG

Goods and Works								
Package Number	**General Description**	**Estimated Value**	**Number of Contracts**	**Procurement Method**	**Review** (Prior/ Post)	**Bidding Procedure**	**Advertisement Date** (quarter/ year)	**Comments**
								conversion
GD-58	3 Microbus	150,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Goods Comments: including registration and CNG conversion
GD-59	1 Sedan car (for PMU)	37,000.00	1	SHOPPING	Post		Q2 / 2018	Advanced Contracting: N Comments: including registration and CNG conversion
GD-60	2 Motorcycles	5,000.00	1	SHOPPING	Post		Q2 / 2018	Advanced Contracting: N Comments: including registration
GD-61	Solar energy system	600,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Goods Comments: Funded from UCCRTF
GD-62 to 64	Climate resilient equipment	235,000.00	3	SHOPPING	Post		Q2 / 2018	Advanced Contracting: N Comments: Funded from UCCRTF
WD-01 to 15	Expansion, renovation, routine maintenance, solar panel, and other "greening of existing 25 PAs"	2,820,000.00	15	NCB	Post	1S1E	Q3 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-16 to 17	Climate resilient civil works	85,000.00	2	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Funded from UCCRTF; eGP
WD-26	PHCC	450,000.00	1	NCB	Prior	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-27	PHCC	450,000.00	1	NCB	Prior	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-28	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-29	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N

Goods and Works								
Package Number	**General Description**	**Estimated Value**	**Number of Contracts**	**Procurement Method**	**Review** (Prior/ Post)	**Bidding Procedure**	**Advertisement Date** (quarter/ year)	**Comments**
								Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-30	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-31	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-32	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-33	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-34	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-35	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2017	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-36	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-37	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-38	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N

Goods and Works								
Package Number	**General Description**	**Estimated Value**	**Number of Contracts**	**Procurement Method**	**Review** (Prior/ Post)	**Bidding Procedure**	**Advertisement Date** (quarter/ year)	**Comments**
								Bidding Document: Others Comments: Delegated to LGED; eGP
WD-39	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-40	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-41	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-42	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-43	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-44	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-45	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-46	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-47	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others

Goods and Works								
Package Number	**General Description**	**Estimated Value**	**Number of Contracts**	**Procurement Method**	**Review** (Prior/ Post)	**Bidding Procedure**	**Advertisement Date** (quarter/ year)	**Comments**
								Comments: Delegated to LGED; eGP
WD-48	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP
WD-49	PHCC	450,000.00	1	NCB	Post	1S1E	Q2 / 2018	Prequalification of Bidders: N Domestic Preference Applicable: N Advanced Contracting: N Bidding Document: Others Comments: Delegated to LGED; eGP

Consulting Services								
Package Number	**General Description**	**Estimated Value**	**Number of Contracts**	**Recruitment Method**	**Review** (Prior/ Post)	**Advertisement Date** (quarter/ year)	**Type of Proposal**	**Comments**
SD-15	Gender Specialist	60,000.00	1	ICS	Prior	Q2 / 2018		Assignment: National Expertise: Gender Advance Contracting: N Comments: 12 pm
SD-16	Capacity Development Specialist	60,000.00	1	ICS	Prior	Q2 / 2018		Assignment: National Expertise: Capacity Development Advance Contracting: N Comments: 12 pm
SD-17	Environment Specialist	60,000.00	1	ICS	Prior	Q2 / 2018		Assignment: National Expertise: Environment Advance Contracting: N Comments: 12 pm
SD-18	Structural/ Civil Engineer	80,000.00	1	ICS	Prior	Q4 / 2017		Assignment: National Expertise: Engineering Advance Contracting: Y Comments: 12 pm; Funded from UCCRTF
SD-19	Electrical Engineer	80,000.00	1	ICS	Prior	Q4 / 2017		Assignment: National Expertise: Engineering Advance Contracting: Y Comments: 12 pm; Funded from UCCRTF
SD-20	Mechanical Engineer	80,000.00	1	ICS	Prior	Q4 / 2017		Assignment: National Expertise: Engineering Advance Contracting: Y Comments: 12 pm; Funded from UCCRTF
SD-21	Medical Waste Management Expert	80,000.00	1	ICS	Prior	Q4 / 2017		Assignment: National Expertise: Waste Management Advance Contracting: Y Comments: 12 pm; Funded from UCCRTF
SD-22	Climate Change Expert	80,000.00	1	ICS	Prior	Q4 / 2017		Assignment: National Expertise: Climate Change Advance Contracting: Y Comments: 12 pm; Funded from UCCRTF

B. Indicative List of Packages Required Under the Project

The following table provides an indicative list of goods, works and consulting services contracts over the life of the project, other than those mentioned in previous sections (i.e., those expected beyond the current period).

Goods and Works							
Package Number	**General Description**	**Estimated Value (cumulative)**	**Estimated Number of Contracts**	**Procurement Method**	**Review** (Prior/ Post)	**Bidding Procedure**	**Comments**
None							

Consulting Services							
Package Number	**General Description**	**Estimated Value (cumulative)**	**Estimated Number of Contracts**	**Recruitment Method**	**Review** (Prior/ Post)	**Type of Proposal**	**Comments**
SD-23	Midterm Review	100,000.00	1	ICS	Prior		Assignment: International Expertise: Evaluation
SD-24	Completion Review (PCR)	100,000.00	1	ICS	Prior		Assignment: International Expertise: Evaluation

C. National Competitive Bidding

A. Regulation and Reference Documents

1. The procedures to be followed for national competitive bidding shall be those set forth for the National Open Tendering Method in *The Public Procurement Rules, 2008* (as updated and pursuant to *The Public Procurement Act, 2006* issued by the Government of Bangladesh) with the clarifications and modifications described in the following paragraphs required for compliance with the provisions of the Procurement Guidelines.

B. Procurement Procedures

1. Eligibility

2. The eligibility of bidders shall be as defined under section I of the Procurement Guidelines; accordingly, no bidder or potential bidder should be declared ineligible for reasons other than those provided in section I of the Guidelines, **as amended from time to time**.

2. Advertising

3. The posting of NCB specific notices for contracts valued at less than $1 million on ADB's website is not required but is highly recommended.

3. Location of Bid Submission

4. Submission of bids to 'primary' and 'secondary' locations, or 'multiple droppings' of bids, shall not be required or allowed. Advertisements and bidding documents shall specify only one location for delivery of bids.

4. Bid Price as Percentage of Estimate

5. Bids shall not be invited on the basis of percentage above or below the estimated cost, and contract award shall be based on the lowest evaluated bid price of responsive bid from eligible and

qualified bidder.

5. Lottery

6. A lottery system shall not be used to determine a successful bidder, including for the purpose of resolving deadlocks.

6. Rejection of All Bids and Rebidding

7. Bids shall not be rejected and new bids solicited without ADB's prior concurrence.

C. Bidding Documents

7. Anti-Corruption

8. Definitions of corrupt, fraudulent, collusive and coercive practices shall reflect the latest ADB Board-approved Anti-Corruption Policy definitions of these terms and related additional provisions (such as conflict of interest, etc.).

8. Qualification Requirements

9. Qualification criteria and specific requirements must be explicitly stated in the bidding documents and applied consistently during bid evaluation.

9. Rejection of Bids

10. A bid shall not be rejected on the grounds that its bid price is not within a percentage range above or below the contract estimate.

10. ADB Policy Clauses

11. A provision shall be included in all NCB works and goods contracts financed by ADB requiring suppliers and contractors to permit ADB to inspect their accounts and records and other documents relating to the bid submission and the performance of the contract, and to have them audited by auditors appointed by ADB.

12. A provision shall be included in all bidding documents for NCB works and goods contracts financed by ADB stating that the Borrower shall reject a proposal for award if it determines that the bidder recommended for award has, directly or through an agent, engaged in corrupt, fraudulent, collusive, coercive or obstructive practices in competing for the contract in question.

13. A provision shall be included in all bidding documents for NCB works and goods contracts financed by ADB stating that ADB will declare a firm or individual ineligible, either indefinitely or for a stated period, to be awarded a contract financed by ADB, if it at any time determines that the firm or individual has, directly or through an agent, engaged in corrupt, fraudulent, collusive, coercive or obstructive practices or any integrity violation in competing for, or in executing, ADB-financed contract.

Table 25: Summary of Indicative Procurement Items

Item No.	Description	Quantity	Unit Cost ($)	Estimated Cost ($)	Mode of Procurement
1	Vehicle			**560,000**	NCB
				(total cost)	
	For PMU and PIU				
	(a) Jeep (Replacement)	4	92,000	368,000	
	(b) Sedan car (for PMU)	1	37,000	37,000	

Item No.	Description	Quantity	Unit Cost ($)	Estimated Cost ($)	Mode of Procurement
	(c) Micro bus	3	50,000	150,000	
	(d) Motor Cycle	2	2,500	5,000	
2	IT Equipment for HMIS			**1,659,913**	NCB
				(total cost)	
	(a) PC	1,113	700	779,100	
	(b) Laptop	187	700	130,900	
	(c) Desktop Printer	673	375	252,375	
	(e) Router	527	100	52,700	
	(f) Tablet	792	150	118,800	
	(g) Internet connectivity charge	1,219	38	45,713	
	(h) Internet modem	1,952	25	48,800	
	(i) UPS	1,446	75	108,450	
	(j) Barcode Scanner	45	35	1,575	
	(k) Barcode printer	45	300	13,500	
	(l) Scanner	264	125	33,000	
	(m) Server at PMU	1	75,000	75,000	
3	Medical Equipment			**1,562,037**	NCB
				(total cost)	
	(a) Ultra Sonogram	23	20,000	460,000	
	(b) ECG Machine-3 channel	21	2,500	52,500	
	(c) Phototherapy machine	23	1,500	34,500	
	(d) Hospital bed	551	312	171,912	
	(e) Generator	31	7,500	232,500	
	(f) Air conditioner	65	3,000	195,000	
	(g) OT light	35	3,750	131,250	
	(h) Blood pressure machine	250	125	31,250	
	(i) Chemical Analyzer	45	5,625	253,125	
4	Equipment climate resilient			**835,000**	NCB
				(total cost)	
	(a) Solar power equipment			600,000	
	(b) Other equipment			235,000	
5	Office Equipment for PMU and PIUs			**452,500**	NCB/ shopping
				(total cost)	
	(a) Computer	60	700	42,000	
	(b) Laptop for PMU	5	700	3,500	
	(c) Printer (PMU-12)	60	375	22,500	
	(d) UPS (PMU-12)	60	75	4,500	
	(e) Air conditioner (PMU need based)	5	3,000	15,000	
	(f) Photocopier (10-new PIUs, 10 need-based for PMU and old PIUs)	20	2,500	50,000	
	(g) Office furniture (New PIU-10 sets)	10	5,000	50,000	
	(h) Office refurbishment for PMU & old PIUs	15	7,500	112,500	
	(i) Upgrading of accounting software	1	60,000	60,000	
	(j) Phone (for new PIUs)	10	200	2,000	
	(k) PA system for PMU	1	6,000	6,000	
	(l) Others	Lumpsum		84,500	
6	Civil Works			**23,510,000**	NCB
				(total cost)	
	(a) New CRHCCs	8	1,166,000	9,328,000	
	(b) New PHCCs	24	424,000	10,176,000	
	(c) Upgrading of CRHCC	8	158,000	1,264,000	
	(d) Upgrading of PHCC	15	96,000	1,440,000	

Item No.	Description	Quantity	Unit Cost ($)	Estimated Cost ($)	Mode of Procurement
	(e) Maintenance of existing facilities			1,210,000	
	(f) Civil works climate resilient			85,000	
7	PP Partners for Service Delivery			**80,440,000**	ICB
				(total cost)	
	(a) Partnership agreement for existing PA City Corp	21	1,880,000	39,480,000	
	(b) Partnership agreement for existing PA Municipalities	4	1,560,000	6,240,000	
	(c) Partnership agreement for new PA City Corp.	11	1,880,000	20,680,000	
	(d) Partnership agreement for new PA Municipalities	9	1,560,000	14,040,000	
8	Consulting services			**10,787,000**	
	(a) Individual consultants			(total cost)	
	i. National consultant	162	5,000	810,000	ICS
	ii. National consultant- Pool	30	5,000	150,000	ICS
	iiI. National consultant- climate change	60	6,283	377,000	ICS
	ii. International consultant- Pool	20	22,000	440,000	ICS
	(b) Firms				
	i. International firms		8 firms	8,520,000	QCBS, CQS
	ii. National firms		4 firms	920,000	CQS
	TOTAL			**120,236,450**	

CRHCC = comprehensive reproductive health care center, FMIS = financial management information system, HMIS = health management information system, ICB = international competitive bidding, IT = information technology, LAN = local area network, NCB = national competitive bidding, PC = personal computer, PHC = primary health care, PHCC = primary health care center, PIU = project implementation unit, PMU = project management unit, PPP = public private partnership, UPS = uninterrupted power supply.
Source: Asian Development Bank.

53. Bidding packages procured 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. All consulting services will be engaged in accordance with ADB's *Guidelines on the Use of Consultants* (2013, as amended from time to time). The major procurement items, estimated costs, and mode of procurement are shown in the table below.

54. **Civil works.** The Central Procurement Technical Unit, Implementation Monitoring and Evaluation Division of the Ministry of Planning has developed three standard tender documents (STDs) based on size and complexity of civil works to be procured. Among them, PW3 STD may be used for the ADB-financed Urban Primary Health Care Services Delivery Project. Because PW3 STD is based upon internationally acceptable model formats, which have been adopted to suit the needs of procurement within Bangladesh. The first draft of the procurement documents for specific packages shall be submitted for ADB review and approval, regardless of the estimated contract amount. The ADB-approved procurement documents will then be used as a model for all procurements financed by ADB for the project and need not be subjected to further review unless substantial changes bring to the approved bidding documents or specified in the procurement plan. The civil works program is detailed in **Annex 3.**

55. Civil works under the proposed additional financing will be carried out through the LGED. Concerned PIUs and PMU will provide necessary support and coordination with LGED including payment of bills. The LGED will be responsible for design, construction, repair, and maintenance

of health centers to be constructed under the project,[18] including managing the tendering and bidding process and ensuring that the civil works are finished on schedule and that the quality of construction is high. Accountability of LGED will be ensured through signing of an MOU between the project and LGED, with result-based payment and delivery. The MOU is to be signed before the start of project activities.

56. Specifically, the LGED will have the following responsibilities: (i) inspect proposed health center sites, survey, and assess the scope of land preparation or demolition work; (ii) finalize design development, documentation, specifications, and schedules of rates; (iii) prepare packages for construction based on the proposals contained in the project documentation, and gain approvals, where required, for any changes; (iv) coordinate with PMU and manage the tendering process, including the preparation of documents, evaluation of tender documents, and engagement of contractors; (v) prepare and update detailed implementation schedules; (vi) ensure timely implementation of the construction through careful supervision of the contractors; (vii) monitor and supervise all civil works to ensure quality of materials, quality of work, and timeliness; (viii) ensure that all project activities related to building construction and maintenance are effectively implemented; and (ix) implement guidelines developed under the project for proper building maintenance.

57. **Procurement of pharmaceuticals.** The procurement of medicines for 45 partnership areas over 5 years (multiple contracts totaling around $5 million) will be done through prequalification process by PMU and shopping/ request for quotation method by the partner service providers, consistent with project procurement guidelines and principles for good pharmaceutical management. PMU will first prequalify interested suppliers considering adherence to good manufacturing practices, licensing validity, past supply performance, financial viability, and related factors. From among the prequalified suppliers, the partner service providers will then use shopping/request for quotation method to contract suppliers according to locally appropriate service arrangements. The contract between partner service providers and suppliers may indicate terms for ‘perpetual purchasing,’ where purchase reorders are placed with the contracted supplier according to partner service providers’ stock and consumption needs. The prequalification process by PMU will be repeated at least every 2 years to ensure continued quality and adequate competition. Project guidelines on procurement of medicines will be developed to ensure uniform and transparent procedures across the partnership areas. A review of the procurement system and procedures, including compliance to ADB’s procurement principles of economy and efficiency, will be conducted at midterm and revisions will be made as needed.

58. A measurement of partner service providers’ performance is maintaining an adequate drug supply system, for which the partner service providers require direct control of related procurement and supply management processes. The principle of efficiency will be ensured by decentralizing procurement of medicines to partner service providers who are much better placed than a centrally procured system to ensure a consistently effective drug supply system to run their facilities. It also avoids the additional hidden costs of inventory management and stock losses (from expiration, etc.) of centralized bulk purchase orders. The PMU also does not have the capacity of a central management store to manage frequent transactions with suppliers, receive orders, and deliver to different health facilities. The principle of economy will be ensured through regular random checking of procured drug prices across partner service providers and benchmarking the prices against drugs procured by similar facilities and hospitals. In addition, the project also has semiannual independent integrated surveys to monitor all aspects of service

[18] Detailed designs of health centers have been updated by consultants under ADB’s project preparatory assistance.

delivery and management, including drugs supply and management. Quality and safety of drugs procured by partner service providers will be ensured through prequalification and requirement for all suppliers to have license and valid certification of international standard (i.e., Good Manufacturing Practices certification in line with World Health Organization [WHO] standard requirements). As Bangladesh is an exporting country in pharmaceuticals and manufacturers are at the level of international standard, there will be no shortage in the pool of qualified suppliers and adequate competition.

59. **Partnership agreements.** The project will invite sealed bids from NGOs, CSOs, private entities, provider associations, etc. to deliver a defined package of PHC services to specific urban partnership areas. A one-stage, two-envelope bidding procedure will be adopted. The evaluation of technically responsive bids will consider technical and price factors using an 80:20 quality to cost ratio. Further details on the implementation plan for partnership agreements are provided in **Annex 4**.

60. **Consulting services.** The LGD will recruit and administer consultants and consulting firms as per ADB's *Guidelines on the Use of Consultants* (2013, as amended from time to time) and other arrangements satisfactory to ADB for recruitment and administration of individual national consultants, which may include the Government's *Public Procurement Regulations* (2008) as acceptable to ADB. Consulting firms will be hired using quality- and cost-based selection, consultants' qualifications selection, and individual consultants selection procedures.

D. Consultant's Terms of Reference

61. National and international consulting firms or research institutions will be engaged by the project to provide support to PMU, PIUs, and partner service providers in specific areas, namely: (i) ULB strengthening; (ii) behavior change communication strategy development and implementation and technical support to partner service providers; (iii) conduct of various surveys; (iv) design of the health management information system (HMIS) and information and communication technology solutions; and (v) conduct of operations research. The expected outputs and terms of reference for these consulting services packages are summarized in the table below.

Table 26.1: Project Performance Monitoring and Evaluation Firm

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
Firm (International)		The firm should have at least 10 years' experience with similar work assignments. Firms with previous experience in the urban health sector will be given preference.	1. End line/baseline and slum survey reports; 2. Semi-annual performance monitoring survey reports; 3. Annual performance linked incentive scheme reports; 4. Training outcome evaluation report; 5. Annual poverty update and red	1. Project evaluation: end line/baseline and slum surveys; 2. Independent performance assessment – semi-annual Integrated Supervisory Instrument (ISI) surveys, and linking ISI survey with PPP service providers performance incentive scheme; 3. Training outcome evaluation; 4. GIS development inputs, database and mapping; 5. Annual update and verification of red card system; 6. Support in data analysis and use including providing technical inputs to HMIS firm and improving data analysis of quarterly progress report.

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
			card verification report; 6. Revised quarterly progress report format to include monitoring of indicators related to quality of services and performance targets.	
Key personnel				
Project Performance Monitoring & Evaluation Specialist (Team Leader)		• Master's degree in Statistics, Demography, or Social sciences with strong research background in health, population, gender and poverty. Higher educational background will be of advantages. • At least 5 years working experience with demonstrable success in designing qualitative and quantitative studies in monitoring and evaluation of health project. • Experience in designing and implementing household survey, health facility survey, and monitoring will be given preference. • Well conversant in computer packages and programs. • Experienced in data management, processing, analysis and report writing. • Able to manage, organize and facilitate training of		The Team Leader will remain responsible for overall monitoring and evaluation of project performance. The specific tasks are: 1. Determine approach to quantify/compile numerators and denominators of indicators to improve data analysis related to quality of services and performance monitoring; 2. Design survey methodology and sampling techniques for household, health facility and periodic monitoring surveys; 3. Design instruments for all PPME surveys as required, following protocols developed by PMU and ADB where appropriate; 4. Coordinate all tasks as outlined in TOR, including scheduling, managing resources, and recruiting field staff; 5. Provide training to field staff; monitoring and supervision of field work; 6. Designing data entry package; 7. Data management and analysis; 8. Linkage with different government, NGO and donor agencies; 9. Prepare survey reports; 10. Disseminate survey findings; 11. Provide feedback about progress and outcome, strength and weakness of the service providers to the stakeholders and assist PAs and other firms in taking necessary decision.

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
		survey team for data collection • Able to develop and maintain an extensive network of professional contacts with a wide cross-section of Government, donor/NGO community and other stakeholders. • Fluent in English with excellent writing and communication skills. • Proven ability to work under pressure with effective leadership quality. • Previous work experience with computer-based geographic information systems will be given preference.		
Public Health Management Specialist		• Physician with MPH or equivalent master's degree; • At least 10 years' experience in monitoring and evaluation of health project or research background in health, population, nutrition and poverty. • Experience in designing and implementing health related survey instruments. Experience of household survey, health facility survey and monitoring will be given preference • Able to manage, organize and facilitate training to the survey team		The Public Health Management Specialist will assist Team Leader (TL) in implementing project performance monitoring and evaluation activities. The specific tasks are: 1. Assist Team Leader in the coordination and management of the project, including designing survey methodology, developing survey instruments, training and field activities in relevant areas; 2. Liaise, collaborate and consult with all project partners and beneficiaries, arrange and attend meetings, producing reports/minutes of meetings as necessary; 3. Plan and administer health facility survey and monitoring survey; 4. Data management and report writing of health facility survey and periodic monitoring survey; 5. Maintain administrative and financial records and participate in general office administration; 6. Training to the field staffs, monitoring and supervision of field work;

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
		for data collection on health issues. • Must be well conversant in computer packages and programs. • Fluent in English with excellent writing and communication skills. • Experienced in report writing. • Able to develop and maintain an extensive network of professional contacts with a wide cross-section of Government, donor/NGO and other stakeholders. • Previous work with computer-based geographic information systems will be preferred.		7. Assist TL in designing data entry package, data management and analysis, and report writing; 8. Staff management and linkage with different government, NGO and donor agencies; 9. Disseminate survey findings and provide feedback to the stakeholders for decision making.
Sociologist		• Masters or higher-level qualification, preferably Ph.D. in Sociology or any other development-oriented discipline; • At least 10 years of research background in health, population, social, gender and poverty; experience with health programs in Bangladesh strongly preferred; • Must have strong conceptual and analytical skills in participatory planning; • Experienced in qualitative research methods including in-depth interview, case study and focus group discussion;		The sociologist will assist team leader (TL) in conducting gender, poverty and equity analyses and based on these analyses recommend mechanisms and strategies to address the health needs of women, children and the poor. The specific tasks are: 1. Assess community awareness of health care providers and knowledge of available services; 2. Identify the health care seeking behavior of the urban poor; 3. Identify criteria used by the urban poor in selecting healthcare providers and assessing quality; 4. Understand information networks and sources of information about health care issues and service providers among the urban poor; 5. Assess the responsiveness of the UPHCSDP and the partners in particular; 6. Identify and assess health service user's role in health care management by the partners; and 7. Assess gender-based equity situation in healthcare service management and responsiveness.

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
		• Experienced in gender networking and advocacy; • Able to manage, organize and facilitate training to the survey team for data collection; • Fluent in English with excellent writing and communication skills; and • Able to develop and maintain an extensive network of professional contacts with a wide cross-section of Government, donor/NGO community, and other stakeholders.		

Source: Asian Development Bank.

Table 26.2: Behavior Change, Communication, and Marketing Firm

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
Firm (International)		Firm should have at least 10 years' experience in undertaking behavior change communication and marketing program must have worked for at least two similar assignments in Bangladesh or a country with similar socioeconomic status. The international firm may associate with local firm(s).	1. BCCM needs assessment report; 2. Proposed revision to BCCM materials; 3. Inception workshop report and campaign brief; 4. BCCM campaign implementation plan including BCC capacity building plan and adoption of popular/feasible media for the target groups; 5. BCCM content development with a strong focus for use of feasible social media.	1. Conduct formative BCC assessments by seeking out all available studies, including data from in-depth assessments or rapid ethnographic assessments, behavioral surveillance surveys, and other related studies; 2. Synthesize the information collected and develop a formative BCC assessment protocol; 3. Segment the target populations based on formative BCC assessment, defining behavior change objectives including knowledge change, attitude change, and environmental change; 4. Develop messages and media materials for dissemination and the right mix of approaches to involve target populations and to promote and enable action; 5. Develop themes and messages that will appeal to and attract target populations; the theme should stem from the BCC formative assessment and further consultation; 6. Select channels that can most effectively reach target populations; 7. Provide technical support to service providers in developing and implementing BCC programs for various target groups concerned; 8. Develop a monitoring and evaluation plan for implementation phase; 9. Develop communication products including print materials for peer

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
				educators, such as flipcharts and picture codes, print materials to support health workers on specific care issues, television spots for general broadcast, promotional materials about the project for advocacy, scripts for theater and street theater; and radio or television soap opera scripts; 10. Conduct pretesting to ensure that themes, messages, and activities reach the intended target populations and implement and monitor by ensuring links among critical program elements, such as supply and demand; and 11. Evaluate project implementation and its success in achieving predetermined objectives of behavior change
Key personnel				
1. BCC specialist/ Team Leader (International)	54	At least a Master's degree in social sciences with 10 years of working experience for similar assignment in public health sector. Must have worked in Bangladesh or in a developing country social economic status of Bangladesh. Must have proven experience leading a team of multidisciplinary experts.		1. Identification of required behavior change objectives including knowledge change; attitude change; and environmental change and methodology to be followed for keeping communication between service providers and recipients by segment of population; Development of messages and media materials for dissemination and the rights mix of approaches to involve target populations and to promote and enable action. Develop themes and messages that will appeal to and attract target populations. The theme should stem from the BCC formative assessment and further consultation; 2. Selection of appropriate channels that can most effectively reach target populations; and 3. Development of monitoring and evaluation plans to focus on the process of implementation. The following should be closely monitored: reach, coordination, scope, quality, and feedback; 4. Development of communication materials in Bangla (in English if required by the project authority) including interpersonal communication materials for outreach workers; print materials to support health workers on specific care issues; television spots for general broadcast; promotional materials about the project, for advocacy; scripts for theater and street theater; and radio or television soap opera scripts; 5. Ensuring that themes, messages and activities reach the intended target populations; 6. Implementing and monitoring by ensuring links among critical program elements, such as supply and demand,

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
				7. Evaluating project implementation and its success in achieving predetermined objectives of behavior change; and 8. As programs evolve, target populations acquire new knowledge and behaviors, and communication needs may change. The needs of target populations will be periodically reassessed to understand where they stand along the behavior change; 9. Training of PMU, PIU and PA staffs on communication. 10. Assisting partners to coordinate activities with other entities providing urban PHC services
2. Marketing Specialist (MS) (International)	30	• Tertiary educational qualification in Marketing or Business Administration or Social Science or another suitable field. • At least 7 years' experience of working in public health or relevant project in marketing health and social awareness related activities and 3 years' experience in marketing of desired messages to the target group (provider and recipient). • Experience working in a team setting, and have excellent interpersonal and effective communication skills (both oral and written). • English language fluency is required. • Managing/ organizing/ conducting previously successful and popular communication interventions in health, population, nutrition care will be preferred.		The marketing specialist will assist the project management unit (PMU) with the suggestions of marketing the services provided by the project and suggested behavior change to be adopted in the project as suggested by the communication specialist to all project City Corporations and municipalities, partner service providers, and target population. This would entail the following specific responsibilities: 1. Branding of project services, sites and networks as "Rainbow Clinics"; 2. innovative marketing to maximize use of the project, targeting providers and potential clients and parties; 3. Involvement of partner NGOs in marketing the services 4. Select appropriate and effective mechanism in marketing the desired service; 5. Development of monitoring and evaluation plans to focus on the process of marketing, 6. Select and make arrangement to communicate with appropriate media for marketing the developed material by keeping close coordination with the Communication Specialist; 7. Ensure that the services are marketed to the target population, supervising field staff to implement community events; 8. Evaluate the marketing status and its success in achieving predetermined objectives; 9. The needs of target population will be periodically reassessed 10. Training of PMU, PIU and PA staffs on communication. 11. Assisting partners to coordinate activities with other entities providing urban PHC services.
3. Communication Specialist	54	• Tertiary education qualifications in social science and 10 years' experience in working on behavior change		Working under the Team Leader and in close collaboration with the other Specialists, the Communication Specialist will ensure that the overarching communications objectives are articulated into clear, appropriate messages for target audiences with a focus on developing detailed, practical

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
		communications projects. • Experience in conducting formative research, developing and pretesting messages and materials targeted at underserved populations and implementing communication activities. • Has excellent interpersonal communications skills and have experience in working with teams will prefer. • English and Bengali language fluency required. • Experience in working with population, nutrition and primary health care preferred.		guidelines for the interpersonal communications. Specific responsibilities include: 1. collaborating with the Marketing Specialist to develop modules and materials in Bengali (and English if required by the Client) for inclusion in the "Rainbow Clinic BCC Toolkit"; 2. collaborating with the Training Specialist to ensure that the creative concepts and corresponding messages developed are clearly articulated within the training curriculum and materials for the respective trainees; 3. assisting the Team Leader in designing activities so that both communication and capacity building related activities are developed in logical, sequential manner and are implemented smoothly and on time; 4. training of PMU, PIU and PA staffs on communication, as needed; 5. conducting regular field visits to ensure that all activities are carried out with good quality and are communicating the messages as designed; and 6. assisting PPP service providers in trouble-shooting and adjusting activities as needed.
4. Capacity building specialist	54	• Tertiary qualifications in education, communication, or public health and 10 years' experience in designing and conducting training in health communications/health promotion for adults. • Excellent interpersonal communications skills and have experience in working with teams will prefer. • Fluent in Bengali and possess strong English speaking and writing skills will prefer. • Experience in working with population, nutrition and primary health care preferred		Work closely with the Team Leader and other Specialists to design tailored curriculums for each type of trainee (decision makers, Master Trainers, local service provider, etc.) to ensure that the key messages developed by the other Specialists are integrated into the curriculum for both interpersonal communications and community marketing events, among others. Specific responsibilities include: 1. reviewing BCCM training curriculum used in the project and, combined with the updated BCCM Needs Assessment, develop the BCCM Capacity Building Plan that will detail the types of training and supplementary materials needed; 2. designing the BCCM Capacity Building Plan to illustrate how post-training, supervision and support will be provided to PPP services providers' staff, 3. ensuring the quality of training through leading key training courses and providing support and supervision of other trainers; 4. conducting regular field visits to ensure that all activities are carried out with good quality and trainees are communicating the messages as designed; and 5. assisting PPP service providers in trouble-shooting and adjusting training activities as needed.

Source: Asian Development Bank.

Table 26.3: Operations Research Firms

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
Firm (National)		A reported research institution and/or qualified national firm will be engaged to conduct/manage the operation research under the project. The institution/firm must have proven experience for conducting/managing research activity related to delivery of health care services in rural and urban areas of Bangladesh.	Operations research reports	Conduct action-oriented operations research on the following indicative topics: (i) urban PHC surveillance; (ii) Nutrition mainstreaming initiative: assessment on user and provider perspectives, and (iii) Promoting need-based cesarean section and normal delivery.

Source: Asian Development Bank.

Table 26.4: Technical Assistance (TA) for strengthening Urban Local Body and Promoting Climate Change Resilience Firm

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
Firm (International)		Firm shall have at least 10 years' experience in consulting services in primary health care services and climate change. The firm shall have experienced for at least two similar assignments in Bangladesh or a country with similar socioeconomic status. The international firm will associate with national individual consultants or firm in providing the services.	Component 1: Strengthen capacity of selected ULBs related to urban PHC services delivery. Component 2: Mitigate climate change risks and promote climate change resilience.	**TA Component 1: Strengthen capacity of selected ULBs related to urban PHC services delivery** 1. Analyze available legislation that impacts on the roles and functions of the Health Department in selected City Corporations; refine organizational structure of health departments and develop framework for strategic health plan to fulfil the city corporations' responsibilities in urban primary health care (UPHC) services delivery. 2. Advocate for reform to restructure the health departments and their work processes to ensure buy-in of higher authorities such as the Mayor and/or the Ministry of Local Government. 3. Implement urban PHC action plan developed and assist in strengthening coordination mechanism for PHC services between relevant ministries and LGD as well as the city corporations/municipalities. 4. Ensure these priorities are addressed in restructuring of health departments: (i) management of PPP contracting for PHC services; (ii) management of Urban Health Management Information System (UHMIS); (iii) ensuring Quality Assurance (QA) mechanism to support city corporations' and municipalities' prime responsibility for primary health care

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
				(PHC) services. 5. Support organizational structure in collection and analysis of basic information on services delivery to enable evidence-based decision making relating to improving basic health governance. 6. Conduct labor market analysis of medical officers and frontline health workers in urban areas. 7. Update costing of essential service package in urban areas to include nutrition and NCDs. 8. Establish guideline/protocol for referral linkages to secondary/tertiary hospitals. 9. Update standard treatment protocols for urban areas. 10. Develop quality assurance monitoring mechanism for ULBs. 11. Identify and implement training programs deemed suitable for enhancing individual management capacity of health department staff members. **TA Component 2: Mitigate climate change risks and promote climate change resilience** 1. Conduct rapid urban climate change assessment (RUCCA) to improve decision making in site selection of new centers to be constructed including in Faridpur and others as determined by ADB. 2. Prepare and update relevant data and information of Bangladesh Risk Atlas, Risk and Vulnerability Atlas, as well as climate and sea level scenarios for these new PAs. 3. Identify and implement climate change impact and risk mitigation measures related to locations, buildings and health care delivery including disaster preparedness. 4. Organize and manage training activities supported by Urban Climate Change Resilience Trust Fund (UCCRTF). 5. Coordinate with LGED on improving UPHC infrastructure resilience measures, e.g., water harvesting, flood protection, water and electricity conservation, solar energy system.
Key Personnel				
1. Urban PHC management specialist, Team Leader	18	At least a master's degree in health management or relevant field with 10 years of working		1. Ensure delivery of the scope of services of the firm. 2. Assist in Inter-Ministerial Coordination based on the National Urban Health Strategy Action Plan and advise how to improve the coordination mechanisms for PHC services between relevant ministries

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
		experience for similar assignment in public health sector. A medical degree and work experience to advice on essential service package and human resources for health will be given preference. Must have worked in Bangladesh or in a developing country social economic status of Bangladesh. Should have proven experience for leading a team of multi-disciplinary experts		and the Local Government Division (LGD), as well as the City Corporations and Urban Local Bodies (ULBs). 3. Assist in the development of strategic health plans for the selected ULBs. 4. Develop organograms and reorganization plans of the health department of the selected ULBs in line with its intended functions. 5. Consult senior officials of ULBs and obtain their agreement on the strategic health plans, organograms, and reorganization plans. 6. Facilitate, monitor and evaluate the regular coordination mechanisms of ULBs with LGD and the ward levels. 7. The expert will contribute to the climate risk and adaptation assessments in the urban PHC sector. Core activities include: a. Conduct CRVA in selected ULBs; b. Assess and report on climate change impacts, risks and vulnerability of projected climate related to services delivery (and sea level, if applicable) change with specific domain/sector, including analysis on the robustness and associated caveats of the assessment findings; **c.** Assist in identifying possible (structural and non-structural) interventions as adaption options to address impacts, risks and vulnerability as identified.
2. Urban PHC management specialist, Deputy Team Leader	36	The consultant shall have at least a master's degree in relevant field with 10 years of working experience for similar assignment in public health sector. Have proven experience for leading a team of multi-disciplinary experts. Fluent in English with excellent writing and communication skills. Experienced in report writing.		1. Assist in ensuring delivery of the scope of services of the firm; 2. Conduct an assessment to determine the demarcated positions according to their roles, responsibilities and functions assigned, in particular the head of units within the health department; 3. Support the formulation of the organizational development plan of the ULB, advising on appropriate staffing; 4. Develop priority functions and job description of the ULB and define the respective organigram including staffing requirements; 5. Support the establishment and implementation of coordination mechanism at ULB; 6. Assist in the establishment of the communication structure to collate and analyze basic information on health services provision and delivery; 7. Collaborate with the HMIS/M&E consultant in internalize data analysis to provide evidence for decision making with

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
				the aim to improve PHC governance. 8. Render operational support to enable the ULB to undertake service delivery for urban primary health care.
3. Monitoring and evaluation/ health management information system expert	24	Shall have a profile in health monitoring and reporting, being familiar with health information systems. Should have at least 10 years' experience of similar assignments, with experience in data management and analysis.		1. Conduct a detailed needs assessment of existing staffing as well as systems application at ULB and ward levels; 2. Develop the organizational set up at ULB level including staffing requirements for data collection, data analysis and tools to allow the ULB to make management decision on primary care services; 3. Conduct training for ULB personnel including Project Implementing Units (PIUs) and partner service providers on data analysis and use; 4. Establish the framework for coordination within the City Cooperation, related agencies and institutions, with regards to the national health data strategy; 5. Assist the ULB in coordinating the health information data with national authorities to ensure a complete representation of urban PHC information at national level; 6. Contribute to the overall organizational structure development of ULB.
4. EPI expert	12	MPH or equivalent degree with at least 15 years of work experience in the public/private health sector, particularly in EPI. Experience in overseeing or managing quality aspects in public/private health care programs, including EPI, will be preferred.		1. Analyze the process of EPI database through monthly EPI data input and quarterly data/immunization status reporting; 2. Review "Vaccines and Vaccines/Targets Planner" for individual EPI service site; 3. Evaluate the "EPI Service Performance Monitor" of the City Corporation; 4. Monitor, supervise and evaluate the outputs of the EPI services delivered at the ward level; 5. Review Quality Assessment Protocol consisting of two selected criteria such as Safe Practice and Client Care and Treatment; 6. Contribute to the overall organizational structure development of ULB.
5. QA expert	18	Physician with MPH or equivalent degree/diploma with at least 15 years of work experience in the public/private health sector, particularly in reproductive, maternal and child health care. Experience in overseeing or managing quality		1. Support the ULB in implementing planned monitoring framework and activities; 2. Support capacity building activities such as on-the-job training during the assessments, facilitation and documentation of the reflection process; 3. Establish selective Quality Assessment Protocol consisting of two selected criteria (e.g. Safe Practice and Client Care and Treatment); 4. Develop policies and strategies for regulatory functions (quality monitoring and regulatory action); 5. Contribute to the overall organizational structure development of ULB.

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
		aspects in public/private health care programs, including clinical programs, will be preferred.		
6. Financial management expert	24	Chartered accountant or a holder of Master's degree in finance, accounting, or another related subject. Fifteen years of work experience in managing finance and accounts of large establishments involving transaction of accounts at multiple subordinate offices. Must be familiar with computerized accounting systems and procedures, and have hands-on experience in designing and managing ICT-assisted financial management systems. Development projects financed by multilateral agencies such as ADB and/or World Bank will be preferred.		1. Develop tools and instruments to estimate required funding and utilization of funds; 2. Align financial strategic plans with the overall health care development plan; 3. Develop mechanism for establishing and utilization of funds related to the sustainability fund; 4. Develop guidelines on utilization of sustainability funds; 5. Support the health department in developing an annual budget plan; 6. Contribute to the overall organizational structure development of ULB.
7. Procurement expert	12	Master's degree in public administration, business management, law or equivalent. At least 10 years' experience in the fields of procurement, preferably in the health sector. Knowledge in Government		1. Assess the procurement capacity within selected ULBs and the health department; 2. Develop a procurement plan template and framework documents for the tendering of health care services; 3. Develop a procurement action plan including the responsibilities for the procurement process considering the two options – procurement through ULBs and LGD; 4. Conduct SWOT analysis for two scenarios: tender conducted by ULBs versus tendering through LGD;

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
		procurement policy and procedures, and experience in managing bid cycles, organizing procurement packages, preparation of bidding documents and evaluation of bid proposals. Experience with ADB and/or World Bank procurement guidelines and procedures.		5. Consider community participation in the tender process of PHC services and define the role of this participation; 6. Contribute to the overall organizational structure development of ULB; 7. Assist in procurement activities related to climate change mitigation measures.
8. Health economist	24	An advanced relevant degree in economics, health economics, or applied economics with a focus on health; At least 10 years' work experience in health sector and health financing at central and local levels; Experience in applied research on economics of climate change impacts and adaptation, or related fields will be given preference; Demonstrable skills to communicate and work with professionals from other disciplines and cultures; and Familiarity with ADB operations and project development processes desirable.		1. Contribute to the economic analysis of potential climate impacts and risks to the investment project, and of alternative adaptation inventions deemed technically possible; 2. Carry out equity analyses through the application of the Health Equity Analysis Tool + and others in consultation with other development partners; 3. Update costing of essential service package in urban settings.
9. Urban PHC climate resilience	24	An advanced university degree, preferably at		The main responsibility is to lead and coordinate all efforts of the climate change team under Component 2 in implementing the

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
coordinator		master's level, in environmental management/engineering or other related fields; At least 15 years of experience in environmental management including at least 5 years in the management of foreign assisted projects, project experience in climate change is an asset; Demonstrable skills to effectively communicating and working with professionals from other disciplines and cultures; and Familiarity with ADB operations and project development processes desirable.		UCCRTF grant activities, training, workshop, and civil works. Under the supervision of the Project Director, UPHCSDP and in consultation with ADB, the coordinator will: 1. prepare detailed general workplan on the implementation of the CRVA, capacity building, equipment, furniture, and civil works proposed under the project; 2. coordinate between the UPHCSDP Project Management Unit (PMU), the selected ULBs, and climate change team in latter's conduct of CRVAs; 3. consult with identified centers of excellence in the conduct of training and workshops, prepare detailed workplans, schedule, budget, training schedule, and seek approvals from the Project Director, UPHCSDP and ADB; identification of participants, resource persons, and venue; manage the actual conduct of all trainings and workshops including but not limited to documentation and post evaluation; 4. coordinate the foreign training and study tour with WHO Kobe Centre and Bangladesh, and ADB; 5. coordinate with the LGED Civil and Electrical Engineers on the needed assessments, equipment, civil works, procurement, and installation; and 6. prepare monthly progress reports, identify gaps and weaknesses in the implementation, and provide management actions to ensure the successful implementation.
10. Climate scientist	8	An advanced university degree, preferably at doctorate level, in climate science; At least 10 years of experience in climate modeling and research; climate change impacts and vulnerability assessments, risk management, adaptation planning and practices; A strong track record of effectively managing large scale and complex research projects;		As Climate Scientist within the climate change team, he or she will be responsible for the development and application of climate (and sea level, if applicable) data and information. Core activities include: 1. Develop an inventory of climate and sea level data required for the CRVA study, based on the agreed CRVA methodological framework and in close consultation with the domain/sector experts; 2. Collate baseline climate (and sea level, if applicable) data; 3. Develop detailed scenarios of climate change variables as required for future time horizons pertinent to the investment project, including documentation of scenario method, data sources, uncertainties and caveats; 4. Provide detailed guidance on how the climate (and sea level, if applicable) data and information should be applied in the CRVA study within the context of the specific ADB investment project; and

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
		Demonstrable skills in effectively communicating and interacting with professionals from different cultural backgrounds and disciplinary fields; Demonstrable knowledge of, and preferably, existing collaboration with regional centers of excellence for climate modeling and research in Asia and the Pacific; Experience of working with research and policy users of climate data and information.		5. Brief other members of the climate change team on the key features of the climate (and sea level, if applicable) scenarios, uncertainties, caveats and implications of their application in the CRVA studies for the outcome of the assessments. Other responsibilities include: 6. Lead the consultations to develop a methodological framework for CRVA studies pertinent to the context and objective for climate risk assessment and management of the investment project; 7. Develop a sound work plan, in consultation with ADB project team; 8. Prepare final CRVA report, through an iterative process of obtaining and addressing review comments on draft reports from ADB project team; and 9. Perform other tasks as deemed necessary to ensure the successful execution of the assignment as specified in the TORs.
11. Environmental engineers/ planners	6	An advanced university degree in environmental engineering or management, or other related fields; At least 10 years of experience, five years of which should be in Asia and the Pacific, in fields that are pertinent to the design and maintenance of infrastructure in ADB's sectors that represent ADB's core investment in its developing member countries; Evidence of work relating to integrating climate change impacts into infrastructure design and maintenance in Asia and the Pacific; and		1. Contribute to the development of the overall CRVA study methodological framework, considering the sensitivity of relevant engineering aspects of the investment project to major climatic parameters; 2. Based on the risk and vulnerability assessments from domain/sector expert, analyze the potential risks and vulnerability of the structural components of the investment projects, and their implications for project design; 3. Considering the adaptation options identified by sector experts and results from (ii) above, refine the adaptation options considering the engineering feasibility. 4. Coordinate with the individual consultants and LGED the implementation of infrastructure mitigation measures.

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
		Demonstrable skills to communicate and work with professionals from other disciplines and cultures.		

Source: Asian Development Bank.

Table 26.5: Information and Communication Technology/ Health Management Information System Firm

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
Firm (International)		The firm shall have at least 10 years' experience in consulting services application of HMIS to improve primary healthcare service delivery services and at least 5 years in implementation of OpenMRS and DHIS2 systems. The firm shall have experience for at least two similar assignments in Bangladesh or a country with similar socioeconomic status. The international firm will associate with national individual consultants or firm in providing the services.	Project Output 1: Situation and Requirement Assessment on facility, PMU and ULB level to ensure that conceptional and organizational plan as well as the hardware allocation complies with the overall ICT implementation goals. Project Output 2: Implementation of an OpenMRS based facility management system as a basis for HMIS data collection and to support facilities in terms of patient registration and management. Project Output 3: Implement a DHIS2 platform on PIU and ULB level with an interface to the facility management system to allow automatic data collection and consolidation for healthcare parameter monitoring and	**Component 1: Situation and Requirement Assessment** 1. Analyze previously prepared planning components in terms of pilot area selection, capabilities and needs on facility level. Outline gaps and align hardware and service provision with project outputs. 2. Evaluate PIU and ULB capabilities, capacities and terms of hardware allocation and projected support and training requirements 3. Prepare an implementation plan for OpenMRS systems on facility level based on the currently implemented manual Unified Record Keeping System (URKS) 4. Communicate and collaborate with current Bangladesh HMIS initiatives, especially the national healthcare information strategy as outlined by the Directorate of Health Services in Bangladesh. Identify and outline interfacing strategies with HMIS initiatives on national level. **Component 2: Implementation of an OpenMRS based facility management system based on current URKS** 1. Based on the requirement study, prepare and design an OpenMRS based system electronically mirroring the current URKS system. 2. Support the PMU to establish the server-side preparation of the facility management system. 3. Closely cooperate and collaborate with facility, PMU and PIU stakeholders to mature the OpenMRS concept into an applicable facility management system. 4. In cooperation with PMU and facilities, establish a roll-out plan to implement the facility management system in the pilot area facilities. 5. Manage go live and post go-live monitoring and support of for pilot area facilities during system implementation.

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
			healthcare policy support. Project Output 4: Capacity building on facility, PIU, PMU and ULB level to allow autonomous long-term support of the implemented ICT components Project Output 5: Capacity building on PMU and ULB level in terms of DHIS2 and HMIS application to provide long-term sustainable capabilities to apply HMIS strategies to monitor, evaluate and improve healthcare service delivery.	**Component 3: Implement a DHIS2 platform on PIU and ULB level with an interface to the facility management system** 1. In close cooperation with PMU, PIU and ULB design a healthcare indicator framework to support primary healthcare delivery services: a. Support ULB and LDG to identify relevant healthcare indicators and underlying policy strategies b. Closely cooperate with national health care management system stakeholders to streamline and synchronize UPHCSDP HMIS goals with overall national strategies c. Design a healthcare indicator framework based on outcomes of component 1 and the evaluation of needs on policy and monitoring requirements of the primary healthcare stakeholders 2. Based on (i) design a DHIS2 warehouse and dashboard to collect and collate relevant health care indicators. 3. Design and implement an interface between the facility based OpenMRS solution and the DHIS2 platform. 4. In cooperation with PIU, PMU and ULB design reporting and monitoring tools to allow access and to facilitate visualization of healthcare indicators. 5. In coordination with ULBs and other potential policy maker, develop a web-based dashboard to present, monitor and visualize relevant healthcare indicators. 6. Develop a GIS platform to visualize geocoded healthcare data, including use of choropleth maps or comparable geo-based visualization tools. 7. Support the PMU to establish the server-side implementation of the DHIS2 platform. **Component 4: Capacity building on facility, PIU, PMU and ULB level to allow autonomous long-term support of the implemented ICT components** **Component 4.1: Support and support capacities for facilities, PIU, and PMU** 1. Design and implement a support structure on facility level to provide support for general, software and hardware related issues. The ICT firm is expected to provide a support structure and framework for all facilities in the pilot area. The support structure for general ICT issue may be provided by the local partner and includes:

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
				a. General hardware, network or software support b. Establishment of a central helpline/support line for facilities to contact c. A preventive maintenance and support strategies for facilities in the pilot areas. 2. Cooperatively plan and execute support measures with PMU and PIUs 3. The ICT firm is expected to design and outline a hand-over strategy to allow ULBs to take over and maintain the required support level post ICT firm commitment. 4. The support commitment of the ICT firm is expected to initially cover the implementation of the pilot areas (Year 1) and expand along the roll-out of remaining project areas during Year 2 and Year 3 **Component 4.2: Training for facilities, PIU, and PMU** 1. The ICT firm is responsible for training plans and training execution in the following areas: a. Basic ICT training for pilot are facility staff b. Software training for the OpenMRS facility management tool on facility level c. Train-the-Trainer for (a) and (b) for PIU, PMU and ULBs 2. It is expected that the ICT firm in cooperation with its local partner will train the pilot area facility in basic ICT capabilities and thoroughly in the use and application of the OpenMRS facility management tool. 3. It is also expected that ICT firm will prepare PMU, PIU and ULBs to seamlessly assume training responsibility for any project areas outside the pilot are post ICT firm commitment. 4. The ICT firm will remain responsible for training planning, management, evaluation and assessment for the post-pilot areas in accordance with the support commitment (Year 2 and Year 3) 5. Develop and provide relevant training materials and user guides to the facilities, PMU, PIUs/ULBs. **Component 5: Capacity building on PMU and ULB level in terms of DHIS2 and HMIS application** **Component 5.1: Support and support capacities for PIU, PMU and ULB**

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
				1. The ICT Firm is expected to provide HMIS and healthcare management related support to the PIUs, the PMU and the ULBs 2. The support shall cover all DHIS2 related issues including technical as well as application issues. 3. In detail, the ICT Firm will support the HMIS stakeholders to efficiently use the DHIS2 based HMIS software including but not limited to: Application usage, report generation, technical support, etc. 4. DHIS2 support will be the sole responsibility of the ICT Firm during Year 1. In subsequent years the ICT firm will be responsible to coordinate and assure quality of support but will provide the PMU, PIU and ULBs with secondary support to establish a support framework within those authorities. Ultimately the ICT firm will implement a support plan that can be autonomously executed by the project stakeholders, in particular the PIU and ULB. **Component 5.2: HMIS Training for PIU, PMU and ULB** The ICT Firm will be responsible to provide training to the PIUs, PMU and ULBs to use and maintain the DHIS2 based HMIS tool. The firm will also be responsible to provide training for especially the PIUs and the ULBs in using, interpreting and applying the data consolidated through HMIS into healthcare service provision strategy and interpretation. 1. Provide training in DHIS2 in general and the project customized DHIS2 platform for the project. 2. Provide in-depth training in HMIS data collection and interpretation. 3. Training to allow PIUs and ULBs to change, adapt and customize the project DHIS2 platform for project needs 4. Train the PMU to establish DHIS2 interfaces with the national healthcare information strategy stakeholders
Key Personnel				
1. Project manager		At least a degree in either ICT or public health with at least 10 years' experience in combination of both fields. Must have worked in		1. Overall project management, resource management and general responsibility for schedules and deliverables. 2. Will represent the PMU and other project stakeholders as HMIS expert as strategy consultant in project and national HMIS strategy dialogue.

Type of Consultant	Person-Months	Qualification and Experiences	Expected Output	Terms of Reference
		Bangladesh or in similar developing country. Must have proven experience as project/implement ation manager.		3. Consult senior officials of all project stakeholder on HMIS matters. 4. Facilitate, monitor and evaluate the regular coordination mechanisms between facilities. PIU, PMU, ULB and LGD. 5. Will apply industry standard ICT project management measures, guidelines and risk prevention measures.
2. DHIS2 health information system implementatio n expert		At least 10 years of working experience with DHIS2 implementation in comparable health system environments.		1. Conduct an assessment to determine the DHIS2 requirements in project context; 2. Support PIUs and ULBs in establishing a data based healthcare delivery strategy; 3. Develop DHIS2 framework and implementation guidelines; 4. Collaborate with the M&E consultant in internalize data analysis to provide evidence for decision making with the aim to improve PHC governance. 5. Lead a DHIS2 implementation team according to best practices to establish an appropriate DHIS2 within the project framework. 6. Facilitate a DHIS2/OpenMRS interfacing system 7. Plan and implement personnel including PIUs, PMU, ULB and PA-NGOs on data analysis and use;
3. OpenMRS expert		Technical Expert with at least 5 years of OpenMRS Project implementation experience in a similar environment to the project requirements.		1. Translate facility requirements and URKS into an OpenMRS platform; 2. Lead a team of technical experts into implementing facility level OpenMRS systems 3. Plan and implement training for facility personnel 4. Contribute to the overall organizational structure development of facilities capabilities using OpenMRS tools.

Source: Asian Development Bank.

E. Individual Consultants

62. In addition, individual consultants will be engaged for the following: (i) support to LGD in the preparation of an operational plan and results framework for the draft NUHS; (ii) support to LGD in the preparation of guidelines on utilization of block grants, PPP contract management, Urban Primary Health Care Sustainability Fund use, and model for public toilet management; (iii) technical support in project management in the areas of urban PHC, procurement, financial management, and human resources development; and (iv) training coordination and evaluation. The terms of reference of the consultants are shown in the table below.

Table 27: Individual Consultants

Specialist	National or International	Person-Months	Qualification and Experience	Terms of Reference
1. Urban Primary Health Care Specialist	National	36	Master's degree in public health, medicine, economics, sociology or another suitable	1. Act as the focal point for all technical matters relating to PHC service delivery;

Specialist	National or International	Person-Months	Qualification and Experience	Terms of Reference
			field. At least 15 years progressively responsible experience in health project management, Experience in providing management support for decentralization or contracting out of health and related services will be of advantages. Experience in organizing and managing teams of advisors, integrating national and international TA support and organizing and scheduling national and international training programs. Previous experience in contracting out of PHC in Bangladesh preferred. Experience in South Asia also preferred.	2. Coordinate with relevant government agencies and development partners on project-related programs and issues; 3. Assist the Project Director in administering the partner service provider contracts and addressing technical problems related to service delivery and quality assurance; 4. Coordinate with the HMIS consultant team on the design, development, and operationalization of HMIS; 5. Provide technical support to the HRD unit in designing training programs for enhancing staff skills at the PMU, PIU, and partner service provider levels; and 6. Assist the Project Director in overseeing evaluating the findings of the PPME program of the project, make initial assessment of performance of each PA NGO, identify and advise any corrective measures, if needed, particularly for ensuring quality service and poverty targeting.
2. Nutrition Specialist	National	36	Master's degree in relevant field with specialization in nutrition. At least 15 years progressively responsible experience in implementation of nutrition project.	1. Act as the focal point for all technical matters relating to nutrition mainstreaming in service delivery; 2. Coordinate with relevant government agencies and development partners on project-related programs and issues; 3. Assist the Project Director in administering the partnership agreement contracts and addressing technical problems related to nutrition care and quality assurance; 4. Provide technical support to the HRD unit in designing training programs for enhancing staff knowledge/skills in nutrition at the PMU, PIU, and partner service provider levels; and 5. Assist the Project Director in overseeing evaluating the findings of the PPME program of the project, make initial assessment of performance of each PA NGO, identify and advise any corrective measures, if needed, particularly for

Specialist	National or International	Person-Months	Qualification and Experience	Terms of Reference
				ensuring quality nutrition service and poverty targeting.
3. Procurement Specialist	National	24	Master's degree in public administration, business management, law or equivalent. At least 10 years' experience in the fields of procurement, preferably in the health sector. Knowledge in Government procurement policy and procedures, and experience in managing bid cycles, organizing procurement packages, preparation of bidding documents and evaluation of bid proposals. Experience with ADB and/or World Bank procurement guidelines and procedures.	1. Provide support to the PMU on all aspects of procurement; 2. Coordinate procurement activities under the guidance and supervision of the PMU and assist the CC and municipalities (PIUs) and the PA NGOs in managing procurement activities; 3. Ensure that capacity building for procurement is carefully synchronized and coordinated with the training provided by other projects and agencies under ADB and other donor-supported projects; 4. Arrange and provide procurement training for PMU and PIU staff and partner service providers, as needed; and 5. Advise and support the implementation of partnership agreements, equipment and supplies procurement, civil works contracts, office and clinic equipment and supplies, and other goods and consulting services.
4. Monitoring and Quality Assurance (QA) Specialist	National	36	Physician with MPH or equivalent degree/diploma with at least 15 years of work experience in the public/private health sector, particularly in reproductive, maternal and child health care. Experience in overseeing or managing quality aspects in public/private health care programs, including clinical programs, will be preferred.	1. Assist PMU, PIUs, and partner service providers in updating and implementing a clinical QA system based on guidelines already development by MOHFW; 2. Support PMU and the PIUs in monitoring the conduct of bi-annual monitoring of partner service providers' performance using ISI covering health service delivery and quality, coverage of the poor, and management and accounting practices; and 3. Assist the QA Team in carrying out regular monitoring and follow-up on ISI findings. 4. Analyze data generated from HMIS – review and finalize denominators proposed in project design stage, perform annual target monitoring, communicate and examine inconsistency, if any, related to target and actual performance.
5. Financial Management Specialist	National	30	Chartered accountant and a holder of master's degree in finance, accounting, or another related subject. Fifteen years of work	1. Assist PMU in rationalizing existing accounting systems for keeping records of all health-related expenditures and revenues

Specialist	National or International	Person-Months	Qualification and Experience	Terms of Reference
			experience in managing finance and accounts of large establishments involving transaction of accounts at multiple subordinate offices. Must be familiar with computerized accounting systems and procedures and have hands-on experiences in designing/managing ICT-assisted financial management systems. Development projects financed by multilateral agencies such as ADB and/or World Bank will be preferred.	2. Assess the existing accounting systems in the participating CCs/ municipalities, particularly the new ones, and suggest a modified uniform accounting system that adequately addresses the identified shortcomings, meets the organization's future and present financial management needs, and is based on sound accounting practices; 3. Assess the knowledge and skills of personnel at PMU, PIUs, and partner service providers in financial management and accounting and identify their training needs. Prepare training programs and materials; 4. Implement, with assistance from the HRD Unit, a training program for accounting personnel at different levels continuous basis (at least once a year) to ensure they are updated on requirements and issues; and 5. Review the process for collection, processing, and submission of expenditure statements from the partner service providers to PMU and identify measures to address the systemic issues causing delays in submission of the expenditure statements to ADB for reimbursement; 6. Review the process for project financial statement preparation and audit, and identify measures to address the systemic issues causing delays in submission of the audited project financial statements to ADB and resolution of audit observations; 7. Design and develop, in coordination with ICT/HMIS consultants, ICT-based financial management systems and procedures for the project; 8. Assist the Training Cell in developing the training program on computerized financial management system for PMU, PIU and PA NGO staff. 9. Provide report on financial management capacity development to ADB. The report will include the status of Financial Management Action

Specialist	National or International	Person-Months	Qualification and Experience	Terms of Reference
				Plan. The report will be provided quarterly during the first year, and semi-annually in the subsequent years.
6. Gender Specialist	National	12	Masters level in social sciences and at least 6-10 years' experience in gender mainstreaming in the development process, training and sensitization programs, social analyses, gender desegregated program networking and advocacy, development and institutionalization of programs dealing with violence against women. Experience of research in the areas of gender, development, social inclusion and empowerment will be preferred. Experience with health programs strongly preferred	1. Provide support to PMU and the PIUs in the implementation of the project's Gender Action Plan (GAP) to ensure the attainment of the project's gender equity objective; 2. Support the gender mainstreaming activities of the project including providing inputs in the planning and development of a BCCM package to mainstream gender issues in ESD service delivery; 3. Assist PMU and the PIUs in monitoring GAP implementation; and 4. Serve as resource person in the conduct of gender training activities.
7. Environment Specialist	National	12	Appropriate tertiary qualifications in environmental science or related disciplines, specializing in environmental management issues especially in the urban sector. At least 6-10 years' experience in the conduct of environmental impact assessment in urban and municipal settings and related activities and development of mitigating measures to reduce possible adverse environmental impact.	1. Assist PMU/PIUs in implementation of the project's Environmental Assessment and Review Framework (EARF) particularly during the construction and operation of health facilities; 2. Monitor the compliance of LGD with the environmental provisions in the Loan Agreement by reviewing regular progress reports; 3. Assist the PMU in checking the provisions of civil works contracts to ensure that environmental safeguards are implemented; and 4. Develop guidelines for environmentally sound treatment and final disposal of hazardous medical waste assist PMU in enforcing implementation of the guidelines.
8. Capacity Development Specialist	National	12	Master's degree in a related subject. Ten years experiences in planning, organizing and implementing training programs for organizations with multiple subordinate offices at various levels. Experiences with guidelines and practices of development financing institutions like ADB and World Bank for contracting	1. Support the Training Coordination Cell (TCC) established within PMU in preparing the design and conduct of a training needs assessment (TNA) for LGD, ULBs, and partner service providers; 2. Assist TCU in designing a comprehensive master training plan for various target training

Specialist	National or International	Person-Months	Qualification and Experience	Terms of Reference
			out training programs to appropriate institutions.	beneficiaries based on the findings of the prior TNA; and 3. Support TCU in managing the implementation of the project's capacity building program including identification of training participants, selection of trainers/resource persons, and preparing training reports.
9. Pool for climate resilience activities	National	60	As described in Urban Climate Change and Health **Annex 15**	As described in Urban Climate Change and Health Annex 15

Source: Asian Development Bank.

VII. SAFEGUARDS

63. **Environment.** The project is classified as Category B for environment in accordance with ADB's Safeguard Policy Statement (SPS) (2009). The project will support construction of several new health care centers and improvement of existing facilities, and the nature of the construction will be quite simple and straightforward. The project will also pilot some 'green clinics' (with solar panels and solar water heaters) and support their operation and maintenance, including medical waste management (MWM). The architectural design of the facilities proposes some improvements over the existing facilities to respond to the needs of doctors, visitors, and in-house patients. The project is not expected to have significant or irreversible negative environmental impacts neither at the construction nor at the operations phases. Impacts of the construction phase will be typical for all medium-scale rehabilitation/construction activities and limited to the project sites. These risks can be effectively addressed through adoption of proper and adequate mitigation measures at the design, planning, construction, and operation phases. An environmental assessment and review framework (EARF) has been prepared since the subprojects for construction facilities, facilities for MWM, and other civil works will be identified and confirmed after Board approval. The borrower also has shown interest in adopting environmental safeguards and compliance measure along with strengthening institutional capacity and commitment to manage the related risks and proper implementation of the EARF. During project implementation, LGD will prepare the initial environmental examination, including the environmental monitoring plan, and semiannual monitoring reports that describe progress of implementation and compliance issues and corrective actions, if any, and disclose on the project website. PMU/LGD must submit safeguards documents for review and approval by ADB prior to implementing subprojects.

64. LGD is responsible for ensuring that the location, design, construction, rehabilitation, MWM, operation and maintenance of health care facilities will follow all applicable laws including Medical Waste (Management and Processing) Rules (2008), Solid Waste Management Rules (2010), other relevant laws, ADB's environmental safeguards policies, and the requirements specified in the EARF. Each city corporation and municipality will prepare an MWM plan, which will be endorsed by the Department of Environment and approved by the LGD. Training will be provided to relevant medical staff in MWM, including waste segregation at source and proper disposal and operation during construction and other civil works. The government will also ensure that the city corporations and municipalities will have sufficient budget to operate and maintain the MWM plan. For all major civil works, the government will ensure that mitigation measures related to the environment are incorporated in the project.

65. **Social safeguards.** A total of 11 city corporations and 14 municipalities will be covered with this additional financing which includes 25 existing partnership areas in 10 city corporations, four municipalities and 20 new partnership areas in 10 new municipalities, four existing city corporations and one new city corporation. No land, structures, or livelihood has been affected in the existing facilities; same modality will apply for the new 20 partnership areas. The overall project is classified as Category C for involuntary resettlement based on ADB's SPS (2009). No land acquisition will be involved for new civil works, as existing, unoccupied land owned by the ULBs will be used by the project. As the specific locations of project infrastructure are uncertain at the time of Board approval, procedural guidelines have been prepared to guide social screening, assessment, and stakeholder consultations during project implementation (see **Annex 18**). Institutional arrangements and assurance mechanisms will be in place to ensure compliance with SPS safeguard requirements during assessment of new constructions. Stakeholder and community consultations will be the responsibility of ULBs during assessment of new civil works. Ward-level community consultation mechanism, including for grievance redress, will be in place. The executive engineer of PMU will be responsible for monitoring and confirmation that adequate stakeholder consultations have taken place during civil works evaluations.

66. As this project covers only urban areas, no impact on tribes, minor races, ethnic sects and community peoples is expected. Existing project areas do not overlap with any areas inhabited by small ethnic communities. The project will facilitate health services delivery to ethnic communities living in urban areas with the establishment of PHC facilities. All project outputs will be delivered in a culturally appropriate and participatory manner to meet the needs of various people in the country. A combined resettlement, tribes, minor races, ethnic sects and community peoples planning framework has been prepared in case any social safeguard issue arises. The framework indicates voluntary land donation requirements, entitlement matrix, compensation method, grievance redress committee procedure, and monitoring and evaluation mechanism. The project will screen the land requirement for new constructions or for improvement on existing facilities as per the checklists provided in the framework and will follow the guidelines provided in the framework for various options as the case may be.

67. **Labor standards**. The executing agency shall ensure that the core labor standards of Bangladesh (Labor Law 2006 and Labor Rules 2015), International Labour Organization standards, and the borrower's applicable laws and regulations, including workplace occupational safety norms, are complied with during project implementation. The executing agency shall include specific provisions in the bidding documents and contracts financed under the project requiring that the contractors, other provider of goods and services, and their subcontractors (i) comply with the country's applicable labor law and regulations; (ii) do not use child labor; (iii) do not discriminate workers in respect of employment and occupation by providing, inter alia, equal pay for men and women or people from different ethnic groups for work of equal value, and to the extent possible, employing women and local people, including disadvantaged people, living in the Project area, provided that the requirements for efficiency are adequately met; (iv) do not use forced labor; (v) allow freedom of association and effectively recognize the right to collective bargaining; and (vi) disseminate or engage appropriate service providers to disseminate, information on the risks of sexually transmitted diseases, including HIV/AIDS, to the employees of contractors engaged under the project and to members of the local communities surrounding the project area, particularly women.

VIII. GENDER AND SOCIAL DIMENSIONS

68. **Gender and development.** The project is classified as highly supportive of gender equity. At present more than 75% of the health services are being used by women since most project

services are covered under the essential service package plus (ESP+) which is for reproductive, maternal, and child health. The project will sustain present use and improvements to be made will contribute to poverty reduction and provide social benefits by increasing the coverage and quality of PHC for urban women and children.

69. Despite progress made, the maternal mortality ratio remains high, reflecting a range of factors including access to health care (only 54% had access to antenatal care from a medically trained provider, and only 37% of births were assisted by a medically trained provider), also issues such as nutrition (almost 50% of pregnant women are anemic). Women's health concerns extend to other issues. For instance, the 2014 Bangladesh Demographic and Health Survey found women of reproductive age who participate less in decision-making in their households (i) are less likely to use any contraceptive method (modern or traditional); (ii) have higher unmet need for family planning; and (iii) are less likely to access antenatal, postnatal care, and delivery assistance from a medically trained provider.

70. To address gender equity issues, a gender action plan (GAP) will support the purpose and overall outputs of the proposed additional financing by the explicit integration of gender concerns in the program outputs and outcome areas. Two main activities, as highlighted in the GAP, aim to (i) reduce inequalities in gender-responsive and sex-disaggregated health indicators, and (ii) provide relevant gender training and institutional support in developing the capacity of all involved in gender mainstreaming and monitoring in the project outputs. Relevant training will be provided to develop the capacity of all involved in gender mainstreaming and addressing gender concerns in the project outputs. The capacity building and behavior change, and outreach project components will focus on strengthening the abilities of government and partner service providers to understand the differential characteristics, needs, and dynamics of the urban poor, and to design effective community services in slums and impoverished areas. The needs of women and girls will be a priority. The specific activities of the GAP are outlined in Table 28.

71. **Consultation and participation.** During the feasibility study of additional financing, primary and secondary stakeholders have been consulted through consultation meetings, FGDs, national workshop, etc. The new project design analyzed the stakeholders and planned the project activities. Civil societies were involved in all consultations, information sharing, and they will be involved during implementation in any form of consultation meetings.

72. During project implementation, participatory process will be incorporated into mapping target beneficiaries from urban slum and low-income areas, and into monitoring health services through the ward urban health care coordination committees at the health facilities. Stakeholders and beneficiaries will also participate in the household's poverty scorecards to be updated regularly. Consultation will also be managed through behavior change, communication and marketing the activities through leaflets, TV broadcasting, short drama, etc.

73. Stakeholder communication and participation will be strengthened through ADB's website, project website, service providers newsletters, and community health bulletin boards to give the public and project stakeholders more information about the project and its related activities that could affect their lives. The project website will be a centerpiece of communication with the public and stakeholders to share all project-related information, including implementation status, field activities, and procurement activities.

Table 28: Gender Action Plan

Activities	Indicators and Targets	Responsibilities	Time Frame
Output 1: Institutional governance and local government capacity to deliver primary health care services sustainably strengthened			
1a. Ensure women representation in Central level permanent structure for administrating and coordinating urban health and nutrition.	• Capacity building of at least 20% women staff of Project Implementation Unit (PIU) and Project Management Unit (PMU) on administering and coordinating urban health-nutrition • 20% women staff trained on gender and program management engaged in administering and coordinating urban health and nutrition. • Gender Coordination Committees are functional at the city corporation and municipality levels. • PIU staff-specific individual gender action plans in line with overall Gender Action Plan (GAP) are developed and implemented.	PIU, PMU	On-going
1b. All project Urban Local Bodies (ULBs) have fully staffed and functioning health departments	• At least one gender focal person included in each department and trained	PIU, PMU	By Year 1
1c. Ensure computerized gender-responsive data collection and analysis.	• Gender responsive computerized Health Management Information System (HMIS) data management system in place in all partnership areas (PA). • At least 2 (1 female and 1 male) staff from each PAs is trained on use of the computerized system. • Gender based data field focusing on Primary Health Care Center (PHCC), Comprehensive Reproductive Health Care Center (CRHCC) are developed and integrated in the electronic system.	PMU	By Year 1– Year 2
1g. Ensure gender sensitivity of the functional health emergencies preparedness and response plan.	• Plan highlights differential impact of disasters on women's health and strategies to address those.	PMU, PIU, PA, Ministry of Local Government, Rural Development &Cooperatives (MOLGRDC), Ministry of Health & Family Welfare (MOHFW)	When plan is developed
Output 2: Accessibility, quality and utilization of urban PHC services improved with a focus on the poor, women and children through public-private partnership			
2a. Ensure 30% of urban health care services including sexual and reproductive health provided free-of-charge to identified poor.	• 100% poor female care seekers are attended. • Mechanisms and procedures for preventing and sanctioning workplace sexual harassment and the designation of tasks, incentives, and rewards in place at PHCC and CRHCC.	PA, User Forum, PMU	From the date contract is effective

Activities	Indicators and Targets	Responsibilities	Time Frame
	• Day care/ Creche facilities for working women patients in place. • Wheel chairs for patients are available in all the PHCCs and CRHCCs. • Adolescent couple and pre-marriage/immediately after marriage counseling are participatory • PHCC and CRHCC timing convenient for working female working in factories located in urban areas. • At least 2 awareness campaigns conducted to community in target areas and promotional materials developed and disseminated on continuous basis. • Elder care/geriatric care through physiotherapy. • ensure effective use of promotional materials to bring gender-sensitive behavioral changes in beneficiaries		
2b. Ensure engagement of women workers/laborers in facilities planned for construction and upgrading. Ensure civil structures are gender friendly (women, men, adolescents, elderly and differently abled).	• Specific clause to engage women in construction work included in bid document. • 30% women laborers are engaged in construction and upgrading work (8 CRHCCs and 24 PHCCs) with equal wage for work of equal value as included in bid documents. • toilet, rest room for women engaged in construction work Ramp, railing, low high stairs constructed • Privacy of the check-up rooms ensured	PIU, PMU	During the construction of facilities
2e. 100% of partnership area nongovernment organizations (PA) achieves internal quality compliance including gender related targets	• PAs comply with gender related targets and indicators as per DMF and GAP.	PIU, PMU	On-going
Output 3: Effective support for decentralized project management provided			
3a. Ensure gender sensitive deployment in PMUs that will be fully functional by loan effectiveness and PIUs are established in ULBs.	• 20% of the staff are female in PMU and PIU of ULB; • Gender Focal Point in each ULB; ULB-specific GAP	PMU, PIU, MOLGRDC	On-going
3c. Ensure gender sensitivity of project monitoring & reporting (quarterly and final).	• Sex-disaggregated data collection, analysis and reporting.	PMU	As scheduled
3d. Each PIU trained on computerized financial management.	• One female and one male staff receive training	PMU	On-going
3e. Ensure gender responsive training on using HMIS for project monitoring and evaluation, and gender responsive urban PHC.	• At least 1 person from PMU and 2 persons (one female) from each PIU.	PMU	On-going

ARH=adolescent reproductive health, BCCM=behavior change communication and marketing, CC=city corporation, DMF=design and monitoring framework, ESD=essential service delivery, FP=family planning, GAP=Gender Action Plan, GOB=Government of Bangladesh, HMIS = Health Management Information System, LGD=Local Government Division, MC=municipality, MTBF=Medium Term Budget Framework, PPME=project performance monitoring and evaluation, PHC=primary health care, PIU=Project Implementation Unit, PMU=Project Management Unit, S&G=Social and Gender Specialist, VAW=violation against women.
Source: Asian Development Bank.

IX. PERFORMANCE MONITORING, EVALUATION, REPORTING, AND COMMUNICATION

A. Project Design and Monitoring Framework

74. The design and monitoring framework (DMF) is a summary of the program design and contains the core indicators that focus on the overall project results.

DESIGN AND MONITORING FRAMEWORK[1]

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)[2]		
Performance Indicators with Targets and Baselines	**Data and Reporting**	**Risks**
a. Current project (2012-2018) By 2020, for urban population: MMR is reduced from 194 to 143 per 100,000 live births	BMMS 2010, MDG reports	
Overall project By 2030, for urban population: Maternal Mortality Ratio (MMR) is reduced from 196 to 70 per 100,000 live births[3] (2018 baseline: 196 [BMMS 2016])	BMMS; SDG reports	
b. Current project (2012-2018) By 2020, for urban population: U5MR is reduced from 63 to 48 per 1,000 live births and gender disparities eliminated (<5% difference)	BDHS 2007, MDG reports	
Overall project By 2030, for urban population: Under-5 Mortality Rate (U5MR) is reduced from 37 to 25 per 1,000 live births and gender disparities eliminated (<5% difference) (2018 baseline: urban 37 per 1,000 [BDHS 2014])	SVRS, BDHS (every 3 years), SDG reports	
c. Current project (2012-2018) By 2020, for urban population: Proportion of underweight is reduced from 28% to 21% and stunted children reduced from 36% to 27% and gender disparities reduced (<5% difference between sexes)	BDHS 2011, MDG reports	
Overall project By 2025, for urban population: Prevalence of stunting among under-five children reduced from 30.8% to 22%[4], and gender disparities reduced, <5% difference between sexes (by 2025 as per Second National Plan of Action for Nutrition) (2018 baseline: urban 30.8% [BDHS 2014])	BDHS, SDG reports	
d. Current project (2012-2018) By 2020, for urban population: TFR is maintained at 2.0	BDHS 2011, MDG reports	
Overall project By 2030, for urban population: TFR is maintained at 2.0 (2018 baseline: urban 2.0 [BDHS 2014])	BDHS	

[1] Baseline and targets at impact and outcome level will be updated following availability of Bangladesh Demographic and Health Survey, 2017; Bangladesh Maternal Mortality Survey, 2016; Urban Primary Health Care Services Delivery Project end line survey, 2018-2018.

[2] Government of Bangladesh, Ministry of Local Government, Rural Development and Cooperatives, Local Government Division. 2014. *National Urban Health Strategy*. Dhaka.

[3] The target for MMR and U5MR is based on the target of SDGs - General Economics Division (GED), Bangladesh Planning Commission, 2016. A Handbook: Mapping of Ministries by Targets in the implementation of SDGs aligning with 7th Five Year Plan (2016-20). With the assistance from Support to Sustainable and Inclusive Planning (SSIP) Project, UNDP Bangladesh.

[4] Target of 4th Health, Population and Nutrition Sector Program is 25% by 2022.

e. Current project (2012-2018) By 2020, for urban population: Differentials in MMR, U5MR, TFR, and child malnutrition between the lowest wealth quintile and the highest wealth quintile in urban areas is reduced by 15% **Overall project** By 2030, for urban population: "unchanged" **Additional indicator** f. By 2025, for urban population: Prevalence of exclusive breastfeeding among children 0-5 months old increased from 55% to 70% (by 2025 as per Second National Plan of Action for Nutrition) (2018 baseline: national 55% [BDHS 2014])	BDHS 2011, MDG reports BMMS; BDHS; SDG reports BDHS	

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)**	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
	At least 90% of project clients express satisfaction with project services (2012 baseline: 76% [UPHCP-II, 2009]) **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
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	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) **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 baseline: 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.

B. Monitoring

75. **Project performance monitoring.** Undertaking project monitoring activities will be the responsibility of the PMU to track progress in implementation and achievement of results, facilitate broader awareness and participation among stakeholders, and account for the use of resources. The overall project performance monitoring and evaluation (PPME) activities and their results will guide continuation and sustainability of the proposed additional financing's activities; collected data and analyses will help determine the significance of PPP as a strategy for filling gaps in the provision and use of health services, especially among the urban poor,[23] and suggest improvements. Improvement in the PPME will focus on improving the analytical quality of quarterly progress reports (QPRs) and consolidated annual reports (CARs) in analyzing and reporting the performance indicators using data generated from the HMIS (impact, outcome, and output level indicators as in the DMF), as well as report on implementation issues and plans. The project monitoring, evaluation, and quality assurance program is further provided in **Annex 5.**

76. For the proposed additional financing, an independent research firm or institute will be contracted to conduct an endline survey (household survey) in the proposed 45 partnership areas. The surveys will be developed to (i) generate data for tracking progress by the end of the project particularly indicators for DMF; (ii) assess the impact of the interventions on health services, particularly on maternal and child health; and (iii) evaluate project sustainability and replicability. Where feasible, the endline survey shall be aligned with the baseline survey to ensure comparable results and measurement of changes over time in the outcome and output indicators.

77. For the household listing of the poor survey, the independent research firm or institute appointed will independently verify identification of the poor and provide technical support to the PPP service providers for better identification of the poor, regular updating of the red card system on an annual basis and ensuring close alignment with partner implementing agencies. The firm will be responsible for the conduct of a biannual integrated supervisory instrument (ISI) on health service delivery and quality, services to the poor, as well as management and accounting practices. In addition, the firm will review the results of training assessment and conduct post-training follow-up assessment for selected training courses organized by the project.

78. Aside from the surveys, field visits by PMU-appointed quality assurance for assessing health service delivery according to MOHFW standard guidelines and review missions will monitor the activities that generate data. For visits to PHCCs/CRHCCs, a checklist will be filled up by the PIUs/PMU, and another type of checklist by members of the review mission. The status of compliance with mission recommendations will also be tracked and described in the QPRs and CARs.

79. **Compliance monitoring.** The status of compliance, including actions taken to comply with the loan covenants, will be reported by the PMU during the review mission. Based on the understanding reached during these missions, the status will be updated in ADB's project performance reporting system. The monitoring mechanism will include reporting by PMU for review and verification during review missions and routine PPME studies.

80. **Safeguard monitoring: environment.** Given the environment categorization of "Orange B" and "B" based on ADB's Environmental Assessment Guidelines (2003), the project is not likely to cause any significant negative environmental impact. Nevertheless, environmental compliance monitoring in line with the monitoring arrangement stipulated in the agreed EARF can be carried

[23] Siddique, MAB. 2011. *Concept of Monitoring and Evaluation – Practice by UPHCP-II.*

out to ensure natural environment, ecological environment, and human environment at the different stages of project implementation, such as pre-construction, construction, and operation:

(i) ADB will monitor the compliance of the LGD with the environmental provisions in the Loan Agreement by (a) reviewing regular progress reports, and (b) periodic supervision missions.
(ii) In accordance with Environmentally Responsible Procurement, the project will not allow the use of products containing hazardous elements such as asbestos. The construction contract documents will include a specific clause to ban the use of such products.
(iii) LGD's PMU will check the provisions of the environmental aspects are present in the contract documents of civil works.
(iv) The project's contractors will ensure compliance of any sub-activities with their in-house environmental code of practice and with Bangladeshi norms. This will apply to health infrastructure projects. The physical works contractors' senior staff will undertake (a) internal quality control procedures, (b) site inspections, and (c) the direct supervision of workers to implement appropriate environmental and health and safety practices on site.
(v) Procedures for environmentally sound treatment and final disposal of hazardous medical waste will be established and implemented.

81. The proposed additional financing will monitor the following environmental indicators, if applicable: (i) dust and noise due to demolition and construction; (ii) encroachment into private property while operating in and around construction sites; (iii) dumping of construction waste and accidental spillage of machine oil, lubricants, etc.; (iv) handling of hazardous waste water, waste gases, and spillages of hazardous materials during operation of the hospitals; and (v) handling of medical waste during hospital operation.

82. **Safeguard monitoring: involuntary resettlement, tribes, minor races, ethnic sects and community peoples.** For the proposed additional 20 partnership areas, ULBs must ensure that social screening forms are filled up to ensure that no land or structures are affected due to the project interventions. All the social screening forms must be submitted to ADB. As and when requested, LGD will provide ADB with information on all contract packages included in the civil works program for their review of performance and compliance with ADB's SPS as agreed in the involuntary resettlement framework. There is no impact on tribes, minor races, ethnic sects and community peoples as none of the city corporations or selected municipalities have large tribes, minor races, ethnic sects and community peoples. A planning framework is suggested in **Annex 18**. If required, the project will ensure widespread participation of tribal people communities with adequate gender and generational representation; customary/traditional tribal people organizations; community elders/leaders; civil society organizations like NGOs and community-based organizations; and groups knowledgeable of tribal people development issues and concerns. The project will also provide them with all relevant information about the nature of the project, available health care facilities, organize and conduct consultations in manners to ensure full coverage of the tribal peoples in urban areas, and free expression of their views and preferences.

83. **Gender and social dimensions monitoring.** The GAP identifies the following specific areas of focus: (i) reducing inequalities in gender-responsive and sex-disaggregated health indicators, and (ii) providing relevant gender training and institutional support in developing the capacity of all involved in gender mainstreaming and monitoring in the project outputs. Other social dimensions with reference to the urban health sector include improved accessibility, quality,

and utilization of urban PHC services through PPP focused on the poor and women and children. Monitoring of the GAP and social dimensions will rely on the sex-disaggregated data provided by data generated from the HMIS, ISI reports, PMU reports on recruitment, and gender training reports.

C. Evaluation

84. The endline survey of Urban Primary Health Care Services Delivery Project conducted by the PPME firm in 2017–2018 will serve as the project's (additional financing) baseline. The midterm review is planned during the third year of the project. During the midterm review, progress on the overall results and project implementation will be reviewed. Special attention will be paid to the implementation of the local governance strengthening and capacity building activities. The project endline survey (including household, qualitative, and facility-based) will be conducted in the last year of the project to assess project impacts and outcomes. Service delivery quality and performance will be routinely collected and analyzed through the HMIS and six-monthly ISIs.

D. Reporting

85. The PMU will provide ADB with (i) QPRs in a format consistent with ADB's project performance reporting system; (ii) CARs including (a) progress achieved by output as measured through the indicator's performance targets, including progress on the outcome and impact indicators, (b) key implementation issues and solutions, (c) updated procurement plan, (d) updated implementation plan for the next 12 months, and (e) compliance with covenants; (iii) ISI reports; (iv) annual financial review reports and coordinating the response to the annual audit report which will be submitted by the FAPAD 6 months after closing of the financial year; and (v) a project completion report within 6 months of physical completion of the project. To ensure that projects will continue to be both viable and sustainable, project accounts and the executing agency-audited financial statement together with the associated auditor's report should be adequately reviewed. Quarterly GAP implementation progress reports will be attached to the QPRs, and a GAP completion report will be attached to the project completion report.

E. Stakeholder Communication Strategy

86. Reports produced using data generated from the HMIS and ISIs, together with other survey and study reports, will be posted on the project website and shared with the LGD, the MOHFW and its Directorate General of Health Services and Directorate General of Family Welfare, development partners, and other stakeholders. These reports will likewise be disseminated to the PIUs, district and sub-district administrators, monitoring committees of the city corporations and municipalities, ward UHCCs, and user forums. The three model ULBs selected for direct management of urban PHC will table these reports during their steering or coordination mechanism meeting. Information bulletin boards outside health facilities will provide information on user fees and availability of free services to the poor, outreach activities, community-based organizations, and other cost-effective means. The UHCCs and 'user forums' will act as key forums for public participation and users' feedback, as well as for stakeholder coordination.

87. ADB's Public Communications Policy (PCP) (2011) encourages feedback and active participation of all project stakeholders (including government, private sector, academia, development partners, civil society, affected persons, and the media). The PCP promotes the release of information to the public to increase transparency and accountability. The Report and Recommendation of the President, including the project administration manual (PAM), will be

posted on the ADB website at the same time the Report and Recommendation of the President is circulated for ADB's Board consideration, subject to government's endorsement. Project description summary and data sheets, including timetable, status, and implementation progress, will be posted on ADB website and also translated into Bangla (by ADB) to be disseminated locally. The project safeguard documents, any major changes of scope during project implementation, completion and evaluation reports, and legal agreements (after removing any information that falls within exceptions to presumed disclosure according to PCP) will also be posted on ADB's website.

88. Stakeholder communication will be strengthened through ADB's website, project website, service providers' newsletters, and community health bulletin boards to give the public and project stakeholders more information about the project and its related activities that could affect their lives. The project website will be a centerpiece of communication with the public and stakeholders to share all project related information, including implementation status, field activities, and procurement activities.

X. ANTICORRUPTION POLICY

89. ADB reserves the right to investigate, directly or through its agents, any violations of the Anticorruption Policy relating to the project.[24] All contracts financed by ADB shall include provisions specifying the right of ADB to audit and examine the records and accounts of the executing agency and all project contractors, suppliers, consultants, and other service providers. Individuals and/or entities on ADB's anticorruption debarment list are ineligible to participate in ADB-financed activity and may not be awarded any contracts under the project.[25]

90. To support these efforts, relevant provisions of ADB's Anticorruption Policy are included in the Loan Agreement and the bidding documents for the project. ADB's Anticorruption Policy will be strictly applied in the project. This policy was explained to and discussed with LGD and the government. ADB, as per policy, reserves the right to investigate directly or through its agents, any alleged corrupt, fraudulent, collusive, or coercive practices related to the project. All those activities would be pursued as part of the good governance, accountability, and transparency. In particular, all contracts financed by ADB in connection with the project shall include provisions specifying the right of ADB to audit and examine the records and accounts of LGD and all contractors, suppliers, consultants, and other service providers as they relate to the project.

XI. ACCOUNTABILITY MECHANISM

91. People who are, or may in the future be, adversely affected by the project may submit complaints to ADB's Accountability Mechanism. The Accountability Mechanism provides an independent forum and process whereby people adversely affected by ADB-assisted projects can voice, and seek a resolution of their problems, as well as report alleged violations of ADB's operational policies and procedures. Before submitting a complaint to the Accountability Mechanism, affected people should try in good faith to solve their problems by working with the concerned ADB operations department. Only after doing that, and if they are still dissatisfied, should they approach the Accountability Mechanism.[26]

[24] Anticorruption Policy: http://www.adb.org/Documents/Policies/Anticorruption-Integrity/Policies-Strategies.pdf
[25] ADB's Integrity Office web site: http://www.adb.org/integrity/unit.asp
[26] Accountability Mechanism. http://www.adb.org/Accountability-Mechanism/default.asp.

XII. RECORD OF CHANGES TO THE PROJECT ADMINISTRATION MANUAL

92. All revisions and/or updates during implementation should be retained in this section to provide a chronological history of changes to implemented arrangements recorded in the PAM, including revision to contract awards and disbursement S-curves.

93. The PAM has been completely updated in August 2018 to reflect the additional financing.

ANNEX 1
DETAILED DESCRIPTION OF PROJECT COMPONENTS

1. **Impact and outcome.** The impact of the project is improved health, nutrition and family planning status of the urban population, particularly the poor, women, and children. The outcome is sustainable quality urban primary health care (PHC) services provided in project areas, targeting the poor and needs of women and children.

2. **Outputs**. The project outcome will be supported through the following outputs: (i) strengthened institutional governance and local government capacity to deliver urban PHC services sustainably; (ii) improved accessibility, quality, and utilization of urban PHC services, focusing on the poor, women and children, through public–private partnership (PPP); and (iii) effective support for decentralized project management (see summary in Table A1 below).

A. Component 1: Institutional Governance and Local Government Capacity to Deliver Urban Primary Health Care Services Sustainably Strengthened

3. Sustainable delivery of urban PHC services requires concerted effort on improvements of institutional governance and local government capacity, as well as financial commitment by the government (Local Government Division [LGD]) for sustainable financing. The governance challenge moving forward is the need to establish a functional institutional structure and coordination framework for urban health, along with appropriate policies and guidelines, to support urban local bodies (ULBs) in delivery of urban PHC. At the ULB level, core project management and administrative capacities need to be strengthened, along with improved ownership and commitment. To ensure sustainable delivery of urban primary health services, it will be necessary to create a dedicated budget-line for urban PHC in city corporations and municipalities. The component interventions delineated below are aligned with priority areas of the government's Seventh Five-Year Plan (SFYP) to strengthen local government and rural development, including (i) promoting devolution to local governments under the responsibility of the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC); (ii) promoting effective local government systems; (iii) addressing human resource shortage; (iv) supporting alternate service delivery mechanisms including PPPs for basic services; and (v) improving the planning and budgeting process.[1] To particularly provide health, nutrition, and population (HNP) services to urban slum and street dwellers, the SFYP acknowledges the needs to facilitate collaboration and cooperation among the Ministry of Health and Family Welfare (MOHFW), LGD/MOLGRDC, development partners, PPP service providers, private sector, and others.[2] Although maintaining a "project" modality, the proposed additional financing supports program-approach elements and enhanced project implementation capacity. The implementation will also include specific capacity development in selected ULBs to empower these ULBs in direct management of urban PHC.

[1] Government of Bangladesh, Planning Commission. 2015. *Seventh Five Year Plan (2016-2020): Accelerating Growth, Empowering Citizen, Part 2 – Sector Development Strategies, Chapter 7 "Strategy for Local Government and Rural Development".* Dhaka.

[2] Government of Bangladesh, Planning Commission. 2015. *Seventh Five Year Plan (2016-2020): Accelerating Growth, Empowering Citizen, Part 2 – Sector Development Strategies, Chapter 10 "Health, Nutrition and Population Development Strategy".* Dhaka.

1. Subcomponent 1.1: Strengthen Local Government Division capacity to support urban local bodies in delivering urban primary health care

4. **National Urban Health Strategy.** The strategy has been formulated and approved in 2014 by the MOLGRDC, considering overall national goals, policies and the necessity of a well-planned strategy for urban health system.[3] The Action Plan for Implementation of the National Urban Health Strategy has been prepared, with increasing focus on practical mechanism for (i) improving coordination at all levels, (ii) strengthening city and municipal health departments, (iii) definition and expansion of service scope, and (iv) financial sustainability.

5. LGD will strengthen the Urban Development Wing with fully dedicated permanent staff based on the developed terms of reference and organogram. LGD will provide stewardship in urban PHC across all the ULBs. LGD will commit to create a revenue budget head specifically for PHC to be provided by the city corporations and municipalities, as well as develop and implement a strategy for retention and career progression of medical officers working in ULBs.

6. LGD staff will be included in the project capacity building program, while the role and capacities of the proposed additional financing's project management unit (PMU) is expected to be eventually absorbed under the newly formed Urban Health Unit of the LGD. To support LGD's role in provision of oversight and policy guidance to ULBs, the project will support review and updating of LGD policies and guidelines for incorporating pro-poor urban health issues. The project will support LGD in (i) reviewing the existing laws and regulations and developing an appropriate regulatory framework, (ii) developing guidelines for contracting-out arrangements of urban PHC, and (iii) developing a budgeting mechanism for the allocation of dedicated urban PHC budget-line for ULBs.

2. Subcomponent 1.2: Strengthen urban local body capacity to ensure delivery of urban primary health care

7. **Management capacities of urban local bodies.** The project will support ULBs to strengthen its core local institutions for delivering urban PHC (i.e., ULB health departments), which will ultimately continue to manage the urban PHC system in their respective cities and municipalities after the project. Capacity building of ULB staff in key management areas will be included in the project training program, and it is expected that core project implementation capacities of project implementing unit (PIU) staff will be increasingly incorporated into the ULB health departments over the project implementation period. Additionally, the medical officers in health departments of ULBs are critical to effective management of urban PHC. Given the scarcity of ULB resources and high turnover of medical officers, the project will assist ULBs in considering reorganizations plan for their respective health departments to improve organizational capacity. The reorganization plans will address staffing levels, job descriptions, career progression of medical officers, and organizational structures.

8. Lessons drawn from previous project phases recognized that more intense capacity development needs to be introduced to ensure that ULBs can manage PHC after the project. As such, selected ULBs will receive comprehensive support in strengthening the ULBs and Health

[3] Ten actions are suggested in the strategy: (i) universal health coverage for urban population for pro-poor focus; (ii) strengthen preventive and PHC management system; (iii) ensure urban poverty reduction to achieve national population policy targets; (v) achieve national nutrition targets; (vi) adopt innovative service delivery using modern technology, management policy, and practices; (vii) improve institutional governance and capacity development; (viii) strengthen health service program of the city corporations and municipalities; (ix) financing and resource mobilization; and (x) attain sustainability.

Departments for direct management of urban PHC services after the project. The project will focus on the development of a strategic health plan for the ULBs. In addition, capacity in human resource recruitment, managing urban health management information system (HMIS), budgeting and financial planning, HMIS/monitoring and evaluation and quality assurance of service delivery. Contracting and contract monitoring of outsourced PHC will be also included. Furthermore, the ULBs should establish linkage with the quality improvement cell of MOHFW to harmonize a national approach in quality assurance. To undertake direct management of PHC service delivery, the selected ULBs will have an expanded PIU which will be absorbed by the health department at the end of the project.

9. **Primary health care advocacy and awareness building**. The project will continue to support and improve the awareness and advocacy program for ULBs to sensitize on urban health issues, which in turn is expected to result in more resources allocation to urban health. The advocacy program will also account for citizens' participation and public influence in local elections and allocation of resources, and thus also include raising awareness among the public on urban health.

10. **Primary health care sustainability fund.** The project will continue to require that ULBs contribute at least 1% of their local revenue to the Urban Health Sustainability Fund to promote commitment of the ULBs. The contribution to the sustainability fund was not evenly contributed among the city corporations/municipalities because no dedicated revenue budget line was established for urban health. In this connection, the project will continue the awareness and advocacy activities at ULBs. Sustainability in the medium and long-term will be ensured through a dedicated revenue budget line for ULBs. The amount collected during the previous and future projects shall be utilized to strengthen the capability of the ULBs and to improve services delivery. The utilization of fund will be based on an annual plan established by the ULBs and approved by LGD. The procedures for the utilization of the fund shall be finalized in the ULB guidelines to be developed.

11. **Improved planning and budgeting.** The project will support developing guidelines on the use of LGD-dedicated PHC funds for the city corporations and municipalities to strengthen ULBs' commitment to PHC service delivery. This will cover improved planning and budgeting processes, along with leveraging PPPs for service delivery.

3. Subcomponent 1.3: Management systems, learning, and innovations on urban primary health care

12. **Urban health management information system.** The Urban Primary Health Care Services Delivery Project is implementing a pilot, real-time patient management and HMIS, adapting the District Health Information System-2 of the MOHFW for easier integration with the MOHFW system at a later stage. The back-end database of the HMIS will be built to keep the data collected from Unified Record Keeping System (streamlined data collection developed under Second Urban Primary Health Care Project). The HMIS will have an automated report-generating function to provide routine reports to support routine performance monitoring and management purposes. Project funds are being used (i) to design and develop the patient management and HMIS; (ii) to cover information technology (IT) costs related to hardware (server, notebooks, routers, printers, tablets, etc.); and (iii) for training and maintenance.

13. In the proposed additional financing, patient management and HMIS will be expanded from the pilot areas to the remaining partnership areas. The project will provide funding for the required hardware, training, and maintenance. To ascertain the compliance of the patient

management and HMIS with the national health care data strategy,[4] sharing of resources and close collaboration with development partners supporting the national HMIS needs to be ensured (see **Annex 12**).

14. **Facility mapping.** The project will continue to support mapping of all facilities, including those of the MOHFW and private service providers, at each partnership agreement area-level to help develop effective referral systems and identify gaps in coverage, particularly for the poor and slum areas and floating population. The mapping will also identify urban areas and populations vulnerable to climate change impacts, including flood prone areas. Facility mapping will eventually be integrated as part of HMIS and will facilitate (i) identification of optimal service delivery points (including for fixed and mobile services), (ii) linking of public and private urban health providers, and (iii) a more efficient organization of the referral system to secondary health care services. The health facilities map will be updated periodically with the support of PPP service providers. The maps will be available from the web portal along with facility details.

15. **Operations research.** The project will support action-oriented operational research (**Annex 8**) in indicative areas covering (i) continuation of the Urban Health and Demographic Surveillance System at the slums of Dhaka North, Dhaka South, and Gazipur City Corporations on registration of health and demographic events; (ii) promoting need-based C-section; and (iii) nutrition mainstreaming. ULBs and reputable research institutions will be involved in the implementation of the project's operations research program to ensure follow-up implementation of recommendations and timely learning of lessons.

B. Component 2: Accessibility, Quality, and Utilization of Urban Primary Health Care Services improved with a focus on the poor, women and children, through public-private partnership

16. By recognizing the linkage between health and nutrition to poverty and growth, the government's SFYP reaffirms the priority objective of the previous Five-Year Plan on improving urban health services to facilitate access and effective use of available essential health services package by the urban poor and slum dwellers.[5] The goals and strategies of the HNP sector, call for, among others: (i) ensuring access and utilization of HNP services for every citizen of the country, with particular emphasis on elderly, women, children, poor, disadvantaged; (ii) improving nutritional status of children and women; (iii) improving quality of maternity services; (iv) reducing total fertility rate; (v) ensuring adolescent and reproductive health care; (vi) providing in-service training; (vii) meeting challenges of emerging, re-emerging noncommunicable diseases and climate change.[6] The SFYP recognizes the needs for collaboration among governments, nongovernment organizations, and development partners in providing HNP services to urban slum and street dwellers.[7]

[4] Government of Bangladesh. *Seventh Five-Year Plan (2016-2020):* Accelerating Growth, Empowering Citizen. December 2015.
[5] Government of Bangladesh. *Seventh Five-Year Plan (2016-2020):* Accelerating Growth, Empowering Citizens, Part 2 – Sector Development Strategies, Chapter 10 "Health, Nutrition and Population Development Strategy". December 2015.
[6] *Ibid.* (p. 514).
[7] *Ibid.* (p. 506, 515).

1. Subcomponent 2.1: Urban primary health care services delivery, including health education and behavior change communication

17. **Partnership agreements.** Building on previous project cycles, the project will further support strengthening the urban PHC delivery system to provide the essential service delivery (ESD+) package through PPP. Provision of PHC will be through contract agreements with partner service providers and other private entities in 45 partnership agreement areas covering all city corporations and selected municipalities. Each partnership agreement will serve about 380,000 beneficiaries on average. The ESD+ package focuses on maternal and child health and is aligned with the priorities of the government to achieve the Sustainable Development Goals. In line with the needs of the target population, the project will enhance the focus on nutrition mainstreaming, neonatal care, and noncommunicable disease detection (see **Annex 10** on ESD+ under the proposed additional financing).

18. **Behavior change communication and marketing.** The proposed additional financing will continue to support the behavior change communication and marketing in key priority areas of the Urban Primary Health Care Services Delivery Project (maternal, newborn, and child health care-related seeking behaviors, nutrition, family planning, hygiene, and sanitation). Behavior change communication and marketing strategy and implementation plan will draw on the experience of the project, revisit the recommendations of a study commissioned by Asian Development Bank,[8] and align with the ongoing initiatives of MOHFW. In particular, attention will be drawn to the use of delivery. A firm will be recruited to design and implement the plan including coaching the PPP service providers in communication outreach activities (see Annex 11 on project social and behavior change program).

(i) Subcomponent 2.2: Effective reaching of the urban poor

19. **Poverty targeting.** Similar to previous project cycles, the project will continue providing for at least 30% of services free of cost to the poor. The proposed additional financing will maintain similar mechanism as practiced in Urban Primary Health Care Services Delivery Project in the identification and targeting of urban poor. The PPP service providers will be provided with technical support for uniform identification of the ‘poor’ eligible for fee exemption (red-cards) and for regular updating and effective management of the red-card system. Monitoring systems will be continued to track achievements in pro-poor targeting (see **Annex 14** on reaching the urban poor and identification criteria).

20. **Mobile services.** Delivery of mobile outreach services to the “ultra-poor” and floating population (who are not reached by red-cards) through “satellite clinic” will be continued. The number of satellite clinics will also be increased from currently two to up-to four per partnership agreement area, depending to the size of catchment population.

21. **Collaborative agreements.** Collaborative agreements, at partnership agreement level or project level, may be established with other urban health actors such as Department for International Development of the United Kingdom, United Nations agencies, BRAC, Concerned Worldwide, United States Agency for International Development, NGOs, private sector, etc. for advancing the project objectives. The agreements may cover but is not limited to harmonized poverty identification; broader reach of the urban poor and/or vulnerable; effective inter-network referrals; demarcation of catchment population; assistance in capacity building/improvement;

[8] Behavior Change Communication Strategy for the Urban Primary Health Care Services Delivery Project, June 2013.

knowledge sharing; knowledge generation; sharing of tools; cross-use of fee exemption cards ("red cards" and "green cards"), etc.

(ii) Subcomponent 2.3: Ensuring quality of primary health care services

22. Quality services will be continuously pursued through support for in-service training of health care personnel, essential drugs and equipment, effective mechanism for quality assurance, and performance management of partner service providers.

23. **Health workers training.** In-service training of health care personnel will be supported to refresh/update their knowledge and skills in delivery and management of ESD+ package. Implementation of the training plan will be coordinated through a 'training unit' established in the PMU.[9] The project will also provide training to enhance nutrition mainstreaming and delivery of newborn care.

24. **Equipment and drugs.** The project will support the cost of new medical equipment for the new facilities and replacement in the existing facilities as needed. Provisions will be made to replace vehicles that are over 10 years old. The project will also cover the purchase of essential drugs for the proposed additional financing, included in the partnership agreements. Additional budget will be included in the partnership agreements to cover the cost of free medicines for the poor, wherein the amount allocated will vary by the number of poor in the partnership agreement areas (see **Annex 6** for List of Equipment to be provided).

25. **Quality monitoring and assurance.** The project will support biannual independent monitoring of partner service providers performance, using an Integrated Supervisory Instrument (ISI) covering health service delivery and quality, coverage of poor, as well as management and accounting practices. In addition, the PPP service providers will be responsible to develop and implement a clinical quality assurance system, based on manual developed following MOHFW standards. A quality assurance team comprising PMU and PIU medical officers, and MOHFW staff, will be continued to carry out regular monitoring and follow-ups on ISI findings.

26. **Performance management of public–private partnership service providers and encouraging innovations.** The project will continue the performance incentive scheme to ensure accountability and transparency in partnership arrangements and to incentivize achievement of good performance and quality health service delivery. Performance is calculated based on a composite index of 12 prioritized service delivery indicators, in which the incentive scheme is expected to promote key results in these areas. Under the ongoing project, the system is performing well. It encourages a higher standard of care, performance monitoring, and healthy competition among the partners. In addition, provisions are available for non-monetary rewards for higher performance (plaques, etc.). The balance of the performance incentives is used toward a small-scale 'innovation fund' encouraging and rewarding partner service providers annually for innovations toward better performance and service delivery (**Annex 9**).

3. Subcomponent 2.4: Access to urban primary health care through improved infrastructure network

[9] A training coordination unit is established under the PMU, consisting core PMU staff under a deputy project director, and will be supported by one national consultant (for 12 months). The consultant will be recruited to review in detail training requirements, collaboration with other agencies/training institutes, and update the human resources development/training plan for the proposed additional financing.

27. **Construction of new health facilities and upgradation.** The project has established an urban PHC infrastructure network comprising 113 PHC centers (PCCS) and 25 comprehensive reproductive health care centers (CRHCCs). However, with the continuous expansion of urban population, the network of urban PHC infrastructure is still inadequate to meet the needs. The proposed additional financing will finance construction of eight new CRHCCs and 24 PHCCs. It will also support infrastructure upgrading of facilities constructed during first and second Urban Primary Health Services Delivery Project where required. The prototype design of CRHCC and PHCC have also been improved to promote more efficient use of space/functionality, hand washing facilities, and climate proofing features such as natural ventilation.

28. **Climate proofing.** Mitigation measures will be implemented according to results of the assessment conducted at project design stage (**Annex 15**). These measures include water and electricity conservation, solar energy, flood proofing, and water harvesting.

C. Component 3: Effective Support for Decentralized Project Management Provided

1. Subcomponent 3.1: Core project management

29. Similar to previous phases, with some modifications, the project will finance PMU and PIU staffing for the 5-year project duration. In addition, vehicles for PMU/new PIUs will be selectively procured. For increased sustainability and aligned with devolution of responsibilities to local governments, it is planned that the PMU will progressively delegate project management authority to the city corporations/municipalities. The PIUs will be integrated into the ULBs, allowing the ULBs taking on more oversight and supervisory role, as well as direct management.

2. Subcomponent 3.2: Technical support for project management

30. The project will continue to provide specialist consultants to assist project implementation in selected technical areas such as urban PHC; behavior change, communication, and marketing; human resources development; quality assurance; medical equipment; procurement; and financial management. In addition, the project will provide funding for specialist consultants related to nutrition, HMIS, and monitoring and evaluation. Funds will also be allocated to assist PMU and PIUs in midterm review and in preparing the project completion report. Some provisions have also been made for two ‘special audits’ during project implementation, focusing on audits of PPP contracts, payments, and performance. Implementation of the civil works program will be through the Local Government Engineering Division.

3. Subcomponent 3.3: Project financial management system

31. Owing to delay in finalizing the information and communication technology contract, currently all financial and accounting data are maintained manually using a spreadsheet program. At the end of the Urban Primary Health Care Services Delivery Project, it will implement the modernization of the financial management system through a computerized financial management information system (FMIS). This will enable streamlined project accounting at PMU, PIU, and partnership area levels. The proposed additional financing will continue FMIS training and IT-focused ‘change management’ for accounting staff. The FMIS manual will guide the finance and accounting staff of the PMU, PIU, and the PPP service providers in the implementation of adequate financial procedures.

4. Subcomponent 3.4: Training coordination

32. **Training coordination unit.** The existing training coordination unit under the PMU will be continued, consisting core PMU staff under a deputy project director, and supported by

consultants. The unit will review, in detail, training requirements, collaboration with other agencies/ training institutes, and update and implement the human resources development/ training plan for the proposed additional financing. Appropriate training guidelines for implementation of the training program have been developed and will be applicable for the proposed additional financing. There will be three major training areas: (i) management, (ii) clinical skills, and (iii) skills related to HMIS and information technology.[10] The training unit will identify necessary capacity requirements for ULB to ensure delivery of PHC services through partnership agreements with PPP service providers, and develop appropriate training modules for ULBs health department staff. At least one international or regional conference will be organized in urban health under local trainings and workshops. A local consulting firm will be recruited to evaluate the training program. (See **Annex 7** on indicative project training plan.)

5. Subcomponent 3.5: Monitoring and evaluation

33. Overall monitoring and evaluation activities will be in line with the previous three project cycles for comparability of key indicators over time, where applicable. In addition to HMIS routine monitoring and independent quality assurance (ISIs), an independent research firm will be contracted to conduct the project endline survey covering the 45 partnership agreement areas. The endline survey of Urban Primary Health Care Services Delivery Project (to be carried out by project performance monitoring and evaluation firm) will serve as baseline for the next phase. The surveys will be developed to generate data for tracking progress by the end of the project to assess the impact of the interventions on health services, particularly on maternal and child health and to evaluate project sustainability and effectiveness. The terms of reference and survey protocol of the endline survey have been developed to ensure comparability of results with previous cycle of endline survey.

Table A1.1: Summary Components and Subcomponents

Components	Subcomponents	Key Activities
1. Institutional governance and local government capacity to deliver urban PHC services sustainably strengthened	1.1 Strengthen LGD capacity to support ULBs in delivering urban PHC	(i) Monitor closely the progress of implementation of the action plan for National Urban Health Strategy, realization of a functional Urban Development Wing, establishment of revenue budget head for urban PHC; (ii) Support LGD staff through the project capacity building program; and (iii) Support LGD to (a) review and develop appropriate regulatory framework, (b) develop guidelines for contracting-out of urban PHC, (c) develop budgeting mechanism for allocation of dedicated urban PHC budget-line, and (d) improve guidelines on the use of Urban Health Sustainability Fund.
	1.2 Strengthen ULB capacity to ensure delivery of urban PHC	(i) Support ULBs in the establishment and/or strengthening of their health departments; (ii) Capacity building of ULB staff in key management areas; (iii) Implement pilot initiative to support four selected ULBs through comprehensive TA in developing a strategic health plan for urban PHC, human resource recruitment, managing

[10] The target groups will include (i) PMU and PIU staff on project implementation (including HMIS); (ii) LGD "Urban Health Unit" staff, ULB health department staff, partner service provider managerial staff (management and HMIS/IT training); (iii) health workers (clinical training and IT/HMIS training); and (iv) LGD and ULB general staff (advocacy and study tours for selected leaders). Most of the training will be in-country. External training will be limited to indicative areas such as study tours on urban PHC—healthy cities for LGD and ULB leaders.

Components	Subcomponents	Key Activities
		UHMIS, HMIS/M&E, budgeting and financial management and QA of service delivery; (iv) Continue to support/improve the awareness and advocacy program for ULBs to sensitize them on urban health issues; and (v) Monitor the progress in contributing and utilization of sustainability fund.
	1.3 Management systems, learning, and innovations in urban PHC	(i) Expand the implementation of patient management and HMIS from the pilot areas to remaining and new PA areas (hardware, training, and maintenance); (ii) Collaborate with development partners supporting MOHFW's HMIS; (iii) Map all PHC facilities, including those of MOHFW and private service providers, at each PA level to help develop effective referral systems and identify gaps in coverage, particularly for the poor, the slum dwellers, and the floating population, and integration of the facility mapping as part of HMIS; and (iv) Conduct of action-oriented operations research by reputable research institutes and in collaboration with ULBs in areas such as (a) continuation of the urban HDSS at the slums of Dhaka North, Dhaka South and Gazipur on registration of health and demographic events; (b) nutrition mainstreaming; and (c) indications for C-section.
2. Accessibility, quality, and utilization of urban PHC services (with a focus on the poor, women, and children) improved through PPP	2.1 Urban PHC services delivery, including health education and behavior change communication	(i) Provision of ESD+ package through PPP contract agreements in 45 partnership areas covering all CCs and selected municipalities; and (ii) Development and implementation of a BCCM program for health education, social and behavior change, and marketing in key selected areas (MNCH-related health care seeking behaviors, nutrition, family planning, hygiene and sanitation, etc.) in close coordination with MOHFW.
	2.2 Effective reaching of the urban poor	(i) Provide technical support to PPP service providers for regular updating and effective management of the red-card fee exemption system; (ii) Deliver mobile outreach services to population who are not reached by red-cards through satellite clinics, the number of which will be increased to improve coverage; and (iii) Establish collaboration agreements, at PA level or project level, with other urban health actors, for harmonized poverty identification, broader reach of the urban poor, effective inter-network referrals, etc.
	2.3 Ensuring quality of PHC services	(i) Provide in-service training for health care personnel to refresh/update their knowledge and skills in delivery and management of the ESD+ package; [a] (ii) Conduct biannual independent monitoring of PPP service providers performance using ISI and covering health service delivery and quality, coverage of poor, management and accounting practices;

Components	Subcomponents	Key Activities
		(iii) QA team comprising PMU and PIU medical officers, and MOHFW staff to carry out regular monitoring and follow-ups on ISI findings; (iv) Implementation of a clinical quality assurance system by PPP service providers based on guidelines developed by MOHFW; (v) Continue the performance incentive scheme for the contract management of PPP service providers; (vi) Procurement of new medical equipment for the new facilities and replacement of those in existing CRHCCs and some PHCCs, as needed; (vii) Replacement of vehicles that are over 10 years old; and (viii) Purchase of essential drugs, including free medicines for the poor.
	2.4 Access to PHC services through improved infrastructure network	(i) Construction of eight new CRHCCs and 24 new PHCCs; and upgrading of eight CRHCCs and 15 PHCCs; (ii) Improve prototype design of CRHCC and PHCC to promote efficient use of space, functionality, hand washing facilities, and climate proofing features; (iii) Provision of solar panels for generating electricity in the new and upgraded facilities in accordance with the government regulations for new construction; and (iv) Implementation of rainwater harvesting in selected facilities.
3. Effective support for decentralized project management provided	3.1 Core project management	(i) Support PMU and PIUs to implement and manage the project; and (ii) Procurement of vehicles and office equipment for PMU/new PIUs.
	3.2 Technical support for project management	(i) Provide specialists/consultants to assist PMU/PIUs in project implementation and in selected technical areas (PHC, BCC, HRD, M&E/QA, procurement, financial management, nutrition, HMIS); and (ii) Engagement of consultants to assist PMU/PIUs in midterm review and in preparing the PCR.
	3.3 Project financial management system	(i) Provide FMIS training and IT-focused “change management” for accounting staff especially for the new PAs; and (ii) Continue training to guide the finance and accounting staff, especially for the new PAs in operation and maintenance of FMIS.
	3.4 Training coordination unit	Coordinate and monitor training activities.
	3.5 Monitoring and evaluation	(i) Conduct PPME activities in line with the previous two project phases for comparability of key indicators over time, where applicable; (ii) Conduct routine monitoring and independent quality assurance (ISIs); and (iii) Conduct project end line surveys in the PA areas by an independent research firm.

BCCM = behavior change, communication, and marketing, CC = city corporation, CRHCC = comprehensive reproductive health care center, ESD = Essential Service Delivery, FMIS = financial management information system, HDSS = health demographic surveillance system, HMIS = health management information system, HRD = human

resource development, ISI = integrated supervisory instrument, IT = information technology, LGD = Local Government Division, M&E = monitoring and evaluation, MNCH = maternal, newborn, and child health, MOHFW = Ministry of Health and Family Welfare, PA = partnership agreement, PCH = primary health care, PCR = project completion report, PHCC = primary health care center, PIU = project implementation unit, PMU = project management unit, PPME = project performance monitoring and evaluation, PPP = public–private partnership, UHMIS = urban health management information system, ULB = urban local body.

[a] The training coordination unit of the PMU will coordinate all training activities under the project.

Source: Asian Development Bank.

ANNEX 2
DETAILED IMPLEMENTATION ARRANGEMENTS

A. National Level Project Management and Organization Arrangements

1. **Project executing agency.** The Local Government Division (LGD) shall provide overall project guidance and coordination and shall delegate all responsibilities in project administration to the project management unit (PMU). The National Project Steering Committee shall exercise project supervision. LGD's principal responsibilities include (i) providing policy coordination and guidance in the implementation of the project; (ii) monitoring implementation of the project; (iii) coordinating and submitting timely and accurate reports and consolidated audited project financial statements to ADB and cofinanciers; and (iv) submitting to Asian Development Bank (ADB) for its approval the detailed program for the implementation of fellowships, training, and study tours prior to implementation thereof.

2. **National Project Steering Committee.** The LGD shall ensure that the interministerial steering committee established under the Urban Primary Health Care Services Delivery Project shall be maintained in a manner satisfactory to ADB. The steering committee shall be responsible for providing overall policy guidance to the project, coordinating and liaising with other government agencies and departments, monitoring the project's activities and outputs including the quarterly report, and providing feedback to the PMU and each project implementation unit (PIU). The steering committee shall be chaired by the secretary of LGD and shall be comprised of the project director and representatives from LGD; Ministry of Health and Family Welfare (MOHFW); Implementation Monitoring and Evaluation Division, Planning Commission; Ministry of Finance; Ministry of Women and Children Affairs; representatives of cofinanciers; other donors involved in urban PHC (representatives: World Bank, ADB, World Health Organization, United Nations Children's Fund [UNICEF], United Nations Population Fund, Joint United Nations Programme on HIV/AIDS [UNAIDS], United States Agency of International Development [USAID], Sweden, Department for International Development of the United Kingdom), representatives from at least two partnership area service providers, and nongovernmental organizations. The steering committee shall meet no less than twice a year.

3. **Chief project coordinator.** The Additional Secretary, Urban Development Wing, LGD will act as a chief project coordinator in addition to his duty to coordinate the project at the national level. He will be responsible for overall coordination of the project with city corporations and municipalities and will chair the project coordination committee that will meet at least every quarter. The project coordination committee will be attended by key officers of the project management unit (PMU), chief health officers and/or health officers of city corporations and municipalities, and representatives of the Directorate General of Health Services and Family Planning. The chief project coordinator will chair the different committees of the project implementation activities.

4. **Project management unit.** The LGD shall ensure that the project management unit established under the Second Urban Primary Health Care Delivery Project within the LGD shall continue as the PMU of the project. The PMU will oversee day-to-day operations of the project, including procurement, disbursement, accounting, logistics management, reporting, monitoring, supervision, organization of research activities, developing programs for overseas training and study tours, local training and study tours, and coordinating with MOHFW, PIUs, city corporations, municipalities, partners, and consultants.

5. The LGD shall also ensure that the (i) PMU is managed and operated by a full-time project director, acceptable to ADB, who will work under the supervision of the chief project coordinator; and (ii) project director is supported by three deputy project directors (DPDs) for (a) administration and training, (b) service delivery, and (c) finance and audit. The DPDs will be at least at the level of senior assistant secretary of LGD. The DPD for finance and audit should have experience in overseeing finance and audit work. The DPD for service delivery should be a medical doctor with a postgraduate degree in public health and should be a staff member of LGD, city corporation health departments, or MOHFW with experience in a similar project. The qualifications and tasks of the key PMU positions are shown in table below. Considering the expanded coverage of the project, the PMU will be substantially strengthened to address the additional partnership areas and enhanced focus on nutrition mainstreaming and neonatal care. It has also been considered that monitoring of service delivery through public–private partnership (PPP) service providers will be critical in providing quality PHC services. Consequently, additional related resources will be included in the PMU structure.

6. The project director will have the overall responsibility for implementation and of the project. His principal tasks are to guide, supervise, coordinate, and allocate works to the officers and staff working for the project, and monitor and supervise the works of the personnel involved in implementation of the physical program. He will keep close contact with city corporation/municipality and provide technical and other assistance as needed by them for proper implementation of the project. He will prepare annual work plan an ensure implementation of the project works according to the approved work plan and procure project vehicles and various equipment and furniture needed by the PMU and PIUs and selected medical equipment for health clinics. He will liaise with development partners and concerned agencies/ministries for timely flow of fund and submitting reimbursements claims. The project director will exercise administrative, financial, and other power as designed by the Government of Bangladesh.

7. For increased sustainability and to align the project with the government's Seventh Five-Year Plan priorities for public administration, capacity development, and devolution of responsibilities to local governments, the direct management and implementation responsibilities of PMU are expected to be progressively devolved into the LGD.

B. Sub-National Level Project Management and Organization Arrangements

8. **Implementing agencies.** Each city corporation and each municipality will be an implementing agency and will be responsible for the execution and implementation of the components of the project to be conducted in their respective geographical areas. Civil works under the proposed additional financing will be carried out through the Local Government Engineering Department (LGED). PIUs and PMU will provide necessary support and coordination with LGED including payment of bills.

9. **City corporation/municipality urban health coordination committee.** Each city corporation and municipality will establish a city corporation or municipality urban health coordination committee, chaired by the chief executive officer or chairman of the municipality, respectively and comprised of chief health officer in case of a city corporation, or health officer in case of a municipality, key staff of the PIU, civil surgeons or the district heads of Directorate of Health and Directorate of Family Welfare of MOHFW, representatives of partner service providers, and representatives of organizations representing nongovernment organizations and private sector groups working in the health sector, and representatives of other urban PHC initiatives. In addition, the committee will have at least three women living in slums to represent the poor women. The coordination committee will meet at least once every 3 months. Each city

corporation and municipality will ensure that its respective coordination committee is provided with adequate staff, logistical support, and budget. In addition to regular review of the project, the committee will coordinate and provide stewardship to urban PHC in the city or municipality by coordinating and co-opting private sector, non-profit nongovernment sector, and other community-based organizations.

10. **City corporation/municipality project implementation units.** The LGD will continue to ensure that a PIU is operational in each city corporation/municipality, and the project officer and appropriate staff are provided with transport and operational budget. The chief health officer of the city corporation and the health officer of the municipality will be the ex-officio project managers of the proposed additional financing in the respective city corporations and municipalities. The PIU supporting the urban local bodies (ULBs) in the implementation of the project will be absorbed into the health department of the ULBs at the end of the project.

11. Each PIU will (i) coordinate and account for all project activities occurring in its respective partnership area, (ii) supervise and guide PHC delivery under partnership agreement, (iii) coordinate with local officials of MOHFW from Directorate of Health and Directorate of Family Welfare to ensure regular supply of contraceptives and vaccines, (iv) prepare and implement annual plans for capacity building of the partners, (v) assist each partner to achieve maternal child health and nutrition related-Sustainable Development Goals through pro-poor targeting and quality assurance, and (vi) investigate and attempt to resolve any complaints concerning the project. Partnership committees, with wide representation from local government and PPP partners, will be established at each PIU level to ensure smooth and efficient relations between public–private contracting parties. The partnership committees will provide fair and transparent forum to raise partnerships contract implementation and accountability issues, including performance assessments, fund flow and payments, and other feedback and concerns.

12. **Ward urban health coordination committee.** Each city corporation and each municipality will establish a coordination committee, chaired by the respective local ward commissioner and co-chaired by the female ward commissioner and zonal health officer. The ward urban health coordination committee will consist of zonal health officers, representative of PPP service providers, in charge of comprehensive reproductive health care center, representatives of private health providers in the ward, representatives of other nongovernment organizations providing urban PHC, community-based organizations, and at least three women living in slums or from poor households. The functions of this committee are (i) to ensure knowledge and access to free health facilities by the poor, especially women and girls; (ii) coordinate the proposed additional financing with other urban health providers and public health initiatives in the ward; (iii) provide ‘user forum’ for public disclosure of services provided by the health facilities; and (iv) ensure grievance and complaint redressal relating to service provision and any resettlement issues.

13. Where there are similar standing committees preexisting (for example, dealing with health and water and sanitation), the role of urban health coordination committees may be subsumed under or combined with the standing committee to avoid creating parallel structures.

Table A2.1: Terms of Reference of Key Project Management Staff

Designation	Qualification & Experience*	Terms of Reference
PMU Personnel		
Project Director	• To be recruited by LGD on deputation from one of the most senior officials with the rank of at least Deputy Secretary;	a. Report to the Steering Committee and the Coordination Committee; b. Ensure that the project fulfills its objectives; c. Recruit and hire project personnel;

Designation	Qualification & Experience*	Terms of Reference
	• With a minimum of 20 years of service; • Preferably similar working experience in donor supported projects	d. Ensure transparency and openness in all project activities, including financial probity; e. Track project progress and resolve any issue that interferes with efficiency of implementation; f. Motivate, supervise, and discipline project staff so as to ensure high morale and effective performance; g. Liaise with ADB and government ministries including MOHFW, MOF, and the Planning Commission; h. Establish close working relationships with counterparts in LGD and with Mayors of the project CC/Municipalities to facilitate project implementation; i. Liaise with multilateral, bilateral, and NGO partner agencies; j. Develop and implement appropriate office procedures for the Project; k. Advise senior staff of CCs, municipalities, and LGD on policy issues arising from the project; l. Produce high-quality quarterly and annual reports as required by the Government and ADB; m. Report on a regular basis to the Steering and Coordination Committees and carry out their directives as efficiently and effectively as possible; n. Regularly visit the project areas and ensure that all project activities are being successfully implemented; and o. Perform any other responsibilities assigned by relevant higher authorities.
Deputy Project Director (Admin & Training)	• To be recruited by LGD on deputation from BCS (Administration) cadre • With at least 15 years' service experience • Preferably working experience in donor-supported projects.	a. Report to the Project Director, b. Assist to recruit and hire, discipline, reward Project personnel c. Arrange human resource development related activities of the Project d. Assist PIUs in developing skills in contract management with support from the relevant consultancy firms that will be recruited by the project; and e. Represent the PD, UPHCP II in relevant meetings and sessions, when required f. Prepare and implementation of Annual Work Plan consistence to DPP g. Assist in organizational and infrastructure development in the project area h. Assist in preparation and implementation of yearly procurement plan i. Perform other relevant duty assigned by authority
Deputy Project Director (Service Delivery)	• To be recruited by LGD on deputation from BCS (Health) cadre • With at least 15 years' service experience • Preferably a health-related post graduate degree/ diploma and working experience in donor-supported health projects.	a. Report to the Project Director; b. Coordination with MoHFW, DGHS and DGFP and other service delivery related organizations c. Assist the project in implementing ESD+ delivery services and BCC activities d. Participate in deciding on rewarding to the better performing PAs; e. Assist implementation of Urban Health Strategy in project area

Designation	Qualification & Experience*	Terms of Reference
		f. Assist in conduct of operational research and studies g. Perform other relevant duty assigned by authority
Deputy Project Director (Finance)	• To be recruited by LGD on deputation from BCS (Audit and Accounts) Cadre • With at least 15 years' service experience • Preferably working experience in donor-supported projects.	a. Report to the Project Director; b. Prepare and implementation of yearly budget c. Ensure good financial practices and management system d. Assist in the conduction of internal and external audits, financial track recording and monitoring, transparency in all Project activities including financial probity e. Oversee the policy reform relating to urban primary health sustainability fund f. Perform other relevant duty assigned by authority g. Assist in establishing a financial management information system (FMIS) h. Perform other relevant duty assigned by authority
Sr. Program Officer (Procurement) G-6	• Master's degree in any discipline at least second class in all level • Preferably at least 5(Five) year working experience in donor supported health related projects. ADB funded project is preferable.	a. Coordinate procurement activities in PMU and assist City Corporation, Municipalities, PIU and PPP service providers in managing procurement. b. Assist and implementation of PPP agreement, equipment and supplies procurement, civil works contracts, office and clinic equipment supplies and other goods and consulting services. c. Reviews the procurement and consultant selection and the contract documents of ADB funded project. d. Prepare Bidding documents, request for proposals, terms of references, invitation to bids, Bid and proposal evaluation reports, Contract awards and negotiation documents; and Other procurement related documents, submissions, and reports. e. Keeping updated on ADB's policies, guidelines and procedures on procurement and use of consultants. f. Keeping track of the country's policies, laws, rules and regulations on procurement; and liaising with the Government and agencies concerned and with other donor agencies on procurement policy and practices. g. Prepares and updates the annual procurement capacity development plans. h. Facilitate internal procurement seminars, feedback sessions and discussions for PMU, PIU and PPP service providers. i. Perform other relevant duty assigned by authority.
Sr. Program Officer (Coordination) G-6	• Master's degree in any discipline at least second class in all level • Preferably at least 5(Five) year working experience in donor supported health related projects.	a. Report to Deputy Project Director (Administration and Training). b. Assist to coordinate the work of the PMU to achieve the goals of the project. c. Track Program progress and resolve any issue that interfere with efficiency in implementation. d. Assist matters related to project steering committee, coordination committee and review

Designation	Qualification & Experience*	Terms of Reference
		mission to be conducted by development partners. e. Assist to resolve all other issues not distributed to a specific person. f. Perform other relevant duty assigned by authority.
Sr. Program Officer (Reproductive Health) G-6	• MBBS with MPH/equivalents degree. • At least 5(Five) years working experience in donor supported health related projects.	a. Report to Deputy Project Director (Service delivery) b. Assist in monitoring and reviewing the partner performance about reproductive health issue. c. Participate as trainer on reproductive health related issue. d. Collaborate with MIS officer in recording and reporting of reproductive health related problem. e. Collaborate with Health Ministry about reproductive health related issue. f. Perform other relevant duty assigned by authority
Sr. Program Officer (MIS) G-6	• Masters in any discipline/MBBS/ B Sc. in Engineering, with MIS or computer software training from a recognized institute. • At least Five (5) year similar working experience in donor supported health related projects	a. Report to Deputy Project Director (Service delivery) b. Assist to develop a Health Management Information systems (HMIS)of the project c. Develop and supervise the maintenance of web site for the project and its frequent updating d. Develop local area network and internet for the program and ensure that servers and data backup are managed e. Develop and implement electronic formats for records and registers for enabling a unified record keeping system f. Data collection, processing and publication of reports g. Perform other relevant duty assigned by authority
Sr. Program Officer (BCC and Research) G-6	• MBBS or Masters in Sociology or equivalent at least second class in all level • At least Five (5) year similar working experience in donor supported health related projects	a. Report to Deputy Project Director (Service delivery) b. Assist to bring in behavior change relating to better public health in the project areas. c. Assist to utilize the project support for effective change in behavior towards health service. d. Coordinate with city corporations, municipalities, NGOs and other stakeholders to enable behavior change towards more effective health service e. Assist to implement gender issues f. Perform as the public relations officer of the project g. Assist to conduct studies and operational researches h. Perform other relevant duty assigned by authority
Sr. Program Officer (Monitoring & Evaluation) G-6	• Master's degree in any discipline at least second class in all level • Preferably at least 5(Five) year working experience in donor supported health related projects • Ability to use SPSS, MS Access and other Analysis, monitoring	a. Establish the overall M&E strategy in accordance with the M&E plan outlined in the project document and promote a results-based approach; b. Provide timely and relevant information to the Authority, Donor agency and other project stakeholders c. Monitor, review, and analyze performance and performance report of the service providers of the project relevant to quality assurance;

Designation	Qualification & Experience*	Terms of Reference
	and evaluation related software	d. Assist service providers (partners) in establishing an internal M&E System in partner facilities, report in a timely manner, and maintain files on the abovementioned activities; e. Make frequent visits to the project area for the purpose of supervising and monitoring service providers' performance and report on the same to the authority for taking necessary and timely action for the success of services; f. Provide technical advice for the revision of performance indicators & ensure realistic intermediate, mid-term and end-of-project targets are defined g. Monitor and evaluate the compliance of actual progress and performance against the planned work plan and expected quality; h. Arrange the dissemination of information obtained from reviews, monitoring and evaluation, and other publications of relevant organizations; i. Perform any other responsibility assigned by authority.
Program Officer (Clinical) G-9	• MBBS degree • Working experience in the field of public health will be given preference	a. Report to Deputy Project Director (Service delivery) b. Monitor, review and analyze of different clinical health related activities. c. Assist in monitoring and reviewing the partner performance relevant to quality assurance d. Management of medical emergency. e. Supervision and monitoring partners performance and report to authority f. Collaborate with Health Ministry about clinical health related issue. g. Undertake any other function that may be requested by the higher authorities.
Program Officer (Preventive Health) G-9	• MBBS degree • Working experience in the field of public health will be given preference	a. Report to Deputy Project Director (Service delivery) b. Monitor, review and analyze of different preventive health activities including diseases surveillance c. Assist in monitoring and reviewing the partner performance about different preventing health related activities. d. Advise the partner service providers on different preventive health issues e. Coordinate matter related to Family Planning program f. Assist partners in nutrition related issues g. Collaborate with Health Ministry about preventive health related issue. h. Perform other relevant duty assigned by authority
Program Officer (Administration & Training) G-9	• Master's degree in any subject at least second class in all levels • Diploma in personnel management/ human resources related subjects will be preferred • At least two years working experience	a. Report to Deputy Project Director (Administration and training). b. Assist in general administration of the project. c. Support in the management and operations of the human resource development related activities including organize training/ workshop and other activities as stipulated in the program document. d. Matter related to discipline and career planning.

Designation	Qualification & Experience*	Terms of Reference
		e. Matter related to Personnel management of PMU, PIU and service providers. f. Perform other relevant duty assigned by authority.
Assistant Engineer G-9	• Graduate in Civil Engineering. • At least Five (5) years working experience in relevant field. • Preference will be given to the candidate those who have working experience in similar project	a. Report to Deputy Project Director (Administration and Training). b. Maintain all records related to civil works. c. Assist to procurement and contract management under the project. d. Develop procurement plan and timeline of procurement processing. e. Prepare monthly, quarterly progress report. f. Perform other relevant duty assigned by authority.
Accounts Officer G-9	• Master's degree in commerce/ accounting at least second class in all level. • At least 2 (two) years' similar working experience in donor supported projects	a. Report to Senior Accounts Officer b. Maintain project accounts and accounts related records c. Maintain records of all drawing and disbursement of the project updated d. Prepare monthly accounts status e. Assist to facilitate external and internal audit f. Prepare bank reconciliation statement. g. Perform other relevant duty assigned by authority
MIS Assistant G-13	• Bachelors or PG Diploma in computer sciences at least 2 years of relevant work experience.	a. Will work under the close supervision of the MIS and Data Management Officer to establish a efficient and effective computerized management systems in the UPEHU and CCPIUs as well as the other facilities to be supported under the projects including the sanitary landfill, public health laboratories and slaughter houses b. Assist the MIS and Data Management Officer to accomplish his/her TORs and execute the task delegated c. Perform any other responsibilities that are bestowed with by the relevant higher authority.
Accountant G-14	• At least a bachelor's degree in accounts with at least 3 years of accountant experience preferably in a foreign aided project (No third division or class will be allowed in any level). Being well versed with computerized financial management system would be preferred.	a. Prepare draft notes related to accounts for the approval of Accounts and b. Maintain constant liaison with Office of the Director General of Accounts and Audit and FAPAD c. Preparation of all vouchers, salary sheet, disbursement, monthly accounts status of UPHCSDP and submit it to the Accounts and Finance Officer for follow-up action. d. Responsible to assist in keeping all records related to accounts of the UPHCSDP. Report to the Acc. And Finance Officer on any discrepancy detected as per accounts manual of the Government. e. Prepare bank reconciliation statement. Maintain a separate program account for program financing, budgeting and control. f. Prepare annual budget for the UPHCSDP and breakdown to monthly, quarterly and half yearly budget. Make budget variance analyze and inform Acc. And Finance Officer for corrective measures. g. Perform any other relevant duty assigned by the higher authority.

Designation	Qualification & Experience*	Terms of Reference
Office Assistant cum Computer Typist G-16	• Bachelor in any subject. Minimum 1 year working experience in the health-related project and have sound knowledge about MS Word and Excel. Preference will be given to the candidate who worked in foreign aided projects.	a. Overall maintenance of the day-to-day activities of the office in relation to cleanliness, logistics supply and other b. Will ensure proper placement of the office furniture and other logistics c. Will act as a messenger to carry out the activities outside the office d. Will provide refreshment and other supports of the visitors coming to the office e. Will be responsible for maintenance of the store located in PMU. f. Helping photocopy, letter and document dispatch to relevant offices. g. Will ensure cleanliness of the premises.
Driver G-16	• Minimum Eight pass. A valid driving lenience with at least two years' experience of driving. Those worked in and are working in UPHCP-I & UPHCP-II will be given preference and their age limit will be relaxed.	a. Check, clean and wash the vehicles prior to duty, b. Collect fuel, repair, service and overhaul in proper time, c. Maintain log register, Drive safely and efficiently
Office Attendant G-20	• Minimum Eight pass. Those worked in and are working in UPHCP-I & UPHCP-II will be given preference and their age limit will be relaxed.	a. Helping to photocopy, letter delivery, protect assets, serve tea, etc. b. Letter delivery, protect office assets, serve tea etc. Responsible for security of office and assets.
Security Guard G-20	• Minimum Eight pass. Those worked in and are working in UPHCP-I & UPHCP-II will be given preference and their age limit will be relaxed.	a. Responsible for security of PMU and assets b. Help visitor in directing towards right place if required.
Cleaner G-20	• Minimum Eight pass.	a. Keep neat and clean of office and equipment's.
PIU Personnel		
Program Officer G-9	• Senior medical officer from respective City Corporation/ Municipality Health Department will be recruited as Program Officer on Deputation.	a. Report to Program Manager b. Will ensure that the project fulfills its objectives c. Will assist the project authority to recruit and hire, discipline, reward Project personnel and arrange human resource development related activities of the Project and will ensure maintenance of personnel file of the Project related staff. d. Will ensure good financial practices and management system including maintenance of records, timely payments to the concerned officials and organizations e. Will assist in conduction of internal and external audits, financial track recording and monitoring, transparency in all Project activities including financial probity f. Will Represent the PIU, in relevant meetings and sessions, when required g. Perform any other responsibility assigned by authority.
Monitoring & Quality Assurance Officer G-9	• MBBS or MPH or equivalent degree; or Master's Degree in social science with 2 years similar working experience.	a. Monitor, review, and analyze performance and performance report of the service providers of the project relevant to quality assurance; b. Assist the PO in monitoring and reviewing the quality aspects of service providers performance;

Designation	Qualification & Experience*	Terms of Reference
		c. Assist service providers (partners) in establishing a quality assurance system in partner facilities, report their quality assurance-related activities in a timely manner, and maintain files on the abovementioned activities; d. Make frequent visits to the project area for the purpose of supervising and monitoring of PPP service providers' performance and report on the same to the authority for taking necessary and timely action for the success of services; e. Organize review meetings and planning workshops and support/ facilitate monitoring visits by higher authorities to facilitate quality assurance in service provision; f. Arrange the dissemination of information obtained from reviews, monitoring and evaluation, and other publications of relevant organizations; g. Perform any other responsibility assigned by authority.
Accountant (For City Corporation PIU) G-14	• Will have at least a bachelor's degree in accounts with at least 3 years of accountant experience preferably in a foreign aided project (No third division or class will be allowed in any level). Being well versed with computerized financial management system would be preferred.	a. Preparation of the draft notes related to accounts for the approval of PO b. Prepare annual budget, quarterly and half yearly budget c. Maintain project account for the project financing, budgeting and controlling d. Make budget variance analyze and advice PO and concerned unit head of corrective action for controlling budgeted expenditure e. Preparation of all billing and salary disbursement in time f. Maintain all records related to accounts like drawing and disbursement g. Prepare monthly accounts status h. Report to the PO regarding financial discrepancy and corrective action as per accounts manual i. Obtain bank reconciliation statements and analyze the discrepancies and advice for corrective action j. Facilitate external and internal routine audit k. Assist in improving the financial management of the city corporations l. Perform any other responsibility assigned by authority.
Accountant cum Computer Typist (For municipality PIU) G-14	• Will have at least a bachelor's degree in accounts with at least 3 years of accountant experience preferably in a foreign aided project (No third division or class will be allowed in any level). Being well versed with computerized financial management system would be preferred.	a. Preparation of the draft notes related to accounts for the approval of PO b. Prepare annual budget, quarterly and half yearly budget c. Maintain separate project account for the project financing, budgeting and controlling d. Preparation of the draft notes related to accounts for the approval of PO e. Make budget variance analyze and advice PO and concerned unit head of corrective action for controlling budgeted expenditure f. Advice accountants for preparation of all billing and salary disbursement in time g. Maintain all records related to accounts like drawing and disbursement h. Prepare monthly accounts status

Designation	Qualification & Experience*	Terms of Reference
		i. Report to the PO regarding financial discrepancy and corrective action as per accounts manual j. Obtain bank reconciliation statements and analyze the discrepancies and advice for corrective action k. Facilitate external and internal routine audit l. Assist in improving the financial management of the city corporations m. Perform any other responsibility assigned by authority.
Office Assistant cum Computer Typist (For City Corporation PIU) G-14	• Bachelor in any subject. Minimum 1 year working experience in the health-related project and have sound knowledge about MS Word and Excel. Preference will be given to the candidate who worked in foreign aided projects.	a. Overall maintenance of the day-to-day activities of the office in relation to cleanliness, logistics supply and other b. Will ensure proper placement of the office furniture and other logistics c. Will act as a messenger to carry out the activities outside the office d. Will provide refreshment and other supports of the visitors coming to the office e. Will be responsible for maintenance of the store located in PMU f. Helping photocopy, letter and document dispatch to relevant offices. g. Perform any other responsibility assigned by authority.
Driver G-16	• Minimum Eight pass. A valid driving lenience with at least two years' experience of driving.	a. Check, clean and wash the vehicles prior to duty, b. Collect fuel, repair, service and overhaul in proper time, c. Maintain log sheet, d. Drive safely and efficiently
Office Attendant G-20	• Minimum SSC pass	a. Letter delivery, protect office assets, serve tea etc. b. Responsible for security of office and assets. c. Keep neat and clean of office and equipment's

*Candidates who have worked in previous phase projects and/or are working in UPHCSDP will be given preference to work in UPHCSDP-AF and their age and educational qualifications will be relaxed.
Source: Asian Development Bank.

C. Urban Local Body's Direct Involvement and Devolution of Power to Few Urban Local Bodies

14. To ensure the ownership of city corporations and municipalities and sustainability of the PHC services delivery program, 10 out of 45 partnership agreement areas have been identified for the devolution of authority for direct management and disbursement of fund, monitoring, and reporting. These partnership agreement areas are Dhaka South City Corporation (three new partnership areas), Dhaka North City Corporation (two new partnership areas), Chattogram City Corporation (two new partnership areas), Gopalganj Municipality (one partnership area), Kushtia Municipality (one partnership area), and Tarabo Municipality (one partnership area).

15. Urban health departments of ULBs designated as PIUs of city corporations and municipalities as per approved organogram (including human resources and structure) will continue to administer the project activities. PIUs may outsource to service providers according to the standard bid documents approved by the government (LGD) and ADB.

16. PIU might disburse funds based on a memorandum of understanding (MOU) with the PMU and will be accountable for managing the agreements, as well as monitoring and reporting to the PMU. The PMU will continue to provide oversight and technical support as and when necessary. The detailed modalities will be determined after the approval of the development project proforma. Financial terms of the MOU arrangement will be based in consideration of size of historical contracts for similar partnership areas, human resources, number of health centers, and the population size and poverty profile in the catchment area.

17. **Financial management.** The city corporation and municipality will follow the financial rules of the respective city corporation and municipality. Details of financial terms will be finalized in the MOU between PIU and PMU. ADB might conduct the audit of city corporations' and municipalities' accounts and records relating to the payments made under the MOU. In case an audit detects contravention related to financial discipline as stated in the Public Procurement Rules (2008) or ADB's guidelines, the PMU and/or ADB may rescind the MOU and terminate the contract.

18. **Integrity and transparency.** In accordance with the prevailing government regulations and the standard guidelines of ADB's Anticorruption Policy, PIU of city corporations and municipalities must observe the highest standards of integrity, transparency, and financial discipline during the execution of this project.

19. **Performance monitoring and evaluation.** City corporations and municipalities will keep all documents ready for any inspection by the government audit team, donors, and PMU officials.

20. **Contract administration.** Detailed procedures for processing payments and contract administration will be specified in the MOU to be signed between PMU and PIU.

ANNEX 3
CIVIL WORKS PROGRAM

Table A3.1: Proposed New Infrastructure and Selection Justification

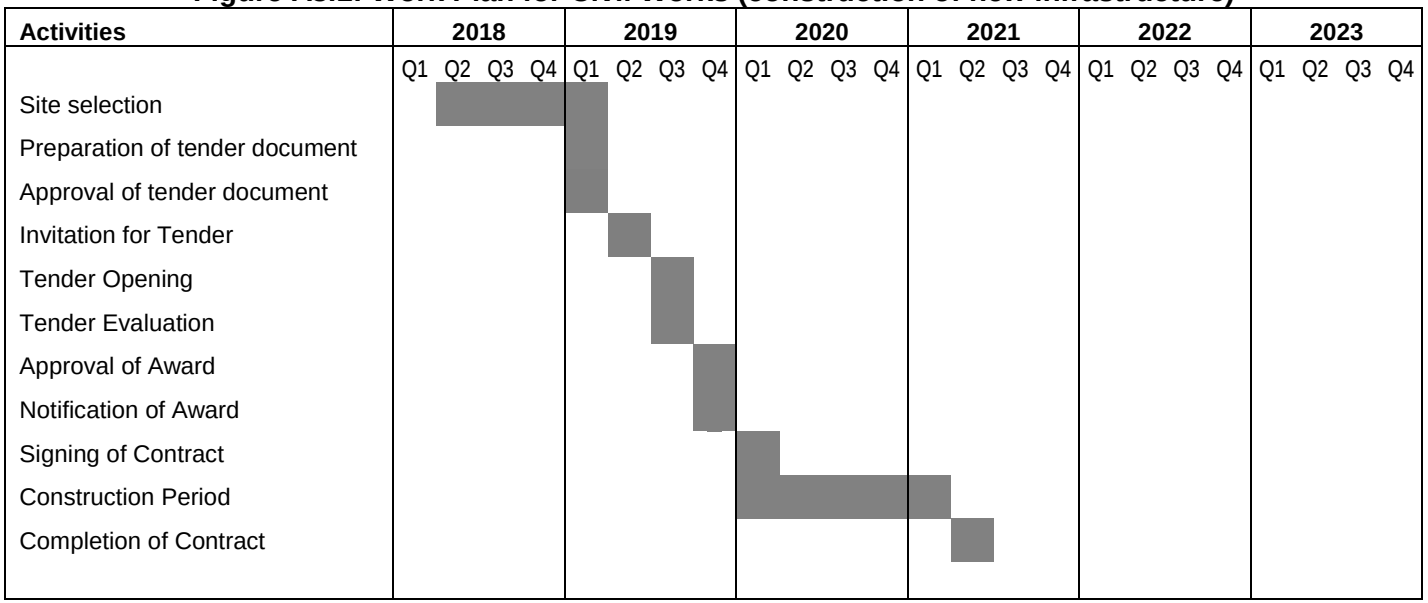
Sl No	City Corporation/ Municipality	Proposed new Infrastructure		Remarks*
		CRHCC	PHCC	
1	Dhaka North	-	4	Out of existing five CRHCCs, three are constructed buildings and two in rented buildings. Due to scarcity of land, no new construction is planned. The proposed four new PHCCs will be identified together with the location of the CRHCCs.
2	Dhaka South	-	5	The land for new PHCCs proposed has not been identified.
3	Narayanganj	1	2	In addition to the existing CRHCC and three PHCCs, the AF will include one new CRHCC and two PHCCs. Site selection is under process.
4	Gazipur	1	1	One CRHCC and one PHCC are proposed for new construction, site selection is under process.
5	Mymensingh	1	2	Mymensingh is newly included in UPHCSDP-AF; one CRHCC and two PHCCs are proposed for new construction, site selection is under process.
6	Faridpur	1	1	Faridpur is newly included in UPHCSDP-AF; one CRHCC and one PHCC is proposed for new construction, site selection is under process.
7	Shariatpur	1	1	Shariatpur is newly included in UPHCSDP-AF; one CRHCC and one PHCC are proposed for new construction, site selection is under process.
8	Gaibandha	1	2	Gaibandha is newly included in UPHCSDP-AF; one PHCC and two PHCCs are proposed for new construction, site selection is under process.
9	Kurigram	-	1	Kurigram is newly included in UPHCSDP-AF; one PHCC is proposed for new construction, site selection is under process.
10	Netrokona	1	1	Netrokona is newly included in UPHCSDP-AF; one CRHCC and one PHCC are proposed for new construction, site selection is under process.
11	Jagannathpur	-	1	Jagannathpur is newly included in UPHCSDP-AF; one PHCC is proposed for new construction, site selection is under process.
12	Derai	1	1	Derai is newly included in UPHCSDP-AF; one CRHCC and one PHCC are proposed for new construction, site selection is under process.
13	Benapole	-	1	Benapole is newly included in UPHCSDP-AF; one PHCC is proposed for new construction, site selection is under process.
14	Tarabo	-	1	Tarabo is newly included in UPHCSDP-AF; one PHCC is proposed for new construction, site selection is under process.
	Total	**8**	**24**	

AF = additional financing, CRHCC = comprehensive reproductive health care center, PHCC = primary health care center, UPHCSDP-AF = Urban Primary Health Care Services Delivery Project-Additional Financing.

* Final allocation of new construction is subject to site availability, therefore the number of CRHCCs and PHCCs and distribution among the city corporations and municipalities may change.

Source: Asian Development Bank and Government of Bangladesh.

Figure A3.1: Work Plan for Civil Works (construction of new infrastructure)



Source: Asian Development Bank estimates.

ANNEX 4
IMPLEMENTATION PLAN FOR PARTNERSHIP AGREEMENTS

A. Background

1. **Defining standards.** The Local Government Division (LGD) of the Ministry of Local Government, Rural Development and Cooperatives, the executing agency, will engage nongovernment organizations, civil society organization, private entities, etc. as partners (henceforth referred to as service providers) for the delivery of a standard package of health services (Essential Service Delivery Plus described in Annex 10) to the catchment population.

2. **Defining partnership areas and baseline data collection.** The project will cover 45 partnership areas covering selected city corporations and municipalities, as shown in Table A4.1 below. The endline survey of the partnership areas under the Second Urban Primary Health Care Project that the National Institute of Population Research and Training (NIPORT) undertook in 2012 serves as the baseline survey for the Urban Primary Health Care Services Delivery Project. The endline survey has been conducted by the project performance monitoring and evaluation firm in late 2017 and early 2018, which will serve as the baseline for the additional financing (2018–2023).

Table A4.1: Proposed Number of Partnership Areas

City Corporation/ Municipality	Number of Existing PAs	Proposed Number of new PAs	Comments
Dhaka South City Corporation	5	8	Additional 3 PAs
Dhaka North City Corporation	5	7	Additional 2 PAs
Rajshahi City Corporation	2	2	No change
Khulna City Corporation	2	2	No change
Barishal City Corporation	1	1	No change
Sylhet City Corporation	1	1	No change
Cumilla City Corporation	1	1	No change
Rangpur City Corporation	1	1	No change
Sirajganj Municipality	1	1	No change
Kushtia Municipality	1	1	No change
Kishoreganj Municipality	1	1	No change
Gopalganj Municipality	1	1	No change
Narayanganj City Corporation	1	2	Additional 1 PA
Gazipur City Corporation	2	3	Gazipur is the third largest CC in Bangladesh by population and area
Chattogram City Corporation		3	New area
Mymensingh Municipality		1	New area
Faridpur Municipality		1	New area
Shariatpur Municipality		1	New area
Gaibandha Municipality		1	New area
Kurigram Municipality		1	New area
Netrokona Municipality		1	New area
Jagannathpur Municipality		1	New area
Derai Municipality		1	New area
Benapole Municipality		1	New area
Tarabo Municipality		1	New area
Total	**25**	**45**	

CC = city corporation, PA = partnership area.
Source: Government of Bangladesh and Asian Development Bank.

B. Responsibilities of the Executing Agency

3. During the project period, the executing agency will provide contraceptive supplies and vaccines on time, allow full managerial autonomy, ensure timely disbursements, and process vouchers and release payments within 21 days.

C. Partnership Agreement Proposal Evaluation Procedures

4. The project management unit (PMU) of the Urban Primary Health Care Services Delivery Project will appoint the selection committee, which will comprise individual recognized experts who have knowledge and experience of primary health care and project management, for the technical evaluation of the proposals.

(i) The selection committee will comprise a minimum of 6–9 individual experts, including:
  (a) a representative from MOHFW (not below deputy secretary level);
  (b) at least two international organization representatives (United Nations Children's Fund [UNICEF], World Health Organization, United States Agency for International Development [USAID], etc.); and
  (c) a PMU/Urban Primary Health Care Services Delivery Project representative (project director or his representative)

(ii) ADB consultant will facilitate and observe the work of the selection committee. Other cofinancer (United Nations Population Fund) also may observe the selection committee meetings.

(iii) The selection committee will review all the proposals by partnership area and mark them, according to the guidelines, against the evaluation checklist.

(iv) Each proposal submitted will receive marks in all checklist categories.

(v) The selection committee will first review the technical proposals for qualification and then conduct a full review of the qualified technical proposals.

(vi) The selection committee members will review the proposals individually and then jointly prepare a common proposal marking table, listing all proposals and the marks they have received in all areas.

(vii) The selection committee will work at a secluded location provided by the Urban Primary Health Care Services Delivery Project and complete its work within 7 days.

5. The selection committee will present its findings to the PMU which will prepare a report describing the evaluation and marking process; scores of technical proposals for each partnership area; and any issues encountered during the marking and evaluation of the technical proposals.

(i) The PMU will present its report at the same time to both ADB and the secretary of LGD within 4 days after receiving the report from the selection committee panel.

(ii) The overall technical proposal review will be completed within 10–12 days.

6. Following ADB and LGD approval of the technical recommendations, the PMU will publicly open the financial proposals of bidders with technically responsive proposals, and publicly record the financial proposals received. Financial proposals of bidders with technically non-responsive proposals will be returned unopened.

7. The selection committee will meet and review the financial proposals of technically responsive bidders and apply an 80:20 quality (technical proposal) to cost (financial proposal) ratio to calculate combined technical and financial scores as described in the bidding documents.

8. The selection committee will send its report on the evaluations and recommendations for partnership area contracts to the PMU and to ADB for concurrence and following receipt of ADB concurrence to LGD for clearance.

9. Following ADB and LGD clearance, the PMU will officially inform each bidder of the results of the evaluation process and inform the approved partners of their selection.

10. The PMU will prepare a report on the selection process and the selection of the partnership agreement service provider in each partnership area and send the report to the mayor and city corporation/municipal health coordination committee for information.

11. The estimated evaluation and implementation time requirements is shown in the Gantt chart on the following page. The total time required is 3.5 months.

D. Partnership Agreement Contracting Procedures

12. The contract with the partner service provider will be signed with an appropriate official of the city corporation/municipality and counter-signed by the project director Urban Primary Health Care Services Delivery Project.

13. The city corporation/municipality health coordination committee is responsible for implementation of the partnership agreements.

14. The chief health officer, as member-secretary of the city health coordination committee, has continuing responsibility for partnership agreement contract implementation between meetings of the city health coordination committee.

15. The city corporation/municipality will establish a dedicated finance unit that works exclusively on financial planning, budgeting, and disbursement of funds for urban PHC.

(i) Financial management and payment procedures have been developed based on the project implementation unit/municipality/city corporation-based reporting and payment process.
(ii) Funds will be provided to the municipality/city corporation under the control of this unit for release to the partnership agreements as well as for other project purposes.

16. The city corporation/municipality will conduct ongoing supervision of the partnership agreement through another unit (not the finance unit), established in the city corporation/municipality.

(i) Municipality/city corporation staff will be trained to use a supervisory check list with marking criteria to assess project progress.
(ii) Payments to the contractor will be based on the results of this monitoring.
(iii) The contractor will report financial and program progress to the project implementation unit, which will certify the results and recommend to the national PMU, regarding the release of funds to the contractor.
(iv) Project funds will be placed with the municipality/city corporation for release to the contractor, following the approval of the PMU.

Figure A4.1: Partnership Agreement Contracting Schedule

Estimated Evaluation and Implementation Times (estimated 75 proposals for 23 partnership agreement areas)

1. Tender release to receipt of proposals – 60 days (from 7 November 2017 to 7 January 2018)
2. Public Opening of Technical Proposals - 7 January 2018
3. Formation of SC (during bid process) 14 days
4. Evaluation of proposals 7 days
5. Report to LGD and ADB 4 days
6. ADB/LGD Concurrence on Technical proposals 4 days
7. Public opening of Financial Proposals 4 days
8. Review and Analysis of Financial Proposals 5 days
9. Report and Recommendations to LGD/ADB 4 days – by 3 February 2018
10. ADB Concurrence 7 days – by 11 February 2018
11. LGD Concurrence 7 days – by 11 February 2018
12. Announcement of Results and Awards on 12 February 2018

Actions/Days	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	1
Evaluation of proposals																																
Report to ADB/LGD																																
ADB/LGD Concurrence on technical proposals																																
Public opening of financial proposals																																
Review and analysis of financial proposals																																
Report and recommendation to LGD/ADB																																
ADB concurrence																																
LGD concurrence																																
Awards announcement																																

ADB = Asian Development Bank, LGD = Local Government Division, SC = selection committee.
Source: Asian Development Bank estimates.

ANNEX 5
MONITORING AND EVALUATION AND QUALITY ASSURANCE

1. The project performance monitoring and evaluation (PPME) system is an integral element for monitoring and assuring quality of the proposed additional financing of the Urban Primary Health Care Services Delivery Project. It will be used by the project management unit (PMU) to track progress in implementation and achievement of results, facilitate broader awareness and participation among stakeholders, and account for the use of resources. The PPME is also a useful instrument that will facilitate continuation and sustainability of the proposed additional financing's activities. Collected data and analyses will help determine the significance of public–private partnership as a strategy for filling gaps in the provision and use of health services, especially among the urban poor, and suggest improvements. This section includes a thorough description of the monitoring and evaluation system for the proposed additional financing, and the different methodologies that will generate, process, and disseminate the required data, such as surveys and health management information system (HMIS).

A. Indicators Defined in the Design and Monitoring Framework

2. The design and monitoring framework is included in Section IX of the project administration manual. The expected impact will be improved health, nutrition, and family planning status of the urban population, particularly the poor, women, and children in the project area. The outcome will be provision of sustainable quality urban primary health care (PHC) services in the project areas that target the urban poor and the needs of women and children. Amongst the targets is at least 30% of each major health care service (including Caesarian section) is accessed by the urban poor (red card holders). There are three main outputs: (i) strengthened institutional governance and local government capacity to deliver urban PHC services sustainably; (ii) improved accessibility, quality, and utilization of urban PHC services, with a focus on the poor, women, and children, through public–private partnership; and (iii) effective support for decentralized project management.

B. Generation of Data for Project Performance Monitoring and Evaluation

3. For the proposed additional financing, an independent research firm or institute will be contracted to conduct an endline household survey for the partnership agreement areas. The surveys are developed to generate data for tracking progress by the end of the project, to assess the impact of the interventions on health services, particularly on maternal and child health, as well as to evaluate project sustainability and replicability. For the household listing of the poor survey, an independent research firm or institute will independently verify identification of the poor and provide technical support to the partnership area nongovernment organizations (PANGOs) for better identification of the poor, regular updating of red card system on an annual basis, and closely aligning with partner implementing agencies. In addition, an independent third-party research firm or institute will be responsible for bi-annual Integrated Supervisory Instrument (ISI) on health service delivery and quality, services to the poor, as well as management and accounting practices.

4. For the household survey, a sample of ever-married women of reproductive age respond to questions in eight areas: (i) household characteristics; (ii) knowledge and utilization of urban PHC services; (iii) reproductive health and reproductive history; (iv) services during and after pregnancy; (v) immunization status of children; (vi) prevalence and treatment received for diarrhea and acute respiratory infection among under-5 children; (vii) nutritional status of children; and (viii) knowledge and awareness about HIV/AIDS and its prevention. Household surveys will

include data collection from an equal-sized sample population in non-project areas to evaluate the causal impact of the project. The implementation protocol for the household surveys will be standardized across partnership areas. For example, surveyors will return up to two additional times if the respondent is not available, which minimizes survey non-response, and these questionnaires will be cross-checked for quality and inconsistencies by a data processor. The Urban Primary Health Care Services Delivery Project endline survey will serve as the baseline for the proposed additional financing. As such, the project area targets and indicators in the design and monitoring framework will be updated from statistics generated from the project's endline survey. The endline survey will include a panel survey in which the sampling design followed that of the baseline survey conducted in 2012. This will ensure the comparability of the surveys in the comparison of trends and indicators between project and non-project, and in impact evaluation. Sampling design of the endline/baseline survey will also consider the new project areas to be included in the proposed additional financing, as well as to capture the slum and non-slum clusters to enable analysis of the poor living in slum areas. Detailed description of the sampling design is attached in the terms of reference of the PPME firm.

5. While household surveys will be managed by a survey firm, the survey to come up with a roster of poor households will be the responsibility of the partner service providers. The PMU will coordinate with partner institutions to agree on criteria to systematically and accurately identify the poor in the project area (Annex 14 on "Reaching the Urban Poor"). It is imperative that the definition of the poor across all partner service providers is the same across all partnership areas to guide issuance of red cards. The indicators may include living conditions, nature of employment, income, rental status, etc. The eligibility requirements for obtaining red cards should be made clear to households in all project areas. PANGOs should regularly update their poor mapping of households and have a consistent definition implemented across all PANGOs. The household listing of the poor survey should also be likewise consistent across all partnership areas. In this way, analyses on health outcomes by both red card status and poverty (calculated from the household survey) can also be cross-validated.

6. **Integrated Supervisory Instrument.** Routine and periodic surveys are carried out by an independent, third-party firm using the ISI, and are aimed at assessing the progress of performance of partner service providers in terms of service delivery and quality, services to the poor, as well as management and accounting practices. As the surveys are designed to be conducted every 6 months, they detect changes in performance and identify the areas that need improvement. The surveys are conducted by trained field investigators including medical and management professionals, who employ scoring procedures to evaluate the project office or headquarters, primary health care centers (PHCCs), comprehensive reproductive health care centers, and satellite clinics in partnership areas. The ISIs will be improved from previous phases by incorporating the updated care guidelines where applicable. Similarly, when creating the ISI performance index, it is equally important to include the same indicators across the different waves of data to make comparisons in trends over time, where applicable. A list of key indicators that are collected by the latest ISI is included in Table A7.1. Both health facility and ISI surveys should be implemented regularly during the same months over time to avoid inconsistencies from seasonal demands. The ISIs will also provide key variables toward the calculation of the performance incentive scheme (see Annex 9). ISI reports should be distributed to partnership area clinic managers to increase awareness of relative performance among other partnership areas and to recognize top-performing partnership areas as a non-monetary incentive to improve performance.

7. Aside from the surveys, field visits and review missions monitor the activities that generate data. For visits to PHCCs/comprehensive reproductive health care centers, a checklist is filled up

by the project implementation unit (PIU)/PMU and another type of checklist by members of the review mission.

C. Dissemination and Use

8. The proposed additional financing will integrate HMIS as a tool for compilation and dissemination of all health-related data. The current HMIS will be further developed to ensure compatibility with the Ministry of Health and Family Welfare's existing National Health Information System based on DHIS2 (District Health Information System) platform (refer to Annex 12 on Information Communication Technology to Support Urban Primary Health Care Services Delivery Project).

9. The results of PPME activities will serve several purposes. For example, during project coordination committee meetings, PMU progress review meetings, and core management team meetings, the information from the PPME and HMIS will be presented and discussed. Also, for funds to be replenished, a PIU officer needs to submit a monitoring report prepared by the senior monitoring and evaluation officer (SMEO) in a city corporation or the PPME officer (MEO) in a municipality.

10. As part of the capacity building exercise, it is expected that the three-model urban local bodies selected for direct management of the urban PHC shall table the PPME report during the steering/coordination meeting. The analysis shall compare the achievements or service data against basic population parameters such as estimated number of total pregnant women, new pregnant women, and births for the reporting period. This will assist in better understanding the market share of each sector/provider as well as monitor the logical consistency of reported data (e.g., number of antenatal care first visit reported by service providers against estimated new pregnant women for the reporting period).

D. Structures

11. At the PMU level, the senior monitoring and quality assurance officer and the management information system (MIS) and data management officer report directly to the deputy project director (DPD Technical) and DPD MIS, respectively, whose job descriptions are posted on the project website. At the PIU level, there is an SMEO in city corporations or MEO in municipalities, each with a senior monitoring and evaluation assistant who is fully-proficient in operating computers. In every project office, there is an MIS officer who oversees data entry in the HMIS system and the production of tables or graphs. City corporations with more than two partnership areas will have more than one MEO so that every SMEO/MEO will oversee at most two partnership areas. An MIS officer will be posted in the project office or headquarters of the implementing partner service providers/city corporations/municipalities. Data that is currently recorded in registers by service providers will be electronically compiled in the form of medical records by a designated health center staff using HMIS software on computers, which will upload to the HMIS server at PMU; ultimately bridging the medical information and communication technology gap.

E. Assuring Quality

12. The PMU will set up several mechanisms to ensure data quality. The DPD MIS at PMU will form three quality assurance teams to analyze the existing situation to promote not only the availability, accessibility, acceptability, and quality of center management and health services, but also to improve data accuracy. Data of doubtful quality will hardly be used. With this premise, the

project will institutionalize a quality assurance system with three major objectives: (i) to verify the quality of data reported in the HMIS; (ii) to assess the systems involved in information generation, analysis, sharing, and use; and (iii) to propose improvements in both the data and systems quality. The quality assurance system will have at least two subsystems: routine verification and tracking of data quality and actions taken (T-DQ/AT). Routine verification will be carried out on data uploaded to the HMIS platform on health status, delivery of health services, medicines, finance, or other management functions. For example, the staff in charge of registering mothers who attended antenatal care will check the accuracy of randomly selected entries. To signify that verification was done, they will sign beside the patient's serial number. Similar mechanisms for self-verification will be introduced such as counter signing entries by another staff member. The subsystem for T-DQ/AT will be integrated within the HMIS platform. It will monitor data quality in terms of seven domains: accuracy, completeness, timeliness, reliability, precision, credibility, and confidentiality. A system for tracking the quantity and quality of use of results will be built in the HMIS and other quality assurance mechanisms will be designed by the PMU and consultants (refer to Section G of this annex).

F. Promote Sharing and Use of Results

13. Defining information needs and generating them is one thing, whereas sharing and using them are another. In fact, high utilization of results and a streamlined process generating good quality data are synergistic. The more information is used, the higher will be the demand for it and the greater the motivation for timely, complete, and accurate processes for it to be generated. The proposed additional financing's HMIS will allow the user to directly produce simple cross-tabs of data, graphs, and summary tables. The results will be disseminated to priority users in the preferred media at the most strategic time for making decisions and/or taking actions. The electronic media will be the most accessible and up-to-date for most users and linked to the project website to enhance visibility.

Table A5.1: Key ISI Indicators List by Health Care Facility

Comprehensive Reproductive Health Care Center
Staff attendance/availability
Staff training (type and date)
Medical equipment (availability and functioning)
Essential drugs (availability at time of visit and 1 month after)
Reproductive health care (for general and red card holder patients)
-normal and Caesarean section deliveries (to add reasons for Caesarean section)
-antenatal care (1st and 4th visits, iron-folic acid supplementation)
-family planning counseling
-other services, such as ultrasonography - timing (gestational age) of antenatal ultrasound, permanent contraceptive methods (NVS, tubectomy), menstrual regulation, postnatal care (PNC within 2 days, Vitamin A supplementation within 42 days of delivery), etc.
Child health care (for general and red card holder patients)
-child immunizations
-diarrhea
-acute respiratory infection
-Vitamin A
VCT center
Eye care center
Verification of service record
Infection prevention and control
Waste management/disposal
Inventory Management

Manual check
Registers check
Method for handling complaints
Service recipients' rights charter
Exit interviews for patient satisfaction
Non-poor and poor patients served
Branding logo

Primary Health Care Center
Staff attendance/availability
Staff training (type and date)
Medical equipment (availability and functioning)
Essential drugs (availability at time of visit and 1 month after)
Reproductive health care (for general and red card holder patients)
-antenatal care (1st and 4th visits, iron-folic acid supplementation)
-family planning counseling
-other services, such as ultrasonography - timing (gestational age) of antenatal ultrasound, permanent contraceptive methods (NVS, tubectomy), menstrual regulation, postnatal care (PNC within 2 days, Vitamin A supplementation within 42 days of delivery), etc.
Child health care (for general and red card holder patients)
-child immunizations
-diarrhea
-acute respiratory infection
-Vitamin A
Adolescent health
VCT center
Eye care center
Verification of service record
Prescription assessment
Patient/child management
Violence against women
Infection prevention and control
Waste management/disposal
Inventory Management
Manual check
Registers check
Method for handling complaints
Service recipients' rights charter
Community participation/management
Referral linkages
Satellite clinics
Exit interviews for patient satisfaction
Non-poor and poor patients served
BBC materials
User forum
Branding logo

Partnership Area Headquarter
Work/action plan
Staff attendance/availability
Staff training (type and date)
Accounting practices

Budget and expenditure
Services received by poor by type of service
Updated poor list
Branding logo

Satellite Clinics
Staff attendance/availability
Staff training (type and date)
Medical equipment (availability and functioning)
Essential drugs (availability)
Client coverage (antenatal care, postnatal care, family planning, child health)
Income
Service promotion
Branding logo
Updated pregnancy list
Verification of service record

Source: Asian Development Bank.

G. Data Analysis and Electronic Health Management Information System/Patient Management System

14. The proposed additional financing will revise the HMIS and MIS reporting format to improve data analysis and to incorporate the requirement of urban HMIS. Improvement in data analysis will necessitate comparing service contact data against the estimated demographic parameters. The quarterly service contact data will be compared against the estimated demographic parameters to determine market share and logical consistency. In addition, the proposed additional financing will computerize the current patient registration system (patient registers), as well as patient management system. In the computerization system, each patient will be assigned a unique number which will be used for all services received at a facility. It is therefore envisaged that the electronic patient management system will be designed to generate several service indicators to be used to monitor the quality of services as well as the progress of related project indicators at facility level (Table A5.2).

15. To analyze the annual performance in terms of coverage and rates at target population level, denominators based on population census are estimated (Table A5.3).

16. The project will also report to the government regularly as stipulated based on the requirement of the Urban Health Management Information System. The existing reporting format is based on aggregated data (Table A5.4).

H. Indicators for Quality of Services to be Generated from the Electronic Patient Management System (Facility Level)

17. Table A5.2 outlined several examples of indicator that could be generated from the electronic patient registration and management system, including the proposed numerator and denominator based on the current recording system.

Table A5.2: Definition of Indicators for Quality of Services (to be generated from electronic patient management system)

	Indicator	Numerator	Denominator
	Maternal and Newborn Care		

	Indicator	Numerator	Denominator
1	Percentage of women receiving care at project facility who had at least four ANC visits	Number of women received ANC four or more times who have also delivered or expected to deliver (based on EDD)* in a given period. *Use EDD if the delivery status of the women is unknown	Total number of women who have delivered or expected to deliver in the same period.
2	Mean ANC visits among women receiving care at project facility	Total number of ANC visits among women who have delivered or expected to deliver (based on EDD)* in a given period. *Use EDD if the delivery status of the women is unknown	Total number of women who have delivered or expected to deliver in the same period.
3	Percentage of women ever received ANC at project facility who did not deliver at the project facility	Number of women received ANC at project facility who did not deliver at the project facility	Total number of women who have delivered (based on EDD) that ever received ANC at project facility in a given time period.
4	Percentage of women and newborn receiving care at project facilities who had PNC within 48 hours of delivery	Number of women who had received antenatal care and who have delivered at the project facility or elsewhere* in a given period that received PNC within 48 hours of delivery. *Women delivered at non-project facility are included because the partner service provider is responsible for BCC and educating the women on PNC during their ANC visit.	The number of women who had received antenatal care and who have delivered at the project facility or elsewhere* in a given period that received PNC. *Women delivered at non-project facility are included because the partner service provider is responsible for BCC and educating the women on PNC during their ANC visit.
5	Mean PNC visits among women receiving care at project facility	Total number of PNC visits in each period.	Total number of women receiving PNC in the same period.
6	Percentage of births by caesarean section among all births conducted at the project facility	Total number of births by caesarean section conducted at the project facility in each period.	Total number of births (all types) conducted at the project facility in the same period.
7	Reasons for caesarean section	Number of caesarean section by category* (of reasons). *to refer to the categorization used by the latest BDHS.	Total number of caesarean section
	Child Health Care		
8	Percentage of under-5 children receiving care at project facility who received growth monitoring	Number of under-5 children receiving care at project facility who received growth monitoring in a given period.	Total number of under-5 children receiving care at project facility (all type of services) in the same period.
	Others		
9	Market share - percentage of men at the catchment area who received diagnostic service from project facility (to estimate screening for NCD)	Number of men who received diagnostic service from project facility in a given period	Total number of estimated men aged 20 and above in the catchment area

Source: Asian Development Bank.

I. Annual Performance Monitoring (Coverage and Rates) at Target Population Level

18. Table A7.3 presents the approach in estimating the denominators for selected indicators for population level. This is a sample annual performance monitoring matrix for an area of 1,000 population. All denominators need to be multiplied by thousands (‘000) based on the catchment population of partnership agreement area.

19. Targets should be realistic considering possible coverage of project clinics in the whole catchment population. Remember, there are other possible sources of services available in the same area including public and private hospitals/clinics.

20. There is a need to introduce computerized patient registration system to avoid duplication of counts of service recipients (numerator) prevailing in existing system of counting service contacts.

Table A5.3: Estimating Denominator at Population Level for Annual Performance Monitoring (Annual Target)

ESD Services and Indicators	Parameter and Data Source for Estimating Denominator (catchment population)	Equation for Estimating Denominator	Denominator	Numerator	Annual Target
	Total population		1,000		
	All women age 15-49, 26.6% of total population, Census 2011	1,000*0.266	266		
Family planning % of currently married women received modern contraceptive methods from UPHCSDP clinics % of currently married women received LARC from UPHCSDP clinics	Currently married women age 15-49, 80% of women age 15-49, BDHS 2014	266*0.80	213	Number of Currently married women age 15-49 received modern contraceptive methods Number of Currently married women age 15-49 received LARC	
	Currently pregnant, 4.4%, BDHS 2014 urban	266*0.044	12		
Antenatal care % of women received at least 4 ANC	Pregnancy in a year, Births*1.14, 14% pregnancy loss, ICDDR, BHDS 2011	21*1.14	24	Number of women having at least 4 ANC visits	
Delivery % of delivery in UPHCSDP clinics % of NVD % of C-section	Live birth in a year, CBR 20.8/1,000 population, BDHS 2014 urban	1,000*0.0208	21	Total number of delivery Number of NVD Number of C-section	

ESD Services and Indicators	Parameter and Data Source for Estimating Denominator (catchment population)	Equation for Estimating Denominator	Denominator	Numerator	Annual Target
Postnatal care % of mothers received PNC at UPHCSDP clinics within 2 days of birth	Live birth in a year, CBR 20.8/1,000 population, BDHS 2014 urban	1,000*0.0208	21	Number of PNC within 2 days of birth	
Immunization % received MR vaccine	Children age 12-23 months, # of U-5 children * 0.21, 21% of U-5, BDHS 2014 urban	99*0.21	21	Number of children received MR vaccine	
Nutrition % of pregnant women received IFA % of children received vitamin A supplementation % of children received de-warming	Pregnancy in a year, Births*1.14, 14% pregnancy loss, ICDDR,B HDS 2011 Children age 6-59 months, # of U-5 children * 0.91, 91% of U-5, BDHS 2014 urban	21*1.14 99*0.91	24 90	Number of pregnant women received IFA Number children age 6-59 months received vitamin A capsule Number children age 6-59 months received vitamin A capsule	
Child health % of U-5 children under growth monitoring % of U-5 diarrhea cases treated % of U-5 ARI cases treated	Children under 5, Births*(1-U5MR/1,000) Diarrhea incidence among U-5, 5.7% of U-5 in last 2 wks., BDHS 2014 urban ARI incidence among U-5, 4.3% of U-5 in last 2 wks., BDHS 2014 urban	21*5*(1-0.053) 99*0.057 99*0.043	99 6 4	Number of U-5 children under growth monitoring Number of U-5 children treated for diarrhea in last 2 wks. Number of U-5 children treated for ARI in last 2 wks.	
Adolescent health % of adolescent girl received health and FP services % of adolescent boy received health and FP services	Adolescent age 10-19, 20.5% of total population, Census 2011	1,000*0.205	205	Number of girl age 10-19 received health care Number of boy age 10-19 received health care	
Non-communicable diseases	Adult age 35+, 29.5% of total population, Census 2011	1,000*0.295	295	Number of adult age 35+	

ESD Services and Indicators	Parameter and Data Source for Estimating Denominator (catchment population)	Equation for Estimating Denominator	Denominator	Numerator	Annual Target
% of adults received services for NCD				consulted for diabetes Number of adult age 35+ consulted for hypertension	

Source: Asian Development Bank.

J. Urban Health Management Information System Reporting Requirement

21. Table below is the required data elements for UHMIS reporting.

Table A5.4: Urban Health Management Information System Reporting

UHMIS data element	
Maternal Health [34 elements]	# new pregnant
	# total pregnant
	TT-1 vaccination
	TT-2 vaccination
	TT-3 vaccination
	TT-4 vaccination
	TT-5 vaccination
	ANC-1 + Registration
	ANC-2
	ANC-3
	ANC-4+
	EOC normal delivery
	EOC caesarean delivery
	EOC forceps/vacuum extraction
	PNC-1
	PNC-2
	PNC-3+
	# Misoprostol tab given
	# pregnant received Misoprostol
	# normal deliveries with Misoprostol
	# Iron Folic tablet for PNC
	# women received iron folic tablet PNC
	Vit A supplement within 42 days of delivery
	EOC maternal death
	Total live births
	Still births
	Maternal anemia
	Maternal malnutrition – acute
	Maternal malnutrition – chronic
	# cases referred (out) to others
	# cases referred (in) treated
	# active management 3rd stage labor
	# cases treated
	# post-abortion care
Child Health [26 elements]	IMCI very severe disease
	IMCI Pneumonia
	IMCI Cough & Cold – no pneumonia
	IMCI Diarrhea
	IMCI fever – malaria

UHMIS data element	
	IMCI fever – no malaria
	IMCI measles
	IMCI ear problem
	IMCI other Diseases
	IMCI children Vitamin A (not EPI)
	IMCI children de-worming tablet (not EPI)
	IMCI anemia – mild
	IMCI anemia – moderate
	IMCI anemia – severe
	IMCI low birth weight – mild
	IMCI low birth weight – moderate
	IMCI low birth weight – severe
	IMCI malnutrition (acute) – mild
	IMCI malnutrition (acute) – moderate
	IMCI malnutrition (acute) – severe
	IMCI malnutrition (chronic) – mild
	IMCI malnutrition (chronic) – moderate
	IMCI malnutrition (chronic) – severe
	IMCI # children referred (in) treated
	IMCI # children referred (out) to others
	IMCI Child Death
Disease Profile [**17**/64 elements]	Diphtheria
	Measles
	Mumps
	Night blindness
	Poliomyelitis
	Rubella
	Tetanus
	Whooping cough
	Bronchial asthma
	Bronchiolitis
	Congestive heart failure
	Dengue
	Diabetes Mellitus
	Diarrhea
	Hepatitis
	Hypertension
	Malaria

Source: Asian Development Bank.

ANNEX 6
EQUIPMENT LIST

1. The following equipment will be supplied by the project for new comprehensive reproductive health care centers (CRHCCs). For existing CRHCCs, the project will replace according to need.

Table A6.1: Equipment to be Supplied/Replaced by the Project for all CRHCCs

Sl.No	Name of the Equipment & Instrument	Equipment & Instrument supply for new CRHCC (new PA)	Replacement for Equipment & Instrument supply for existing CRHCC as per need
1	Ultrasonogram	√	√
2	ECG Machine	√	√
3	Baby Warmer	√	√
4	Fetal Doppler (Color)	√	√
5	Fetal Care Monitor	√	√
6	Ventous Extractor	√	√
7	Diathermy Machine	√	√
8	Wrigley's Forceps	√	√
9	Pulse-Oxy meter for OT	√	√
10	BP machine	√	√
11	Stethoscope	√	√
12	Pediatric Stethoscope	√	√
13	Phototherapy machine	√	√
14	Oxygen cylinder with flow meter	√	√
15	Baby sucker	√	√
16	Sucker	√	√
17	Big Instrument trolley	√	√
18	OT Table	√	√
19	Labor Table	√	√
20	Generator (20 KVA)	√	√
21	OT Light (12 Bulb)	√	√
22	Autoclave (UNFPA)	√	√
23	Air Conditioner (for OT& Labor room)	√	√
24	Incinerator	√	√
25	Fire Extinguisher	√	√
26	Rechargeable light	√	√
27	Sterilizer, boiling type	√	√
28	Ambu resuscitator	√	√
29	Mayo trolley	√	√
30	Thermometer	√	√
31	Thermometer: Jar	√	√
32	Lifter jar	√	√
33	Lifter	√	√
34	Surgical Drum: big	√	√
35	Surgical Drum: Medium	√	√
36	Surgical Drum: small	√	√
37	Flat Tray with lid: big	√	√
38	Flat Tray with lid: medium	√	√
39	Saline Stand	√	√
40	Single Spot Light	√	√
41	Baby Weighing machine	√	√
42	Bowl sponge	√	√
43	Bowl utility	√	√
44	Bowl stand (double)	√	√
45	Bed pan	√	√

Sl.No	Name of the Equipment & Instrument	Equipment & Instrument supply for new CRHCC (new PA)	Replacement for Equipment & Instrument supply for existing CRHCC as per need
46	Ice beg	√	√
47	Gloves surgical	√	√
48	Gloves disposable	√	√
49	Gloves utility	√	√
50	Syringe disposable, 5cc, 2cc	√	√
54	Plastic bucket without lid (15-20 liters)	√	√
55	Plastic bucket with lid (15-20 liters)	√	√
56	Plastic bowl (medium for ins. cleaning)	√	√
57	Plastic rack (for drying instruments)	√	√
58	Plastic Waste Receptacle	√	√
59	Timer, 60 minutes with buzzer	√	√
60	Spoon (plastic/melamine)	√	√
61	Cup for measuring bleaching powder	√	√
62	Wooden stirrer	√	√
63	Incinerator	√	√
64	Brush nylon	√	√
65	MUAC tape	√	√
66	Measuring tape	√	√
67	Gauge; as required	√	√
68	Cotton: as required	√	√
69	Adhesive plaster: as required	√	√
76	Gloves surgical: size 6.5, 7:	√	√
77	Disposable polyethene gloves:	√	√
78	Bag of hot water and Ice combination	√	√
82	Ryles tube Tourniquet	√	√
83	Tourniquet as required	√	√
84	Catheter, Urethral, Foley's as required	√	√
85	Plain Cather as required	√	√
86	Metallic Catheter as required	√	√
87	Uro bag: as required	√	√
88	Butterfly needle: as required	√	√
89	IN Cannula: as required	√	√
90	Hospital Bed	√	√
91	Bed Side Locker	√	√
92	Baby Cot	√	√
93	Wheel Chair	√	√
94	Pat. Trolley	√	√
95	Linen Trolley	√	√

Source: Asian Development Bank.

2. The following equipment will be supplied/ replaced by the project fund for all new primary health care centers (PHCCs) and need based for existing PHCCs.

Table A6.2: Equipment to be supplied/ replaced by the project for all PHCCs

Sl. No	Item	Equipment & Instrument supply for new PHCC (new PA)	Replacement Equipment & Instrument supply for existing PHCC as per need
1	Height and Weight machine	√	√
2	Baby weighing machine (Salter Type)	√	√
3	Weighing machine (Bathroom scale for MC)	√	√
4	Length Board	√	√
5	Baby weighing machine (Salter Type)	√	√

Sl. No	Item	Equipment & Instrument supply for new PHCC (new PA)	Replacement Equipment & Instrument supply for existing PHCC as per need
6	BP instruments for static and MC	√	√
7	Stethoscope for static and MC	√	√
8	Sucker Machine	√	√
9	Oxygen cylinder with flow meter	√	√
10	Spotlight	√	√
11	X-Ray view box	√	√
12	Diagnostic set	√	√
13	Autoclave (electric)	√	√
14	Sterilizer- boiling type	√	√
15	IUD insertion table	√	√
16	Physical Examination table	√	√
17	Foot step	√	√
18	Myo Trolley	√	√
19	Instrument Trolley	√	√
20	Ambu resuscitation bag with mask	√	√
22	Rechargeable light	√	√
23	Fire Extinguisher	√	√
24	Utility gloves	√	√
25	Mackintosh/Rubber gown	√	√
26	Plastic Bucket without lid (15-20 liters)	√	√
27	Plastic Bucket with lid (15-20 liters)	√	√
28	Plastic bowl (medium for ins. cleaning)	√	√
29	Plastic rack (for drying instruments)	√	√
30	Plastic Waste Receptacle	√	√
31	Timer, 60 minutes with buzzer	√	√
32	Spoon (plastic/melamine)	√	√
33	Cup for measuring bleaching powder	√	√
34	Wooden stirrer	√	√
35	Incinerator	√	√
36	Jar Thermometer	√	√
37	Thermometer	√	√
38	Tongue Depressor(metallic)	√	√
39	Mouth gage	√	√
40	Drum surgical (big)	√	√
41	Drum surgical (medium)	√	√
42	Drum surgical; small	√	√
43	Cuscos speculum- big size for RTI screening	√	√
44	Cuscos speculum- medium size for RTI screening	√	√
45	Sponge holding forceps for RTI screening	√	√
47	Scissors for stitch removing	√	√
48	Artery forceps -straight medium	√	√
49	Artery forceps -curved medium,	√	√
50	Artery forceps -straight small	√	√
51	Artery forceps - curved small	√	√
52	Volsellum forceps/Tenaculum	√	√
53	Artery forceps -long	√	√
54	Scissor uterine curved	√	√
55	Plain scissors for cutting threads	√	√
56	Cuscos speculum for IUD insertion	√	√

Sl. No	Item	Equipment & Instrument supply for new PHCC (new PA)	Replacement Equipment & Instrument supply for existing PHCC as per need
57	Mosquito forceps- curved and straight	√	√
58	Knife handle surgical for minor surgery	√	√
59	Norplant insertion Trocher and canula	√	√
60	Norplant removal forceps	√	√
61	Bowel stand (double)	√	√
62	Bowel sponge	√	√
63	Bowel utility: Plastic	√	√
64	ARI Timer	√	√
65	Speculum nasal- child size	√	√
66	Speculum nasal- adult size	√	√
67	Kidney tray/ Basin kidney	√	√
68	Gullipot	√	√
69	Lifter Jar	√	√
70	Lifter forceps	√	√
71	Deep tray with lid	√	√
72	Tray with lid: medium size	√	√
73	Tray with lid: Big size	√	√
74	Macintosh/rubber gown (as required)	√	√
75	MUAC tape	√	√
76	Measuring tape	√	√
84	Gloves surgical: size 6.5, 7 (as required)	√	√
85	Disposable polythine gloves (as required)	√	√
86	Bag of hot water and Ice combination	√	√
87	Pelvic Model	√	√
88	Penile model	√	√
89	TUNSV demonstration model	√	√
90	Aeroscope	√	√

Source: Asian Development Bank.

3. The following equipment of caesarean section set will be supplied/replaced for all new CRHCC and for existing CRHCC as per need:

Table A6.3: Caesarean Section Set to be Supplied/ replaced by the project for all CRHCCs

No.	Item	Equipment & Instrument supply for new CRHCC (new PA)	Replacement of equipment & instrument for existing CRHCC as per need
1	Towel clip	√	√
2	BP handle	√	√
3	BP blade	√	√
4	Mosquito curved	√	√
5	Mosquito straight	√	√
6	Tissue forceps- medium	√	√
7	Tissue forceps- small	√	√
8	Artery-curved medium sized	√	√
9	Sponge holding	√	√
10	Doyens retractor	√	√
11	Fine scissors- medium size	√	√
12	Rough Scissors- medium size	√	√
13	Needle holder- medium size	√	√
14	Needle holder- large size	√	√
15	Dissecting forceps-Toothed- medium size	√	√
16	Flat Tray with lid	√	√
17	Surgical drum- 16"	√	√
18	Surgical drum- 12"	√	√
19	Surgical drum- 9"	√	√
20	Stainless steel bowl	√	√
21	Stainless steel bucket	√	√
22	Gully pot	√	√
23	Toothed dissecting forceps	√	√
24	Gloves	√	√
25	Disposable syringe: 5cc	√	√
26	Chromic catgut 0	√	√
27	Chromic catgut 1	√	√
28	Dexon	√	√
29	Needle curved, cutting assorted, 1 pk	√	√
30	Needle, curved, round body, assorted 1 pk	√	√
31	Gown	√	√
32	Mask	√	√
33	Cap	√	√
34	Gouge (as required)	√	√
35	Cotton (as required)	√	√
36	Plain catheter	√	√
37	Adhesive tape (as required)	√	√

Source: Asian Development Bank.

4. The following equipment of **D&C Set** will be supplied by the project for all new CRHCC and replaced for existing CRHCC as per need.

Table A6.4: D&C Set to be supplied/replaced for all CRHCCs

No.	Item	Equipment & Instrument supply for new CRHCC (new PA)	Equipment & Instrument to be replaced for existing CRHCC as per need
1	Towel clip	√	√
2	Gully pot	√	√
3	Sponge holding forceps	√	√
4	Hagars Dilator-one set	√	√
5	Currate - sharp and blunt	√	√
6	Ovum forceps	√	√
7	Metallic catheter	√	√

Source: Asian Development Bank.

5. The following equipment of **Normal Delivery Set** will be supplied/ replaced by the project for all new CRHCC and for existing CRHCC as per need:

Table A6.5: Normal Delivery Set to be supplied/ replaced for all new and existing CRHCC

No.	Item	Equipment & Instrument supply for new CRHCC (new PA)	Equipment & Instrument to be replaced for existing CRHCC as per need
1	Sponge holding forceps	√	√
2	Needle holder- medium size	√	√
3	Episiotomy scissors	√	√
4	Plain scissors	√	√
5	Artery- straight -medium size	√	√
6	Kochers forceps	√	√
7	Sims Vaginal speculum	√	√
8	Stainless steel bucket	√	√
9	Stainless steel bowl	√	√
10	Gully pot	√	√
11	Toothed dissecting forceps,	√	√
12	Gloves	√	√
13	Disposable syringe: 5cc	√	√
14	Chromic catgut 0	√	√
15	Needle curved, cutting assorted, 1 pk	√	√
16	Needle, curved, round body, assorted 1pk	√	√

Source: Asian Development Bank.

ANNEX 7
INDICATIVE HUMAN RESOURCE DEVELOPMENT PLAN

1. A training coordination cell will be maintained under the project management unit (PMU), consisting of core PMU staff under a deputy project director, and supported by consultants. The unit will review, in detail, training requirements, partnership opportunities, and collaboration with other agencies/training institutes, and update and implement the human resource development (HRD) plan for the proposed additional financing of Urban Primary Health Care Services Delivery Project, with full participation of the Local Government Division (LGD), urban local bodies (ULBs), partner service providers, and other stakeholders. With support from consultants, the unit will identify the capacity development and training needs of ULBs to enable them to continue/sustain the delivery of primary health care (PHC) services through partnership agreements with nongovernment organizations (NGOs). The unit will also develop appropriate training modules for ULBs' health department staff and develop appropriate training guidelines for implementation of the training program. It will also explore the possibility of establishing long-term relationships with local or international training institutions (e.g., through memoranda of understanding) to deliver specific capacity development services.

2. The project's HRD plan will address knowledge and skills of project stakeholders in the following general areas (see table below for the indicative HRD plan):

(i) Management skills for officers and staff of LGD, PMU, project implementation units, city corporation and municipality health departments, partnership area nongovernment organizations (PANGOs), comprehensive reproductive health care centers, PHC centers, and communities to be able to plan and manage PHC service delivery (including environmental safeguard issues, drugs stock management, staff retention issues, etc.).
(ii) Clinical skills of all medical staff[1] (doctors and paramedics) to be able to update new practice (e.g., Kangaroo Mother Care, nutrition mainstreaming, long-term family planning, integrated and comprehensive quality care [Essential Services Delivery+] through continuing education and short-term refresher training).
(iii) Skills in health management information system (HMIS) and basic information technology skills at all levels to enable the project to expand its reach and equip staff in the effective operation and maintenance of the integrated HMIS.

3. An indicative HRD plan is given below which will be reviewed in detail and updated at the early stage of project implementation. Target groups of the HRD plan will include managerial and clinical staff of the PMU/project implementation units, LGD/ULBs, and PANGOs. Most of the training will be in-country. External training will be limited to selected study areas such as (i) study tours on urban PHC (e.g., healthy cities) for LGD and ULB leaders; and (ii) specific management-related subjects. Management training will consist of integrated planning and budgeting for basic services, contract management of public–private partnerships, HMIS, and core project management skills (procurement, project accounting and disbursement, and finance).

[1] It is assumed that all medical staff to be hired by PANGOs will have the necessary qualifications and experience in PHC and limited curative care provision.

Table A7.1: Indicative HRD Plan

Training Program	Target Group	Programs/ Courses	Program Length and Timing	Means of Implementation	Number of Participants	Implementing Unit
Output 1: Institutional governance and local government capacity to deliver urban PHC services sustainably strengthened						
Project orientation and management training	Mayors of CCs/municipalities, PMU and PIU project managers	Training on project orientation and management. municipality;	1 days Year 1-2 I session in each ULB	Consultant team/experts, training proving firms	Total = 65 3x21Mayors/CEO/ CHO /HO, 2 PMU	PMU/PIU
Study visit on urban PHC delivery system	LGD, CCHD/MHD, PMU, PIU, PA NGO	Study visits on community based Urban PHC services delivery system in the region	7 days 2 batch	External training management institutes	Total= 30 LGD/ULB/PIU (Mayors/CEOs/ CHO/HO), PMU-4, PA NGO	PMU
Health care management	LGD/ULBs/ PMU/PIU/ PANGO	External training on Health management	7 days	External training management institutes	20 officials of LGD/ULBs/PMU/PIU/PA NGO	PMU
Leadership management training	LGD/ULBs/ PMU/PIU/ PANGOs	External training on leadership management training	7 days 2 batch	External training management institutes	30 officials of LGD/ULBs/PMU/PIU/PA NGO	PMU
Financial management, planning and projection	LGD/ULBs/ PMU/PIU/ PANGOs	Financial management, planning and projection training in the region	7 Days	External training management institutes	14 officials of LGD/ULBs/PMU/PIU/PA NGO	PMU
Monitoring and Evaluation	LGD/ULBs/ PMU/PIU/ PANGOs	Monitoring and Evaluation training in the region	10 Days	External training management institutes	14 officials of LGD/ULBs/PMU/PIU/PA NGO	PMU
Solid and Clinical waste management	LGD/ULBs/ PMU/PIU/ PANGOs	Overseas training on Solid and Clinical waste management in the region	7 Days	External training management institutes	14 officials of LGD/ULBs/PMU/PIU/PA NGO	PMU
Computer based project management	LGD/ULBs/ PMU/PIU/ PANGOs	Computer based project management (MIS) training	10 Days	External training management institutes	20 officials of LGD/ULBs/PMU/PIU/PA NGO (MIS officers)	PMU
Training on clinical management with focus on quality of services	LGD/ULBs/ PMU/PIU/ PANGOs	Training on clinical management with focus on quality of services	7 Days	External training management institutes	16 officials of LGD/ULBs/PMU/PIU/PA NGO	PMU
Human resource management	LGD/ULBs/ PMU/PIU/ PANGOs	Training on Human resource management for PHC services Delivery	7 Days	External training management institutes	10 officials of LGD/ULBs/PMU/PIU/PA NGO	PMU
Study visit on medical IT related to Urban PHC	LGD/ULBs/ PMU/PIU/	Study visit on medical IT related to Urban PHC	7 Days	External training management institutes	10 officials of LGD/ULBs/PMU/PIU/PA NGO	PMU
Participation in related workshop/ conference/ seminar	TBD	TBD	TBD	PMU	TBD	PMU
Training on Operation and Maintenance (O&M)	LGD/ULBs/ PMU/PIU/ PANGOs	Training courses on: (i) Training on Building Maintenance Guidelines (BMG) developed for HCC (building);	5 days	Credible training provider institution	100 officials/ personnel	PMU

Training Program	Target Group	Programs/ Courses	Program Length and Timing	Means of Implementation	Number of Participants	Implementing Unit
		(ii) Operation and routine maintenance training on Generator and other electric devices; (iii) Operation and routine maintenance training on Solar System (iv) Operation and routine maintenance training on Water supply; (v) Operation and routine maintenance training on Sanitary works; (vi) Training on Waste management system and other O&M training as applicable.				
Output 2: Accessibility, quality, and utilization of urban PHC services improved with a focus on the poor, women and children, through public-private partnership						
Inception Workshop – Project Interventions	LGD, ULBs, PMU, PIUs, heads of PA-NGOs and others	Inception and Orientation workshop on project interventions	1 day; Years 1 and 2	National level, to be provided by consultants/ Training firms	Total = 300 LGD – 4; ULB –21 Mayors, 21 CEOs, 21 PIU PM, 10 PMU, 45 PA NGO PM, 180 CM	PMU
Essential service delivery (ESD+) package, referral, QA	PMU, PIU and PANGOs	Training on ESD+ package, referral and QA	2 days in Years 1-5	Training to be provided by related training organization	Total = 250 21PIU CHO/HO, 8 PMU, PA NGO–45 PM, 180 CM	PMU/PIU
ESD+ training, clinical	Doctors, paramedics of all PA NGOs	Training on ESD + clinical	5 days Year 1	Medical training providers (medical colleges/institutes etc.)	Total-270 2 Medical staffs x 45 CRHCCs; 2 x 180 PHCC	PMU/PIU/
Effective pro-poor targeting	PIU, PA NGO officials, Outreach workers and service providers;	Training on Effective pro poor targeting and distribution of red cards	2 days; years 1-2	PMU consultants, training providing firms	450 participants 10 staff of CRHCC/PHCCs/ Satellites x 45 PAs;	PMU/PIU
Medical IT technology, IT-based training	Physician, Paramedic, Outreach workers staffs;	Training on implementing IT technology in the project	7 days, years 1-2	IT/ computer based training institutes	360 participants 2 x 180 CRHCC/PHCCs/ Satellites	PMU

Training Program	Target Group	Programs/ Courses	Program Length and Timing	Means of Implementation	Number of Participants	Implementing Unit
Community engagement (Orientation) workshop	LGD, ULB officers; PMU, ward counselors, WCC members, CRHCC /PHCC field supervisors and outreach workers	Community engagement and orientation workshop on PHC service delivery	1 day, Years 1-5	Related training providing firms	Total = 1200; LGD, ULB, PMU, PA NGO staffs, Ward Counselors /Ward committee members and community volunteers	PMU/PIU
Outreach and community participation in PHC services (targeting)	PMU/PIU, ULB officers; PA NGOs, CRHCCs/ PHCCs	Training on Issuance of red cards; information and dissemination of ESD+	1-day workshop Year 1-3	Training providing organization	Total = 600 LGD, ULB, PMU, PA NGO staffs, Ward Counselors /WCC members and community volunteers	PMU/PIU/ PA NGOs
Referral system and linkages	PIU; PA NGOs, CRHCCs/ PHCCs	Training on developing referral system and linkages	2 days	Training providing organizations	Total =500 21 PIU, 2 x 45 PA NGO staffs, 2 x 200 CRHCC/PHCC	PMU
New born and Child health care training	CRHCC/ PHCC doctor, paramedic and nurses	Clinical training on new born and child health care	5 days; Years 1-5	Medical institutes, training provider organization	Total = 600 6 doctor, paramedic and nurses of CRHCC/ PHCC x 45 PAs	PMU
BCC/Counseling training on FP, RH, Nutrition, VAW	CRHCC/ PHCC medical staff, outreach workers, and service providers	Counseling training on FP, RH, Nutrition, VAW	3 days, Years 1-5	Experts, training providers	Total = 550 180 Counselors CRHCC/PHCC, 2 Health workers of satellites clinics	PMU/PIU
Adolescent Friendly Services	PIU/PA NGO officials and staffs	Training on Adolescent health friendly services	3 days 4 Batch	Training proving firm	300 participants PA NGO Counselor / outreach workers	PMU/PIU
Counseling and Training	PA NGO staffs	Training on Basic voluntary and clinical Counseling	4 days 12 batch	BCCM firm/ BCC training proving firm	600 participants 180 x PA NGO CRHCC/PHCC counselors, field supervisors, service promoters and FWA	PMU/PIU
RTI/STI	PMU/PIU/PA NGO physicians and paramedics	Training on Updated Management of RTI/STI	3 Days	OGSB/other training provider organization	400 participants PA NGO Physicians /paramedics	PMU/PIU
Infection prevention	PMU/PIU/PA NGO physicians and paramedics	Training on management of Infection prevention	12 Days	OGSB/other training provider organization	400 participants PA NGO Physicians /paramedics	PMU/PIU
Management of Childhood Illness	PMU/PIU/ PA NGO physicians and paramedics	Training on Integrated management of childhood illness	10 Days	Training provider organization	400 participants PA NGO Physicians /paramedics/ counselors	PMU
PAC & Septic Abortion	CRHCC Physicians and Nurses of PA NGOs	Training on PAC & Septic Abortion	5 Days	OGSB/other training provider organization	200 participants Physicians and Nurses of PA NGOs CRHCC	PMU
Rational Drug Use	PMU/PIU officials, PA NGO physician and paramedics	Training on rational use of drugs	5 Days	Training provider organization	200 participants	PMU/PIU
Nutritional Deficiencies in Children	PMU/PIU officials, PA NGO physician,	Training on Nutritional Deficiencies in Children	5 Days	Training provider organization	500 participants	PMU/PIU

Training Program	Target Group	Programs/ Courses	Program Length and Timing	Means of Implementation	Number of Participants	Implementing Unit
	paramedics and counselors.					
Refresher training for Laboratory Technicians	PA NGO laboratory technicians	Refresher training, dengue screening, blood transfusion	5 Days	Training provider organization	200 participants 1x all PA NGO Lab. Technician in CRHCC/PHCC	PMU/PIU
Clinical Contraception	PA NGO Physicians/ Nurse	Training on clinical contraception with long acting methods	15 days	MFSTC	Total = 180 4x 45 CRHCC Physicians/ Nurses	PMU
Skill Building Training on Nutrition Service deliveries for the Outreach	ToT for the Master Trainers and Cascade Trainings for the outreach workers/Nutrition Service Providers whoever assigned to deliver the : Complementary feeding along with associated hygiene education MUAC screening for detection & referral of severe acute malnutrition	Tailor made (for urban context) Complementary feeding counseling; MUAC screening and detection of severe acute malnutrition	3 days TOT for the Master Trainers & Supervisors and 2 days cascade trainings for the service providers	TOT by the Identified credible Institution; Cascade Training by the Master Trainers.	As many as relevant	PMU
Skill Building Training on Nutrition Service Delivery for the Facility	TOT for the Master Trainers and Cascade Trainings for the facility workers/Nutrition Service Providers	Breastfeeding counseling (at ANC/PNC); In-patient Management of acute malnutrition; Counseling on Maternal, diet, rest, & supplementation	3 days TOT for the Master Trainers & Supervisors and 2 days cascade trainings for the service providers	Identified credible Institution; Cascade Training by the Master Trainers	As many as relevant	PMU
Skill Building Training on Nutrition Service Delivery support Supervision, mentoring, monitoring, & reporting	Supervisors, Frontline managers	Nutrition Service Delivery support Supervision, mentoring, monitoring, & reporting	2 days	Training to take place in PIU level by the Identified credible Institution	As many as relevant	PIU
Newborn Care including Kangaroo Mother Care (KMC)	Doctors, Nurses and paramedics	Skill based training on comprehensive Newborn care package (CNCP)	5 days	Credible training provider institution	600 participants	PMU/ PIU
SBCC training for preparedness of newborn care.	Doctors, Nurses and paramedics	Training on SBCC for preparedness of birth & newborn care, newborn danger sign and care seeking	2 Days	Credible training provider institution	600 participants	PMU/PIU
Capacity building of primary healthcare workforce on NCD and disability	Doctors, Nurses and paramedics	NCD and disability prevention and management for ESP	5 days	Credible training provider institution	600 participants	PMU/ PIU

Training Program	Target Group	Programs/ Courses	Program Length and Timing	Means of Implementation	Number of Participants	Implementing Unit
prevention and management for ESP implementation, incl. mental health)						
Output 3: Effective Support for Decentralized Project Management Provided						
Project Management	Management staff of PMU, PIU and PA NGOs managers	Comprehensive training on project management	5 days; Years 1-5	BDPA/ training institutes and providers	Total = 300 8 PMU, 21 x PIU, PA NGOs- 2 staff x 45 CRHCCs -1 staff x180 PHCCs	PMU/PIU
Management Training/ Strategic Planning/ Budgeting	Management, finance, planning staff of LGD, ULBs, PMU, PA NGO	Training on management, strategic planning, health management, results-based management and budgeting	3 days; Years 1- 3	Management consulting firms or university	180 participants : 5 LGD, 4 staffs x 4 x 21 ULB, 2 staffs x 45 PA NGO,	PMU/PIU
Health financial Management	Management staff of PMU, PIU, PA NGOs;	Training on the financial management system, using the FMIS software	5 days, Years 1- to 3	Financial/IT specialist firm, financial training providers	Total = 160 6 PMU, 3 x 21 ULB/PIU 21PIU, 2x 45 PA NGO staffs (PM, finance)	PMU/PIU/PA NGO
IT and HMIS	PMU, PIU, PA NGO PM, MIS & Admin officers	Training on basic skill developing and management of HMIS system	7 days	IT /computer Management consulting firm/ other training providers	120 participants: 10 PMU; 21 PIU; 2 x 45 staff from PA NGOs	PMU/PIU
Skill building training on the Data System Management,	M&E and Program Managers	How to record, manage, track data through MIS, analyze data, synthesize information/dashboard and prepare reporting	2 Days	Training to take place in PIU level by the Identified credible Institution	As many as relevant	PIU
Orientation on the use of MIS/Data System	Senior Program Mangers both at the Government and NGO level	Enhancing understanding & technical capacity to use the data system-based information for corrective actions	1 day	Training to take place in PIU level by the Identified credible Institution	As many as relevant	PIU
FMIS Implementation	PMU, PIU, PA NGO finance and accounting officers	Essential knowledge, skills in FMIS	5 days	Management/IT consulting firm/, other training providers	200 participants: 10 staff from PMU; 3 x 21 staff from each PIU; 3 x 45 staff from PA NGOs	PMU/PIU
Monitoring and Evaluation	PMU, PIU, PA NGO officers	Essential knowledge and skill development training in project Monitoring and evaluation	5 days	Management firm/institution, related training providers	200 participants : 10 staff from PMU; 2 x 21 staff from each PIU; 3 x 45 staff from PA NGOs	PMU/ PIU
Project performance Tracking	PMU, PIU and PA NGO staffs	Monitoring and evaluation for routine PPME and ISIs	4 days year 1-5	MIS/PPME Specialist, PPME consulting firm	300 participants: 4 staff from PMU; 2 x 21 staff from each PIU; 4 x 45	PMU/PIU

Training Program	Target Group	Programs/ Courses	Program Length and Timing	Means of Implementation	Number of Participants	Implementing Unit
					staff from PA NGOs	
Project Financial Management Systems	PMU, PIU and PA NGO PM/F&A officers	Training on budgeting, disbursement, procurement, and project accounting and reporting	5 days; year	Financial training provider organization	250 participants: 10 staff from PMU; 2 x 21 staff from each PIU; 2 x 45 PPME staff from PA NGOs	PMU/PIU
Management training with health care management	PMU, PIU and PA NGO officials	Management training with special attention to health care management	5 Days	BIM	Total = 300 8 PMU, 2 staff x 21 CCs/ Municipalities /PIU 2 x 45PA NGOs, 1 clinic manager x 180 CRHCC/PHCC	PMU
Procurement management training	PMU/LGED /PIU procurement team	External training on procurement management	21 days	External national procurement training institutes	10 officials of each of PMU/LGED/PIU	PMU
Occupational health, safety and Environment Training	Construction staff of PMU and contractor; Operation and maintenance staff of Municipality /corporations	procedures. Implementation of environmental mitigation measures;	3 days Year 1 2 batch	Consultant team/experts, training proving firms	Total = 60 PMU/contractor/PIU/CHO /HO, PA NGO	PMU
Environmental monitoring (sampling, testing and documentation training	Environmental monitoring staff of PMU, PIU and Municipality /corporations	Sampling, testing, and use of environmental monitoring equipment, recordkeeping. Implementation of environmental mitigation measures	3 days Year 1 1 batch	Consultant team/experts, training proving firms	Total = 30 PMU/PIU/CHO /HO, PA NGO	PMU
Biomedical waste management: awareness training	Environmental monitoring staff of PMU, PIU and Municipality /corporations	Medical waste, ways of separation and safe management	3 days Year 1 1 batch	Consultant team/experts, training proving firms	Total = 30 PMU/PIU/CHO /HO, PA NGO	PMU
Clinical Waste Management	PMU/PIU and PA NGO officials	Training on Clinical Waste Management	3 Days 4 Batches	DGHS/PRISM/Other Provider Institutes	200 participants	PMU/PIU
Gender-related training						
Gender concepts and approaches in relation to UPHCSDP:	CC's/municipalities, PMU and PIU project managers, Counselors	Gender and MCHN, Nutrition, VAW, Family planning, Adolescents	3 full days in Year 1; 2 batches	Gender Specialist and a hired co-facilitator	25 selected persons including Gender Focal Persons (maximum 25 in one batch); 2 batches	PMU/PIU
UPHCSDP Project Management and Gender	Project Managers, Counselors	Gender issues in personnel, finance and program management; result based management	2 full days in Year 1; 2 batches	Gender Specialist and a hired co-facilitator	All managers (maximum 25 in one batch); 2 batches	PMU/PIU
UPHCSDP relevant gender tools	Project Managers, Counselors	Gender Action Plan, health and women's empowerment through BCC	2 full days in year 2	Gender Specialist and a hired co-facilitator	25 selected persons including Gender Focal Persons (maximum 25 in one batch; 2 batches	PMU/PIU

Training Program	Target Group	Programs/ Courses	Program Length and Timing	Means of Implementation	Number of Participants	Implementing Unit
Women's Rights and VAW	PMU/PIU/ PA NGO officials	Women's Human Rights and VAW	3 Days	Training provider organization on Gender	Total= 250 PMU-4, PIU-21, PA PM -45, Clinic managers-180	PMU

Source: Asian Development Bank.

ANNEX 8
OPERATIONS RESEARCH

A. Implementation

1. The project will provide financial resources to an academic research institution or private firm (henceforth called “research firm”) for management and administration of several operations research studies. The scope of the studies is not restricted but should include at least three to four studies. The project will continue the Urban Health and Demographic Surveillance System at the slums of Dhaka North, Dhaka South, and Gazipur City Corporations on registration of health and demographic events. This will enable comparison of changes over different time points. Some examples are provided below, including need-based cesarean section (C-section) and nutrition mainstreaming.

2. The operations research itself will also be funded by the project and conducted by experts in academic and research institutions and will be subjected to external peer review through a committee established to oversee scientific and ethical issues. The Operations Research Committee (ORC) will comprise of one representative from the following organizations: (i) Ministry of Health and Family Welfare, (ii) project management unit, (iii) Ministry of Women and Children Affairs, (iv) World Health Organization, (v) United Nations Children’s Fund (UNICEF), (vi) Planning Commission, and (vii) Bangladesh Medical Research Council. The committee will be responsible for ensuring that the research meets internationally recognized ethical standards for studies involving human subjects.

3. The project management unit will establish the ORC to review and select research proposals based on technical merit, including the (i) ease of implementation, (ii) cost of the intervention, (iii) track record of the research firm, (iv) methodological quality of the proposal; and (v) feasibility of the study including the likelihood of obtaining definitive results. All proposals will be reviewed by the committee and by experts in the particular field (to be selected by the committee). A standard format, devised by the committee, will be used by all interested researchers when they submit proposals. The proposals will be reviewed in a blinded manner, i.e., there will be no information presented to the committee at the time of review that identifies the author(s) or their institutions.

B. Terms of Reference (Indicative Topics)

1. Promoting Need-based Cesarean Section and Normal Deliveries

4. **Rationale.** Bangladesh is committed to improving the access to comprehensive emergency obstetric care including C-section. Service innovation is adopted whereby C-section is provided at the urban primary health care facilities (comprehensive reproductive health care centers), improving the access of the urban poor to this critical maternal service. In recent years, the rising C-section rate however is receiving closer attention, both globally and in the country. The risk associated with C-section is well-studied, in particular, the association of higher rate of complications found in subsequent pregnancies. As a result, the trend is to prevent primary C-section and to advocate for vaginal birth after C-section. Nevertheless, both strategies demand the ability of the health facilities to handle emergency C-section.

5. **Potential research scope.** The scope may focus on how to promote need-based C-section and normal vaginal delivery at health facilities. To inform policy formulation, a more comprehensive insight on C-sections will be required, including whether the intervention is user

or provider initiated. The survey should also include if the risk associated with C-section is well-communicated to the women.

6. **Methods.** A mixed method may be applied, including systematic randomized audit of medical records and individual surveys.

2. Nutrition Mainstreaming Initiative: Assessment on User and Provider Perspectives

7. **Rationale.** Nutrition mainstreaming is gaining importance and has been incorporated into the national health, nutrition and population sector program and will be included in the proposed additional financing of Urban Primary Health Care Services Delivery Project. However, little is known concerning what works and what do not work, particularly within the context of urban primary health care as well as the standpoints of users versus providers. The project will provide supply-side and demand-side interventions, namely in-service training to health care providers to update their knowledge and skills, and behavior change communication (BCC) activities to target population. Though the project conducts immediate post-training evaluation, medium-term training outcome has yet to be institutionalized, especially concerning the application of new knowledge and skills acquired by the health care providers.

8. **Potential research scope.** Thus, the extent of providers' compliance to care guidelines needs to be better analyzed. Likewise, the influence of the nutrition-related BCC activities on the knowledge, attitude, and practice of the users' needs to be assessed to determine limitations in BCC.

9. **Methods.** A mixed method may be used, including individual surveys on perception, compliance to nutrition guidelines, challenges encountered and analysis of associated factors, in addition to qualitative focus group discussions.

C. Implementation Schedule

10. The following activities will take place from the date of loan effectiveness:

First year

- One month from loan effectiveness: Constitute the ORC
- Three months from loan effectiveness: Prepare detailed terms of reference for both administration and implementation of research proposals and obtain approval of ADB.
- Six months from loan effectiveness: Advertise for expression of interest and detailed proposals.
- Twelve months from loan effectiveness: Evaluate proposals and issue consultant contracts for operations research.

Second year

- Implement the operations research.
- Complete the operations research.
- Disseminate the operations research findings.

Third year (by midterm review)

- Incorporate findings of the operations research into the implementation of the project

D. Dissemination Strategy

11. To reach both local and regional audiences, a multi-pronged dissemination strategy will be employed. Each operations research study will include a dissemination plan that will generally include seminars at appropriate administrative levels in the area where the study was carried out, and a variety of media to reach a larger audience such as monographs of research results, presentations at international conferences, and summaries in the project newsletter and on the project webpage.

12. **Dissemination seminars.** Dissemination seminars are an important medium for discussing results with those involved in the study, especially decision makers. The seminars are designed to be as participatory as possible, creating an open atmosphere to discuss the results of a given study and the appropriate actions to be taken to improve the program.

13. **Research Results Series.** Research reports are often very detailed, lengthy, and not easily digestible by non-researchers. To bring the key results of operations research studies to a larger audience, each study report will include an executive summary that will be published in the project newsletters through a Research Results Series. The series will provide the reader with essential information on the study including objectives, methodology, and key findings. The series will be widely disseminated both within and outside Bangladesh to share lessons learned.

14. **Webpage.** The project website will contain a section on operations research to provide a forum for disseminating the results of studies in summary form as well as provide access to the complete papers.

15. **Presentations at international conferences.** While presentations at international conferences may not directly lead to programmatic improvements at the local level, they foster the sharing of lessons learned across borders, and will be encouraged.

ANNEX 9
SERVICE PROVIDER PERFORMANCE INCENTIVE SCHEME

1. Like the previous project phases, the performance incentive scheme will be implemented; however, with minor updating of the performance assessment instrument and the addition of a small penalty. The performance incentive scheme is a performance-based aspect of the partnership agreement to enhance accountability of service providers to achieving results and quality health service delivery. Performance will be calculated based on a composite index of 12 performance-linked indicators for health service delivery (Table A9.1). The index will include coverage statistics for pro-poor targeting and preventive services, including antenatal care, family planning, child health, quality of care, etc. These indicators are clear priorities for the Urban Primary Health Care Services Delivery Project and the incentive scheme will promote key results in these areas.

Table A9.1: Service Provider Performance Incentive Scheme

SL	Performance Indicators	Target 2023	Year 1	Year 2	Year 3	Year 4	Year 5
1	% of identified new pregnant women who completed at least four ANC visits	60%	52%	54%	56%	58%	60%
2	% of identified new pregnant women who received skilled birth attendance	80%	60%	65%	70%	75%	80%
3	% of women of reproductive age (15–49) use modern contraceptives	65%	55%	57%	60%	63%	65%
4	% of eligible FP contraceptive users use long acting/permanent methods (includes any current contraceptive users in denominator)	18%	14%	15%	16%	17%	18%
5	% of Growth Monitoring and Promotion performed against total number of under 5 children attended at facilities	80%	60%	65%	70%	75%	80%
6	% of measles vaccination by number of BCG vaccination for 9-12-month-old children	90%	70%	75%	80%	85%	90%
7	% of children consulting project PHC services for diarrhea received oral rehydration therapy (ORT) and zinc	90%	70%	75%	80%	85%	90%
8	% of each major health care services (including Caesarian section) by the identified poor (red card holders)	30%	30%	30%	30%	30%	30%
9	Satellite (mobile clinics) sessions conducted regularly as planned	100%	100%	100%	100%	100%	100%
10	Monthly FMIS reports submitted online within given timeframe	100%	100%	100%	100%	100%	100%
11	Quality and completeness of online HMIS service delivery statistics	100%	100%	100%	100%	100%	100%
12	Internal quality compliance (i) clinical waste management, (ii) data/record keeping, (iii) inventory management, and (iv) updating of target registers (yearly)/pregnancy registers (monthly), completed and report submitted	100%	100%	100%	100%	100%	100%

Source: Asian Development Bank.

2. Health service delivery performance will be assessed annually by an independent, third-party survey firm using data and reports from the semiannual Integrated Supervisory Instruments and also from health facility registries. The composite performance index is matched to a graduated achievement schedule (Table A9.2) that corresponds to a percentage of an incentive, warning, or penalty. The incentive is capped at $10,000 and set aside annually for each

partnership agreement (total fund is $300,000 over 5 years). The service provider can use the incentive at their discretion related to service delivery or incentives to health workers/managers. Similarly, service providers that do not achieve at least 75% of their targets are penalized, where the second quarter bill will be deducted according to the schedule (the penalty amount, however, is not significant to disrupt regular service delivery in any way). The formula is simple to understand and will be made known in advance to service providers (Table A9.3). New service providers may be eligible for up to 5 percentage point decrease per indicator target as per contract agreement (with the exception of indicators 8 through 12). To prevent accrual of benefits from only a few indicators, at most 10 percentage points for the top three indicators with the highest achievement will count toward the achievement score.

3. A score sheet like what is produced from the Integrated Supervisory Instrument's ranking of all partnership areas on a regular basis will be developed. The results of this score sheet will be shared via e-newsletter to the partnership area health facility manager/MEIS assistant/officials and on the Urban Primary Health Care Services Delivery Project website. This would encourage competition towards improving health services delivery and build a network across the partnership areas to share lessons.

4. This performance incentive scheme may be trialed on a pilot basis and closely assessed for its impact on service provider performance and delivering key results. At midterm, based on an assessment of its effectiveness, a decision will be made on whether or not to continue the scheme in management of performance-based contracts.

Table A9.2: Achievement Schedule

<70%	penalty of 10% on first quarter bill
70%–74%	penalty of 5% on first quarter bill
75%–79%	warning issued
80%–84%	receives 10% of total incentive
85%–89%	receives 25% of total incentive
90%–94%	receives 50% of total incentive
95%–99%	receives 75% of total incentive
>99%	receives 100% of total incentive

Source: Asian Development Bank.

Table A9.3: Example of How Performance is Calculated for a Hypothetical PA NGO based on Four Hypothetical Indicators

	Performance Targets		Hypothetical PA NGO case	
	Year 1	Year 2	Year 1	Year 2
Indicator 1	60%	65%	60%	65%
Indicator 2	40%	45%	42%	20%
Indicator 3	40%	50%	40%	50%
Indicator 4	60%	65%	60%	25%
Total Achieved (sum of total achieved indicators)	-	-	202	160
Total Possible (sum of total target indicators)	200	225	200	225
Achievement (Achieved*100)/Possible			101%	71%
			Receives 100% of total incentive	Penalized 5% on first quarter bill

Source: Asian Development Bank.

5. **Innovation awards in health care service delivery.** At midterm, the balance of performance incentive funds will also be used toward a small-scale 'innovation fund' to honor and

support innovative practices in health care services delivery by partnership agreement nongovernment organizations. This award recognizes service providers that address (or proposes to address) needs creatively and innovatively to improve quality of service delivery and patient experience. The criteria for selection are implementing (or proposing to implement) a technology or process change that has positively impacted the ability of the organization to provide services, such as, by measurably increasing the number of constituents served, by measurably increasing the extent to which one or more constituents has been served, by measurably increasing generation of funds through fundraising efforts, or by achieving some other significant described impact. The selection committee will consist of national-level technical representatives from the project management unit of Urban Primary Health Care Services Delivery Project, Asian Development Bank, UNFPA, and independent research organizations. Written nominations or proposals in English of maximum 20 pages are accepted on a rolling basis for a maximum award of $10,000. The innovation funds will be managed, monitored, and administered by the project management unit under the Local Government Division. Expenditures financed by the fund will be supported by adequate supporting documents in accordance with Asian Development Bank’s Loan Disbursement Handbook (2017, as amended from time to time).

ANNEX 10
ESSENTIAL SERVICE DELIVERY PLUS

A. Primary Health Care

1. Primary health care (PHC) is defined in the Declaration of Alma Ata in 1978 as "essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination."[1] Bangladesh's long-term commitment to the principles of PHC has since been ongoing in rural areas at three tiers: *upazila*, union, and the community clinics with linkages to the district as part of the public sector health service. The priority interventions for provision of PHC services through primary health care centers (PHCCs) and comprehensive reproductive health care centers (CRHCCs) in urban areas mirror closely to those in rural areas. The priority interventions identified for PHC relate entirely to (i) "how" services can be provided more effectively touching on challenges of ensuring adequate and efficient supplies and use of human resources, (ii) defining referral and supervision linkages, and (iii) strengthening management capacity.

B. Integrated Package of Essential Services

2. Bangladesh has given priority attention to the following elements of PHC: (i) health education, (ii) nutrition, (iii) adequate and safe water and sanitation, (iv) maternal and child health, (v) immunization, (vi) prevention and control of endemic diseases, (vii) treatment of common ailments and injuries, and (viii) provision of essential drugs. Prioritizing these PHC service elements at the national level, the first sector program (Health and Population Sector Program) in 1996–1997 came up with a remodeled package called the Essential Service Package (ESP), which includes (i) child health care, safe motherhood, family planning, menstrual regulation, post-abortion care, and management of STIs; (ii) control of communicable diseases (including tuberculosis, malaria, others); (iii) control of emerging noncommunicable diseases (diabetes, mental health, cardiovascular diseases); (iv) limited curative care; and (v) behavior change communication. With the addition of nutrition, ESP has been renamed "Essential Service Delivery" (ESD) under the previous Health, Nutrition, and Population Sector Development Program (HNPSDP), 2011–2016, and remains a priority of the Government of Bangladesh. Aligned with the HNPSDP, the ESD+ package under the proposed additional financing of Urban Primary Health Care Services Delivery Project will consist of a combination of services proven to be effective and with high-impact results in terms of preventing deaths and improving the health of mothers and children (see table below).

Table A10.1: List of Services Proven to be Effective and with High-Impact Results

SL	Activities under ESD+ provided by Partner Service Providers	CRHCC	PHCC	Satellite Clinic	Domiciliary
A	**Maternal, Neonatal, Child, Reproductive and Adolescent Health (MNCRA)**				
I	**Maternal Care**				
1	**Antenatal Care**				
1	Pregnancy Registration, Regular Follow-up and update including maternal deaths				√

[1] World Health Organization. Declaration of Alma-Ata. Adopted at the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

SL	Activities under ESD+ provided by Partner Service Providers	CRHCC	PHCC	Satellite Clinic	Domiciliary
2	Counsel women and husband / family on recommended maternal nutrition/diet, supplementation (iron-folic acid, IFA) and care (rest) danger sign, clean delivery, Trained birth assistance, delivery planning, Preparation for possible emergency, breast feeding, and Contraception	√	√	√	√
3	Antenatal care (check weight gain, height, eyes, blood pressure, edema, anemia testing, urine sample, blood sample)	√	√	√	
4	Obtain antenatal history	√	√	√	
5	TT Vaccination (pregnant women)	√	√	√	
6	Fe/Folate /Calcium Supplementation	√	√	√	√
7	Detect early, refer promptly women with danger signs/ complications with primary management	√	√	√	√
8	Mobilize community to arrange transportation, blood donors for obstetric emergencies, (blood will be supplied to EOC referral locations for screening prior to possible use)			√	√
2	**Delivery Care (NVD & CS)**				
1	Create awareness on safe and clean delivery	√	√	√	√
2	Conduct clean and safe delivery by skilled health personnel at facility level and ensure taking and recording birth weight and length of the new born within 24 hours to assess the low birth weight (LBW) and length for full terms babies	√			
3	Support lactation management, ensure initiation of breastfeeding within one hour of birth and counsel on exclusive breastfeeding	√	√	√	√
4	Comprehensive emergency obstetric care	√			
5	Detect early and refer promptly women with Danger signs or complications with primary management	√	√	√	√
3	**Postnatal Care**				
1	Counsel women/family on recommended maternal diet, post-partum supplementation and rest, Exclusive Breast Feeding (EBF) until 6 months and age-appropriate complementary feeding during 6-23 months, danger signs (mother & infant), immunization, Post-partum Contraception, Birth Spacing	√	√	√	√
2	Provide Postnatal Care	√	√	√	
3	Provide post-partum contraceptive	√	√	√	√
4	Provide Vitamin A Supplementation within 42 days of delivery	√	√	√	√
5	Detect early and refer promptly women with danger signs/complications with primary management	√	√	√	√
4	**Menstrual Regulation**				
1	Encourage use of post MR FP methods	√	√	√	√
2	Create awareness on unsafe abortions and its complications	√	√	√	√
3	Provide MR on medical grounds only	√	√		
4	Provide contraceptive supplies	√	√	√	√
5	Detect complications and refer promptly with primary management	√	√	√	√
5	**Post Abortion Care**				
1	Encourage use of post abortion FP methods	√	√	√	√
2	Encourage MR within safe period	√	√	√	√
3	Provide PAC, including supplementation (IFA)	√	√		
4	Detect complications and refer promptly with primary management	√	√	√	√
II	**Population & Family Planning Services**				
1	**Family Planning**				
1	Eligible Couple Registration, regular update				√

SL	Activities under ESD+ provided by Partner Service Providers	CRHCC	PHCC	Satellite Clinic	Domiciliary
2	Create awareness on Family planning with emphasis on permanent and longer acting methods	√	√	√	√
3	Counsel on appropriate method, pre-pregnancy counseling, delay pregnancy those are under aged and or having young kids along with counselling on adolescent nutrition	√	√	√	√
4	Provide contraceptive supplies- Temporary Methods (Pill, Condom, Injectable)	√	√	√	√
5	Provide Long Acting methods (IUD, Implant)	√	√		
6	Provide Permanent method (Tubectomy, NSV)	√			
7	Treat/refer for side effects and complications with primary management	√	√	√	√
8	Refer for other methods (Sterilization, IUD, Implant)			√	√
9	Provide ECP	√	√	√	
III	**Neonatal Care**				
1	**Neonatal Care**				
1	Provide Neonatal Care	√	√	√	
2	Newborn resuscitation	√			
3	Kangaroo Mother Care (KMC) support	√			
4	Counsel women/family on Exclusive Breast Feeding (EBF), support lactation management, hygiene, cord care, danger signs (mother and newborn), prevent hypothermia, immunization	√	√	√	√
5	Health education for mothers on cleanliness and care for the newborn				√
6	Detect early and refer promptly neonates with complications with primary management	√	√	√	√
IV	**Child Health Care**				
1	**Immunization Program – EPI**				
1	Mobilize caretakers to have their children fully immunized by 12 months of age	√	√	√	√
2	Conduct immunization sessions	√	√	√	
3	Surveillance and notification including acute flaccid Paralysis, measles and neo-natal tetanus	√	√	√	√
4	Counselling on age appropriate complementary feeding for 6-23 months children (including demonstration with bowl, spoon at the facilities)	√	√	√	√
2	**Immunization Program – NID**				
1	Observe National Immunization Program	√	√	√	
2	Child to Child Search				√
3	**Diarrhea**				
1	Detect, manage and refer severe cases with “danger signs”	√	√	√	√
2	Advise caretaker on correct home care (fluids, feeding, referral)	√	√	√	√
3	Advise caretaker on prevention	√	√	√	√
4	**Measles**				
1	Detect and manage; refer severe/complicated cases	√	√	√	√
5	**Acute Respiratory Infections**				
1	Treat pneumonia with oral antibiotics	√	√	√	
2	Advise caretaker on correct home care	√	√	√	√
3	Detect and manage; refer severe/complicated cases	√	√	√	√
6	**Other Childhood Illness**				

SL	Activities under ESD+ provided by Partner Service Providers	CRHCC	PHCC	Satellite Clinic	Domiciliary
1	Detect and manage; refer severe/complicated cases (including drowning, accidental poisoning, autism, disability, other injuries etc.)	√	√	√	√
2	Screening, detection and referral of severely acutely malnourished (SAM) children	√	√	√	√
V	**Reproductive Health Care**				
1	**RTI/STI Care**				
1	Counsel on RTI/STI & related Infertility	√	√	√	√
2	Health Education on RTI/STI & related Infertility				√
3	Supply condoms	√	√	√	√
4	Refer for complaints of vaginal discharge, lower abdominal pain, genital ulcers, swellings in groin in men	√	√	√	√
5	Follow syndromic approach	√	√	√	
6	Service Provider management	√	√	√	
7	RTI/STI Screening	√	√		
2	**Other Reproductive Health Care**				
1	Identify & Refer Out of Breast Cancer, Cervical Cancer, Fistula etc.	√			
2	Other Reproductive Tract Disease	√	√		
3	TT Vaccination (19+ non-pregnant women)	√	√	√	
VI	**Adolescent Care**				
1	**Adolescent Health Care**				
1	Counsel/create awareness of sexuality, safe sex, menstruation, adolescent nutrition and care, hygiene, TT vaccination; reducing early marriage, pregnancy; high risk behavior, psychological issues, gender issues to both girls and boys	√	√	√	√
2	Identify and treat anemia for girls and boys	√	√	√	
3	Identify and treat RTI/STI for girls and boys	√	√	√	
4	Identify and treat Dysmenorrhea and other RH problems	√	√	√	
5	TT Vaccination (adolescent girls)	√	√	√	
B	**Nutrition (N)**				
I 1	**Maternal Nutrition**				
1	Create awareness/counsel on maternal nutritional/diet nd care; along with promoting access to health care services available that prevent Malnutrition	√	√	√	√
2	Counsel pregnant & lactating women (+ Husband/ Family) on recommended nutrition/diet, supplementation (IFA, post-partum vitamin-A), care (rest) and essential health services.	√	√	√	√
3	Provide elements such as community nutrition including nutritional assessment with targeted supplementation as per national program, detection & referral of severe cases of malnutrition	√	√	√	√
II 1	**Child Nutrition**				
1	Promote (& support) exclusive breast feeding, timely introduction of complementary feeding and age appropriate complementary feeding (Minimum Acceptable Diet)	√	√	√	√
2	Promote WASH for children (handwashing before feeding, ensuring food safety and hygienic disposal of child defaces etc.)	√	√	√	√

SL	Activities under ESD+ provided by Partner Service Providers	CRHCC	PHCC	Satellite Clinic	Domiciliary
3	Implement community nutrition activities such as breastfeeding support, supporting for screening, detection, referral and follow-up on the severe acute malnutrition, supplementation as per national program.	√	√	√	√
III 1	**Control of Micronutrient Deficiency**				
1	De-worming of Under 10 Children	√	√	√	
2	Vitamin A for post-partum lactating women	√	√	√	√
3	Vitamin A for children (6 months to 6 years)	√	√	√	
4	Vitamin A Supplementation for sick children (ARI, diarrhea, severe malnutrition, measles)	√	√	√	
5	Detect and manage children with night blindness & Refer other cases	√	√	√	√
6	Detect and refer suspected iodine deficiency cases	√	√	√	√
C	**Communicable and Non-Communicable Disease (CNCD)**				
I	**Communicable Diseases Control**				
1	**Tuberculosis Control**				
1	Counseling on prevention of communicable diseases	√	√	√	√
2	Detect and refer suspect cases	√	√	√	√
3	Support and promote DOTS		√		
4	Advise patients/families/close contacts on TB Symptoms and treatment compliance		√	√	√
5	Defaulter tracing				√
6	Promote self-reporting of patients		√	√	√
2	**Other Communicable Disease Control**				
1	Counseling on prevention of communicable diseases				
2	Detect and refer suspect cases	√	√	√	√
3	Advise patient/families/close contacts on symptoms and treatment compliance	√	√	√	√
4	Diagnosis, Treatment and referral of Leprosy, Malaria, Dengue, SARS, Kala-azar, Filariasis, Enteric Fever, Hepatitis etc.	√	√		
II	**Non-Communicable Diseases Control**				
1	**Emerging Non-Communicable Disease Control**				
1	Detect and Refer Suspected cases of Diabetes, Mental Health and Cardiovascular disease etc.	√	√	√	√
2	Support and promote preventative/control measures	√	√	√	√
3	Advice patients to seek treatment, improve lifestyle and promote self-reporting	√	√	√	√
D	**Limited Curative Care**				
I 1	**Basic First Aid**				
1	Provide Basic First Aid for Common injuries (cut, burn, fracture, etc.)	√	√	√	
II 1	**Emergency Care**				
1	Treat Medical Emergencies – Management and Referral of Pain, high fever, shock, asphyxia, poisoning, drowning and other incidence of emergencies	√	√		
III 1	**Minor Infection & Disease Control**				
1	General Health Checkup, Asthma, Skin Diseases (Scabies etc.), Dental Diseases, Ear diseases, Peptic Ulcer, Geriatric care and Other Minor Ailments	√	√	√	
IV 1	**Primary Eye Care**				

SL			Activities under ESD+ provided by Partner Service Providers	CRHCC	PHCC	Satellite Clinic	Domiciliary
		1	Clinical Consultation; Medical Treatment, Refraction Test, Prescribed/Provided Spectacles, Identification and refer out for Cataract Surgery		√		
	V	1	**Disaster Management**				
		1	Extended services for any emergency outbreak within the scope of work	√	√	√	√
E			**Behavior Change Communication (BCC)**				
	I	1	**Health Education**				
		1	Health Education on cross cutting all categories above				√
		2	Health Education on Personal hygiene, hand washing, gender awareness				√
		3	Awareness on availability of PHC services (branding) at UPHCSDP centers				√
	II	1	**Clinical Counseling**				
		1	Clinical Counseling on cross cutting all categories above	√	√	√	
F			**Diagnostic & Emergency Transport* (DET)**				
	I	1	**Diagnostic Service**				
		1	Blood Grouping, Urine for Pregnancy	√	√	√	
		2	Blood for Routine (TC, DC, ESR, Hb), Cross Matching, Sugar, Platelet Count, Serum Bilirubin, CRP, RF, Widal, ASO Titre, BT, CT, MP, KOS, WetMount, Hbs Ag, Hepatitis B Confirmation, VDRL, TPHA etc.	√	√		
		3	Urine for Routine (Sugar, Albumin, PS, Phosphate) etc.	√	√		
		4	Stool for Routine (Occult Blood, RS), Floatation Method etc.	√	√		
		5	Biochemical Tests	√	√		
		6	Ear Swab, Puss Swab, High Vaginal Swab, Skin Scrapping Fungus, Mauntox etc.	√	√		
		7	VIA	√			
		8	Ultra-sonogram	√			
		9	Sputum (AFB)		√		
		10	Liver function test (SGPT & SGOT),	√			
		11	Fasting Lipid profile	√			
		12	Uric acid, Electrolytes	√			
	II	1	**Emergency Transportation Service**				
		1	Ambulance Service	√			
G	I	1	**Violence Against Women* (VAW)**				
		1	Identify and register cases, provide medical care	√	√	√	√
		2	Refer victims for legal assistance, counseling and Crisis management	√	√		
		3	Provide psychological support	√	√	√	√
		4	Increase community awareness				√
H	I	1	**Miscellaneous**				
		1	Medical Waste Management	√	√	√	
		2	Diet for admitted patients	√			
		3	Evening Clinic		√	√	
		4	Holiday clinic	√	√		
		5	Medicine distribution	√	√	√	
		6	Monitoring & Quality Assurance	√	√	√	√
		7	Record Keeping & Reporting	√	√	√	√
		8	Financial Management	√	√	√	

SL	Activities under ESD+ provided by Partner Service Providers	CRHCC	PHCC	Satellite Clinic	Domiciliary
9	Regular update of Pro-poor listing, pregnancy registration, eligible couple registration etc.				√

BCC = behavior change communication, CRHCC = comprehensive reproductive health care center, CS = caesarian section, EOC = emergency obstetric care, EPI = expanded program on immunization, ESD+ = essential service delivery plus, LBW = low birthweight, NID = National Immunization Day, NVD = normal vaginal delivery, PHCC = primary health care center, VAW = violence against women.
* Provided under ESD+.
Source: Asian Development Bank.

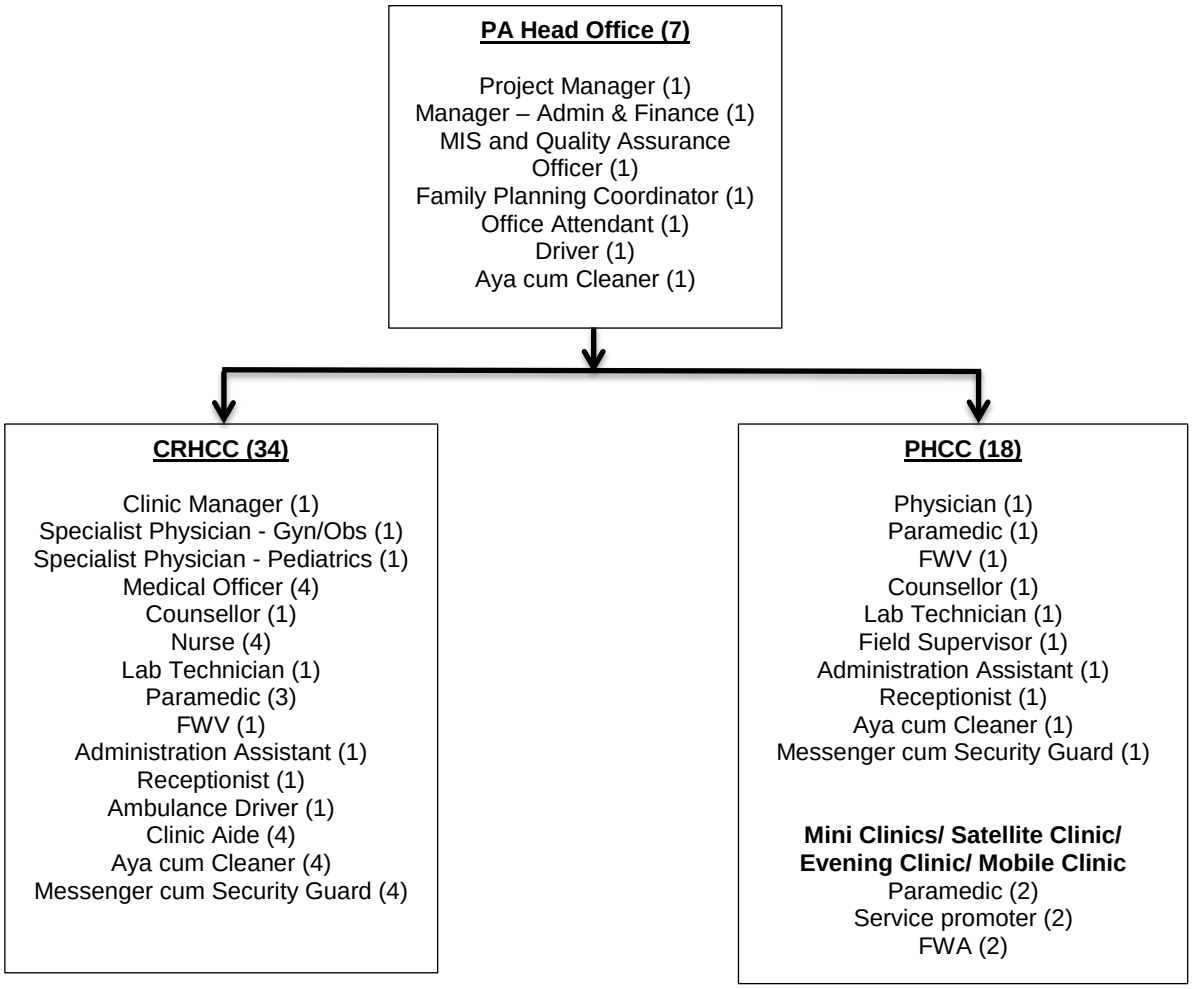
3. **Health centers under the proposed additional financing.** The project will have three levels of care: (i) CRHCCs), (ii) PHCCs, and (iii) satellite clinics. Each partnership area will have one CRHCC. These centers, with 10 to 20 beds for in-door patients, will provide the following services:

(i) normal delivery care including antenatal care and postnatal care;
(ii) comprehensive emergency obstetric care;
(iii) management of neonatal complications including Kangaroo Mother Care;
(iv) all available contraceptive methods including permanent methods;
(v) selected laboratory tests;
(vi) possible reproductive health and other related interventions as required for the referred cases from the PHCs including diseases of the reproductive tract; and
(vii) management of reproductive tract infections.

4. Each partnership area has more than one PHCC, normally one PHCC serving 30,000–50,000 people. PHCCs provide ESD+ services. Under each PHCC, there are two satellite clinics established in disadvantaged urban locations with fairly large concentration of target group population. Services provided at the satellite clinics normally include ESD outreach services. At least one satellite session per week will be mobile services delivery targeting groups of ‘floating’ population and other ultra-poor in the partnership agreement area.

5. Partnership agreement nongovernment organizations are responsible developing a simple method of referral of patients to hospitals and counter-referral to partnership health services which will be used by the facilities. Such a system may involve color coded forms for use by the partnership agreement nongovernment organizations ensuring that referred patients are well received at the hospitals and that a proper counter-referral note is made.

Figure A10.1: Staffing of the Partnership Agreement Areas



Source: Asian Development Bank.

C. Monitoring and Record Keeping

6. The following four types of cards, six types of registers, 10 types of sub-registers, and 16 types of forms are to be used in the clinics under the proposed additional financing as record keeping instruments.

Table A10.2: List of Record Keeping Instruments for UPHCSDP-AF Clinics

Sl	Instrument Type	Code	Instrument Name
1	Card	101	Seba Grahitar Card
2	Card	102	Health Card (Male)
3	Card	103	Health Card (Female)
4	Card	104	Health Card (Child)
5	Register	201	Master Register
6	Register	202	PECC Register
7	Register	204	OT Register

Sl	Instrument Type	Code	Instrument Name
8	Register	205	Pregnancy Record Register
9	Register	206	Motor Vehicle Journey Log Book
10	Register	207	Emergency Transport Register
11	Sub Register	301	Delivery Register
12	Sub Register	302	RH Register
13	Sub Register	303	CH Register
14	Sub Register	304	LCC Register
15	Sub Register	305	VAW Register
16	Sub Register	306	Lab Register
17	Sub Register	307	Medicine Consumption Register
18	Sub Register	308	Clinical Counseling Register
19	Sub Register	309	Satellite Service Delivery Register 1
20	Sub Register	310	Satellite Service Delivery Register 2
21	Form	401	Money Receipt
22	Form	402	Prescription Pad
23	Form	403	Referral Slip
24	Form	404	Pathology Report
25	Form	405	USG Report (Pregnancy Profile)
26	Form	406	USG Report
27	Form	407	VAW History Form
28	Form	408	Satellite Spot List
29	Form	409	Satellite Work Plan
30	Form	410	Satellite Duty Roster
31	Form	411	Pregnancy Registration Form
32	Form	412	Health Education Form
33	Form	413	MR/D&C Consent Form
34	Form	414	Surgical Operation Consent Form
35	Form	415	Available Medicine Chart
36	Form	607	EDD Report

Source: Asian Development Bank.

D. UPHCSDP-AF Network, Facilities, and Human Resources

Table A10.3: Network, Facilities, and Human Resources

PA NAME	PAHQ	Per Unit Human Resources			Number of Facilities			Total Human Resources				Total
		CRCC	PHCC	Satellite	CRHCC	PHCC	Satellite	PAHQ	CRHCC	PHCC	Satellite	
DSCCPA1	7	34	12	6	1	6	12	7	34	72	72	
DSCCPA2	7	34	12	6	1	6	12	7	34	72	72	
DSCCPA3	7	34	12	6	1	6	12	7	34	72	72	
DSCCPA4	7	34	12	6	1	6	12	7	34	72	72	
DSCCPA5	7	34	12	6	1	4	8	7	34	48	48	
DSCC NewPA1	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
DSCC NewPA2	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
DSCC NewPA3	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
DCCNPA1	7	34	12	6	1	5	10	7	34	60	60	
DCCNPA2	7	34	12	6	1	6	12	7	34	72	72	
DCCNPA3	7	34	12	6	1	6	12	7	34	72	72	
DCCNPA4	7	34	12	6	1	4	8	7	34	48	48	
DCCNPA5	7	34	12	6	1	6	12	7	34	72	72	
DCCN NewPA1	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
DCCN NewPA2	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
KCCPA1	7	34	12	6	1	6	12	7	34	72	72	
KCCPA2	7	34	12	6	1	6	12	7	34	72	72	
RCCPA1	7	34	12	6	1	6	12	7	34	72	72	
RCCPA2	7	34	12	6	1	4	8	7	34	48	48	
SCCPA1	7	34	12	6	1	7	14	7	34	84	84	
BCCPA1	7	34	12	6	1	4	8	7	34	48	48	
COCCPA1	7	34	12	6	1	6	12	7	34	72	72	
NACCPA1	7	34	12	6	1	3	6	7	34	36	36	
NACC New PA	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
GACCPA1	7	34	12	6	1	3	6	7	34	36	36	
GACCPA1	7	34	12	6	1	3	6	7	34	36	36	
GACC New PA	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
RACCPA1	7	34	12	6	1	3	6	7	34	36	36	
KMPA1	7	34	12	6	1	2	4	7	34	24	24	

PA NAME	PAHQ	Per Unit Human Resources			Number of Facilities			Total Human Resources				Total
		CRCC	PHCC	Satellite	CRHCC	PHCC	Satellite	PAHQ	CRHCC	PHCC	Satellite	
SMPA1	7	34	12	6	1	3	6	7	34	36	36	
KsMPA1	7	34	12	6	1	2	4	7	34	24	24	
GMPA1	7	34	12	6	1	2	4	7	34	24	24	
Chattogram CC New PA1	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
Chattogram CC New PA2	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
Chattogram CC New PA3	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
Mymensingh Municipality New PA	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
Faridpur Municipality New PA	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
Shariatpur Municipality New PA	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
Gaibandha Municipality New PA	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
Kurigram Municipality New PA	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
Netrokhona Municipality New PA	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
Jagannathpur Municipality New PA	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
Derai Municipality New PA	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
Benapole Municipality New PA	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	
Tarabo Municipality New PA	7	34	12	6	1	TBD	TBD	7	34	TBD	TBD	

Source: Asian Development Bank.

ANNEX 11
BEHAVIOR CHANGE COMMUNICATION AND MARKETING

1. Behavior change communication (BCC) is to influence individual and collective behavior. The development and implementation of an effective Behavior Change Communication and Marketing (BCCM) program for health education, social, BCC, and marketing in key priority areas will be supported by the proposed additional financing of the Urban Primary Health Care Services Delivery Project (UPHCSDP). Development of the program strategy and implementation plan will take into account the experiences under the previous phases of urban primary health care (PHC) project and the ongoing initiatives of the Ministry of Health and Family Welfare (MOHFW). In addition, the BCC Strategy developed in June 2013[1] will be an important input to be considered for the new project design. The project will implement the BCCM program, in close coordination with MOHFW, and greater effort will be made to reach the most vulnerable populations and to go beyond information dissemination to strategically target key desired behavior changes. The lessons learned and strategic considerations delineate below also drew on the findings of the independent midterm review of UPHCSDP,[2] review of project documents, and consultations with partner service providers, project management unit, and Asian Development Bank.

2. **Lessons from UPHCSDP**. The BCCM program of UPHCSDP faced several challenges: (i) Delayed signing of BCCM contract has resulted in missed opportunity—there was a strong demand at the field level for the services of BCCM firm to disseminate information and create more demand of the services provided by the project. As a result of the delayed signing, there was short interval between baseline and end line surveys, hindering the evaluation on resulted changes. (ii) The end line survey of BCCM component shows exceptional results. However, as the survey was administered by the BCCM firm, there might be a risk of conflict of interest. (iii) The implementation of BCCM has not applied the project's BCC Strategy. The firm's activities were heavy on standard printing of materials and non-specific messaging. Emphasis should be on problem areas of PHC (e.g., nutrition, sexual and reproductive health, etc.), in-person face-to-face interactions for targeted demographic groups, and making better use of community groups such as ward health committees to generate the demand and health-seeking behavior. (iv) Lack of focused advocacy initiatives for political, administrative, technical, and grass-top levels to create more publicity for the project. BCCM needs to plan for advocacy initiatives at the level of political i.e., Local Government Division (LGD,) MOHFW, and urban local body (ULB) leadership, administrative i.e., officials of LGD, MOHFW, ULBs, and technical i.e., inspiring research firms and development partners to share evidence of good practices in integrating public health functions through ULBs; and at grass-top i.e., beneficiary and user forums. Strategic advocacy campaigns would require substantial time to design and develop, with inputs from government, development partners, and other stakeholders. (v) Miss-opportunity to optimize high impact delivery channels such as mobile phone.

3. **BCCM strategies for the project**. The BCCM activities need to emphasize on three key sub-components: (i) Advocacy initiatives at the institutional levels (LGD, MOHFW, and ULB), to prioritize PHC and increase ownership of the UPHCSDP. (ii) At facility level, BCCM shall continue to market the rainbow clinic service delivery as part of the public health functions through ULBs. Increase and generate demand for rainbow clinic services by poor, urban households and improve quality of customer service provided to patients by all rainbow clinic staff. (iii) At target

[1] Behavior Change Communication Strategy for the Urban Primary Health Care Services Delivery Project, June 2013.
[2] Final Report of Independent Review Team at Mid-Term Review of Urban Primary Health Care Services Delivery Project, February 2016.

population level to promote correct knowledge, attitude and practice related to target interventions.

4. **Key behaviors.** Five key behaviors and related key project indicators were identified in the BCC Strategy developed in June 2013.[3] The following outlines the key behaviors and key project indicators, which have been updated according to the project design of the additional financing period, to be achieved for the project (to refer to the BCC strategy paper for details):

Key behavior I: Urban local bodies prioritize PHC and have greater ownership of the project.

- Indicators:
  Urban PHC budget line in LGD's revenue budget is established
  Financing provided for urban PHC through LGD's revenue budget

Key behavior II: Poor, urban household access Rainbow clinic services

- Indicators:
  At least 90% of urban population have access to public health service

Key behavior III: Married women of reproductive age (15–49) use modern contraceptives

- Indicators:
  At least 65% of currently married women of reproductive age (15–49) use modern contraceptives

Key behavior IV: Women deliver with presence of skilled health personnel

- Indicators:
  At least 70% of births attended by skilled health personnel

Key behavior V: Caretakers of under-five children practice improved infant and young child feeding behaviors.

- Indicators: Prevalence of underweight and stunted children reduced by 20%.

5. Depending on further consultation during project implementation, other targeted BCC messages and materials may include the following to address some of the current challenges influencing health status:

(i) **Child health.** Expanded Program on Immunization**:** mobilize caretakers to have their children fully immunized by 12 months of age; Diarrhea: advise caretakers on home care (fluids, feeding, referral), advise caretakers on prevention; Acute Respiratory infections: advise caretaker on correct home care; advise caretakers on prevention.

(ii) **Adolescent care.** Counsel on/create awareness on a number of key areas crucial to the needs of adolescent including sexual reproductive health and nutrition.

(iii) **Emerging noncommunicable diseases.** Advice target population to seek treatment, improve lifestyle, and promote self-reporting.

6. Nutrition is a cross-cutting issue that affects child health, maternal health, and adolescent health. The prevalence of child malnutrition and stunting are major concerns among the poor (urban slum). Nutrition health for adolescent and pregnant women may contribute to improving the situation of neonatal mortality.

[3] Behavior Change Communication Strategy for the Urban Primary Health Care Services Delivery Project, June 2013.

7. BCC at target population level also needs to consider creating awareness on effective and low-cost intervention aims at reducing the rate of neonatal mortality such as cord care, early recognition of newborn infection, and possibly educate the mothers on the needs for referral of low birth weight babies.

8. **BCC delivery mechanism.** The implementation of the BCC component during the current project has focused on interpersonal communication and mainly information provision through printing material. Currently, the rainbow clinics are not part of the government SMS messages scheme to remind people to immunize their children and to pay taxes, and to broadcast cyclone warnings to people living in areas affected by flooding. Mobile phones have been cited as a reason for the drop in maternal mortality in Bangladesh, as health workers are able to use them in their referral efforts. Mobile phones should be strongly considered in this program as a viable channel as several communication programs already exist to promote improved maternal and child health practices, including:

(i) **Health phone.** A program whereby pre-existing messages are downloaded onto inexpensive mobile phones that could be used by health workers as a training tool or a supplemental communication tool with mothers.
(ii) **Maternal Alliance for Maternal Action (MAMA).** Provides free, adaptable mobile health messages for programs that are using mobile phones to inform and empower new and expectant mothers. There is currently the Aponjon program in Bangladesh where mothers can call 16227 to receive messages about maternal and child health.

9. In light of the increasing coverage of mobile phones in Bangladesh, BCC could optimize the technology for message dissemination as a communication channel to market clinic services, disseminating BCC messages/reminders to patients, etc.

10. Bangladesh Television network is one of three state-owned networks in the country and covers 95% of the population. Its free-to-air status makes it attractive to households who cannot afford to pay for a satellite connection to watch television. Using the television network as a channel for communication should be considered as an option to reaching out to a larger population.

11. Current BCC activities of UPHCSDP lack community interaction with potential clients, occasional Ward Urban Health Coordination Committee and User's Forum meeting are not sufficiently appealing to local dwellers; it requires more community meeting involving local-elected and non-elected leaders, religious leaders, and representative from educational institutions. Possible activities envisaged are:

(i) audiovisual show at strategic gathering point;
(ii) group meeting/courtyard meeting;
(iii) adolescent programs/various contest;
(iv) use of local cultural group's performance in service promotion and promotion of healthy behavior; and
(v) observing "Service Week" by respective partnership area units.

ANNEX 12
INFORMATION AND COMMUNICATION TECHNOLOGY TO SUPPORT URBAN PRIMARY HEALTH CARE SERVICE DELIVERY

1. Implementing a rudimentary management information system/health management information system (HMIS) is a core condition for long-term successful management of primary health care delivery. The current HMIS[1] development and implementation are underdeveloped in terms of detailed functional structure of the HMIS which is in stark contrast to its extensive implementation strategy. The assessment of the current HMIS status quo showed that the HMIS implementation is still at very early stages and has not progressed beyond the (unawarded) tender stage. Therefore, the HMIS consulting services in this project preparatory technical assistance will firstly and primarily focus on strategies and measures to enable the project management unit (PMU) to at least re-initiate and implement the core activities of HMIS.

2. These measures will aim to ensure that all facilities in the project are equipped with sufficient hardware, knowledge, and skills to operate an electronic HMIS and that the system to be developed is detailed enough to capture data on patient level as well as flexible and open enough to seamlessly integrate into national health data strategies.

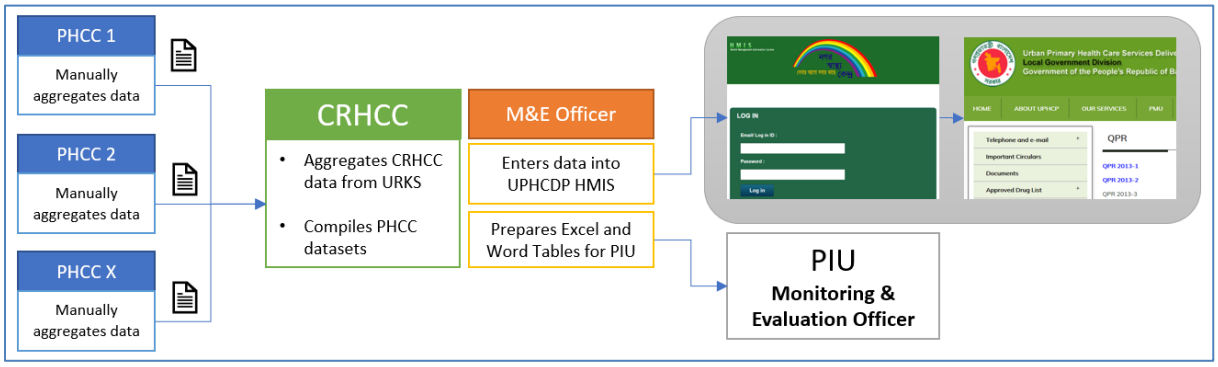
A. Situational Analysis

3. The Urban Primary Health Care Services Delivery Project (UPHCSDP) HMIS was tendered in 2015. Tender evaluation was executed, and a bid winner was determined. However, the bid contract failed to be approved on urban government level and the HMIS development process has been dormant since then.

4. Comprehensive reproductive health care centers (CRHCCs) have a very limited number of PC workstations (1–3 per CRHCC). This very basic IT equipment was purchased under the office equipment budget provision and is exclusively used to prepare aggregated monthly reports for the UPHCSDP PMU as well as for the project implementation unit (PIU). There is no evidence that primary health care centers (PHCCs) have any IT equipment at all and data collection and dissemination is purely manual on PHCC level.

5. The foundation for the data collection process in facilities is the Unified Record Keeping System (URKS) which was developed by the PMU and is based on a manual ledger/form/card system. The implementation of the URKS is comprehensive and works considerably well in the visited facilities. Ledgers, cards, and forms are standardized across all facilities and provided by the PMU. Based on the URKS, the facilities will—on a monthly basis—compile the required reports for PMU and PIU by manually aggregating figures from the various ledgers. The PHCCs will forward their reports to the CHRCCs where those are—again—manually aggregated. Finally, the manually compiled lists will be entered by the CHRCC's monitoring and evaluation officers into the current UPHCSDP web portal http://qpr.bdhims.com/. The PMU will use the data from the web-portal to include statistics in the quarterly progress reports which are available at http://uphcp.gov.bd/QPR.html . This is currently the termination point for the collected data and there is no subsequent dissemination of data beyond this point. The CRHCC's monitoring and evaluation officers will also generate an additional report for the PIUs since the PIUs have no access to the PMU's HMIS portal.

[1] For better understanding and clarity, the term HMIS will be used for software-related discussions while the term information and communication technology (ICT) will be applied for hardware and network infrastructure. However, for consistency with previous documentation, the term "ICT firm" means the firm to be engaged to develop and implement the HMIS software and related services.



6. There are several workflow issues that are a direct result of the current data collection process. Five to six person-days per month are used exclusively to manually find and aggregate data for the monthly data entry. This is aggravated by the fact that most of this work has to be done by medical staff who is experienced in the ledger system. And due to the running-number based system it is very difficult and time-consuming for medical staff to track patient-based information. Finding previous visits for patients requires a complicated manual search in various ledgers based on date, number, and name. Facility staff unanimously stated that having an IT-based system would greatly reduce workload and improve accuracy.

7. In the current URKS, it is and will never be possible to research and investigate patient-based data. There are no means or tools for data evaluation other than for aggregated data. The URKS cannot be easily expanded or adapted. It is not only the effort of redesigning cards and ledgers, reprinting and re-distribution which alone is a daunting task by itself but would also require a change of all data collection tools and forms.

8. The assessment showed that real-time data entry of individual patient information would not only improve the workflow and decrease the workload of medical staff in the facilities but would also facilitate a more extensive, in-depth, and accurate data analysis of urban health primary health service delivery. This Patient Management System should be used in all facilities (including satellite clinics) and be based on a variation of the existing URKS.

9. Current data evaluation is restricted by the limited availability of data elements, and in turn, a narrow range of primary health care data is collected and analyzed. While the current UPHCSDP HMIS seems to have some limited flexibility in terms of data entry and processing, the core issue with the current system is that it is proprietary and has no clear defined interfaces to the outside world. Therefore, it is necessary to implement a platform that allows (i) the automatic extraction of data from the patient management system and (ii) a flexible capability for extensive report generation and in-depth data analysis.

B. Recommendations for Health Management Information System

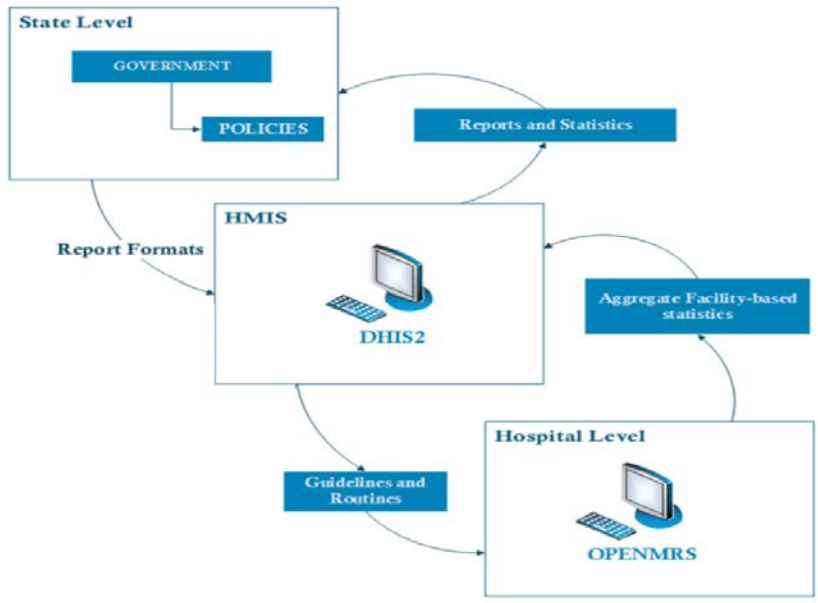
10. To achieve the initial goals and scope of the HMIS, it is necessary to design and implement a real-time Patient Management System based on the URKS for all facilities as data foundation for the data evaluation and analysis. In conjunction with the Patient Management System, it is also necessary to define and outline the scope of data collection, evaluation and dissemination and to implement a District Health Information System Version 2 (DHIS2) platform customized and based on the scope of data requirements and to develop internal and external interfaces.

11. The HMIS scope should be adjusted as outlined below. This adjustment also takes into consideration the reduced timeframe of est. 6 months from contract to hand-over for the HMIS development.

Patient Management System based on OpenMRS
- Detailed needs analysis on facility level
- Prototype based on URKS
- Implementation and roll-out plan
- Training plan and program for facilities
- Training plan and superuser training for PMU
- Long-term service and support plan

DHIS2 platform customized for UPHCSDP:
- Detailed data collection, evaluation and dissemination needs analysis
- Data requirement framework for DHIS2
- Interface development with patient management system and
- Interface development for national data warehousing approach
- Training plan and schedule for PIU and PMU
- Superuser training for core PMU data management team
- Long-term service and support plan

12. The HMIS components will be linked and interact as follows:



C. Patient Management System

13. As outlined in the initial terms of reference, the Patient Management System must be based on the OpenMRS platform, not only to facilitate reduced development time and cost but also to ensure compatibility with other likewise initiatives in the government health facilities in Bangladesh. OpenMRS is a software platform and a reference application which enables design of a customized medical records system based on forms and data requirements. The Ministry of Health and Family Welfare (MOHFW) has successfully used the OpenMRS approach in clinics and OpenMRS is a core component of the national health care data strategy. The Directorate

General Health Services (DGHS) has established a permanent knowledge center in cooperation with international experts to enable and support this strategy and it is of essential importance that any development in the UPHCDP's Patient Management System provides the means of interfacing to existing national data stores—which OpenMRS allows. In addition, OpenMRS is a part of a suite of interoperable health information systems of which DHIS2 is also an integral part. The use of OpenMRS provides an integrated tool for data and meta-data exchange (SDMX-HD) between OpenMRS and DHIS2. The OpenMRS also allows a comparatively simple and straight forward way to develop the patient management system based on the paper-based URKS.

14. It is exceptionally important to establish that the electronic patient management system will ultimately replace the manual ledger/card based URKS. It must be understood that the patient management system implementation will not be successful if it is only considered to supplement the manual entry system. Therefore, the information and communication technology (ICT) firm must provide a solution that can seamlessly mirror the management information system capabilities of the URKS while adhering to best practice guidelines for software usability and user friendliness.

15. The Patient Management System must also establish a unique patient ID system that will allow facilities to identify patients across all facilities with a certainty of above 80%. The unique patient ID could for example be based on a combination of date of birth, telephone number, name and national ID (or any combination thereof). The ICT firm should be encouraged to propose alternative solutions like biometric data but only if they can be reasonably accommodated within the required hardware budget and pose an actual improvement over traditional patient ID approaches.

D. Data Management

16. The Data Management System will be the DHIS2 platform customized to the specific needs of the projects. All stakeholders must understand that DHIS2 is an existing open-source software that is used widely in developing countries for health care data analysis and visualization. The focus of the HMIS implementation is not the development of a new system but to adapt and customize an existing system to the (i) needs of the UPHCDP and (ii) interface with other DHIS2 instances on national level. Most of the work for the ICT firm is therefore to identify the UPHCSDP (data analysis) needs and to establish core competencies for use of DHIS2. It is also highly recommended that the ICT firm and the PMU actively seek dialogue with the DGHS on DHIS2 implementation, in general, and how the UPHCDP fits into the national DHIS2 Framework.

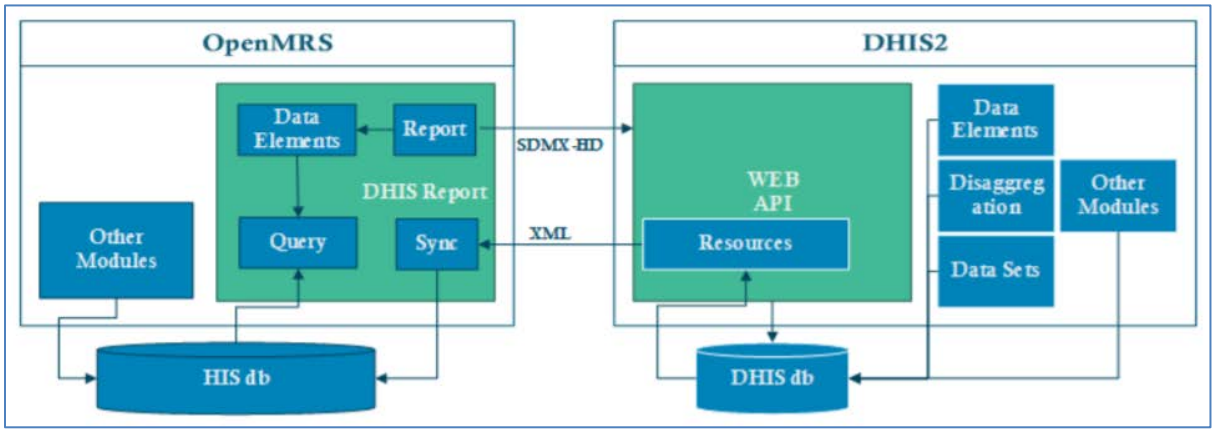
17. In addition to the development of the DHIS2 data sets, forms and rules, there are three additional major components to be considered in this implementation:

(i) Establish a clear framework of data collection, evaluation, and dissemination. This must include the answers to the following questions:
   a) What data should be collected/included?
   b) How is the data extracted from the Patient Management System?
   c) Who will use that data?
   d) What are the goals of the data evaluation and what analysis should be performed? This should at least include analysis tools for service provision and coverage, policy evaluation and amendment, and trend analysis and prediction.

e) How will the data and subsequent data evaluation be disseminated?

(ii) Cooperate closely with DGHS and DHIS2 experts to establish the following:
- a) How will the UPHCSDP link to the national DHIS2 warehouse?
- b) What are the lessons learned from other DHIS2 implementations and how can they potentially help the UPHCSDP DHIS2 implementation?
- c) Coordinate with DGHS, MOHFW, and other stakeholders regarding Point (1) above
- d) How will the UPHCDP DHIS2 fit into the overall national health care data initiative?

(iii) Establish a rigorous training concept that includes beside the basic user training but also advanced DHIS2 trainings for PMU key users and trainings for data analysis and evaluation for decision and policy makers.



E. Recommendations for ICT Firm Contract

18. The above aspects for the HMIS implementation have been largely outlined in the initial terms of reference for the ICT/HMIS package tender. However, the definition of the HMIS scope was on a very high and theoretical level, occasionally unclear and partially misleading. Under the circumstances, it was likely very difficult to envision the actual HMIS system and its interaction with users and national interfaces. It is also important that the PMU commits to an HMIS approach that allows integration and interaction on urban and national level and supports data exchange between the UPHCSDP HMIS and government HMIS structures. The UPHCSDP data pool must not remain an insular solution and the interfacing with the MOHFW and other authority's systems must be elevated to a mandatory component.

19. The established tender framework and proposal submission can remain in place since it does not contradict a revised approach to the scope reduction (other than the scope). In other words, the tender and proposal evaluation should NOT be considered invalidated and a re-tender should be avoided. It is recommended that the PMU engages in negotiation with the ICT Firm and establishes the groundwork for amended scope, time and fee and a potential re-engagement for the next phase (see below). The result of the re-negotiation should be presented to the steering committee and with additional highlights on the proposed added interoperability with existing national health care data initiatives and the potential benefit of integrating access to UPHCSDP data to higher (urban and national) planning levels.

F. Sustainability and Capacity Measures

20. To transform the initial implementation into a reliable and solid HMIS and ICT infrastructure it is necessary to consider long-term sustainability and capacity building measures on all project levels. The measures should focus on Technical Support Infrastructure, Patient MRS user capacities and DHIS2 support and user capabilities.

21. Initially the support and training capacities must be built on project implementing side but should be transferred in a phased approach to facility side. The phased concept envisions a gradual shift of the support capacities from implementer and project management units to facility and post-project facility management units. In addition to the support and maintenance of infrastructure and general user support, a dedicated HMIS maintenance and development team is required to maintain, expand and adapt the HMIS to changing requirements.

22. Capacity sharing between the project and the DGHS technical development team is not only possible but should be actively evaluated.

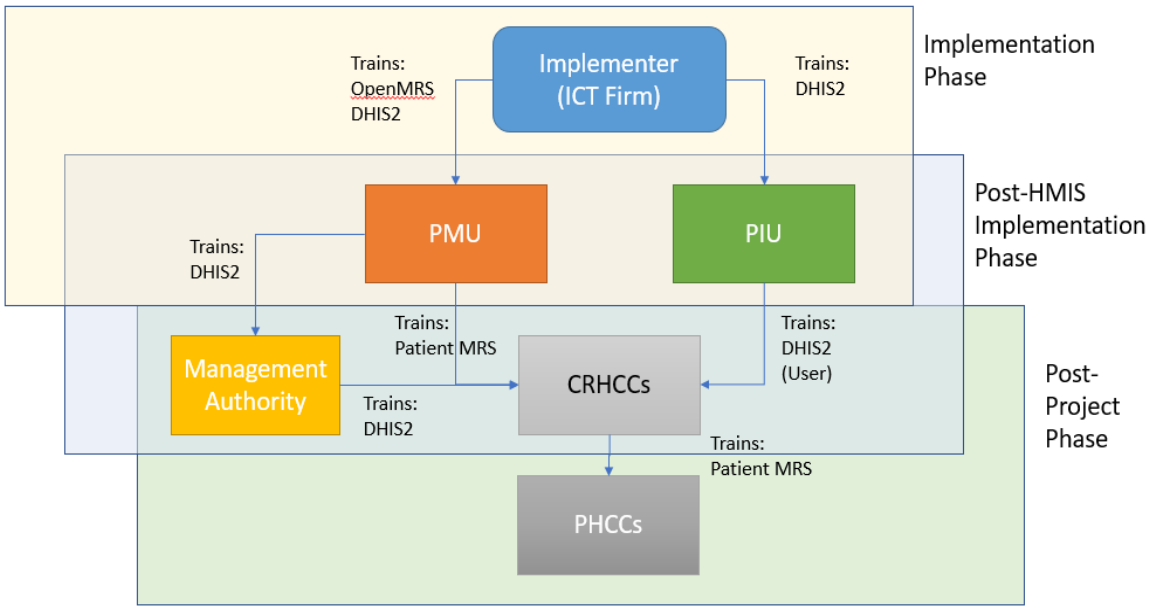
G. Training Capacities

23. Initial training capacities will be provided by the implementer (ICT firm). One of the core requirements of the ICT firm will be the establishment of a training network to support PMU, PIUs, and facilities that is sustainable after the initial support phase for the ICT firm and—long-term—after project resolution. The approach is that the ICT firm initially trains on PMU level and PIU level in Patient MRS, OpenMRS maintenance, DHIS2 maintenance, and DHIS2 data management. At the end of the HMIS implementation phase, two knowledge hubs (PMU and PIUs) should be established in the project framework.

24. In the post HMIS implementation phase, the PMU will take over the role of the ICT firm as the primary training and capacity building authority and will be responsible for training the CRHCC staff in Patient MRS. The PIUs responsibility will be to train CRHCC staff in DHIS2 use and data quality. The goal is that in each CRHCC is one super-user able to train the relevant PHCC staff in the use of Patient MRS. By the end of the project, each established CRHCC has a trainer capable of training staff in PHCCs and does not require support in Patient MRS training from PMU. Likewise, the PIUs will train a DHIS2 super-user in each CRHCC to make the CRHCCs independent from PIUs after project resolution. The PMU also has to transfer knowledge to the future facility management authority (once they are established) prior to project wrap-up in terms of Patient MRS maintenance, DHIS2 maintenance, and DHIS2 customization.

25. As outlined under “Support Capacities”, if cooperation with existing DHIS2 and OpenMRS knowledge centers (like DGHS) can be established, the PMU has to prepare a hand-over framework with those knowledge centers before project resolution.

Training and Training Capacity Outline for Health Management Information System



H. Information and Communication Technology Hardware Allocation

26. Since one of the core requirements for both Patient MRS and DHIS2 is real-time data entry and availability, all facilities except satellite clinics **must** be equipped with a reasonably reliable internet connection. Onsite research has shown that telephone line-based digital subscriber line (DSL) connections are available in the Dhaka urban area except for fringe districts. Based on telecommunication provider information, 85%–90% of facilities can be equipped with a line-based internet connection.

27. Ideally, each CHRCC facility will be equipped with a line-based DSL connection and a 4G/LTE mobile internet connection as failover. PHCCs can reasonably rely on a single stable 4G/LTE connection since workload throughput and data volume is substantially lower than in CRHCCs.

28. A current estimation of cost for internet connectivity puts a DSL connection and roughly $18/month and 4G/LTE connections at approximately $12/month. Considering the comparatively high number of facilities, it is recommended that the PMU directly negotiates a lumpsum contract with a national provider. Operational cost for internet access should not exceed $240/year for each CHRCC and not exceed $120/year for each PHCC. Total operational cost for all facilities' internet access should be expected to be below $30/year.

29. Overview of required ICT equipment for CHRCCs and PHCCs based on functional and general allocation:

CHRCC ICT Equipment

Functional Assignment	PC Workstation	Laptop	Printer	Wi-Fi Routers	MF Network Printer	Fixed Line Internet	LTE/4G Internet
Registration	1		1				
Specialists	2						
Medical Offices	2						
Paramedics	1						
Councillor	1						
Lab Tech	1						
Nursing	1						
General Admin	1				1		
Manager		1	1				
Spare/Contingency PC	1						
Per Facility				3		1	1
Total	**11**	**1**	**2**	**3**	**1**	**1**	**1**

PHCC ICT Equipment

Functional Assignment	PC Workstation	Laptop	Printer	Wi-Fi Routers	LTE/4G Internet	Tablet Computer
Registration/Physician	1		1			
Paramedic	1					
Counselling	1					
Admin/Supervision		1	1			
Satellite Paramedic						2
Per Facility				1	1	
Total	**3**	**1**	**2**	**1**	**1**	

30. The allocated data entry points take into consideration shared workspaces for medical officers and paramedics. This allocation will allow a complete representation of the manual URKS. However, not all functional areas justify their own equipment and some URKS forms and register will need to be entered at a shared nurse station workstation (i.e., overtime record) or general administration workstation (i.e., vehicle register).

31. One Network (Wi-Fi) enabled multi-functional business printer will be available in each CRHCC for general printing needs to reduce waste and consumable cost. This equipment will also be used as a scanner.

32. ICT and monitoring and evaluation computer equipment is already available in the CHRCCs and does not require additional provision.

33. Pharmacy is omitted from the data entry allocation since prescription documentation and data entry is done on specialist/medical officer level.

34. There are two possible approaches to address the hosting situation for the Patient Management System as well as for DHIS2: (i) A hosted solution from a service provider who will be responsible for the basic server maintenance, back-up, and security; or (ii) with PMU-hosted servers, where the project will purchase (minimum) 2 servers and install them at appropriate premises within the PMU. Should the PMU opt for a solution that requires hosting on PMU premises, the following basic ICT needs arise:

PMU Hosting Solution requirements (minimum)		**Qty**
a	Midrange Server class servers	2
b	Server grade UPS	1
c	Network attached storage (Backup)	1
d	High Speed fiber-optic internet connections	2
e	Server Rack and Rack installation	1
f	Continuous high reliability air-conditions	2
g	General server room infrastructure installations	1

35. For operational and sustainability reasons, it is recommended that the HMIS servers will be hosted at the PMU initially. The ICT firm will develop a long-term operational plan for the operation and maintenance of the HMIS servers post-project.

ANNEX 13
CRITERIA FOR SELECTION OF MUNICIPALITIES

1. **Objective criteria for selection of new partnership agreement areas.** The ongoing project (Urban Primary Health Care Services Delivery Project) has 25 partnership agreement areas (PAA) in 14 city corporations and municipalities. Twenty new PAAs will be added in the proposed additional financing: (i) one PAA for each of the selected 10 municipalities new to the project, (ii) three PAAs for Chattogram City Corporation, (iii) three additional PA areas for Dhaka South City Corporation, (iv) two additional PAAs for Dhaka North City Corporation, and (v) one additional PAA each for Narayanganj City Corporation and Gazipur City Corporation.

2. The 10 new municipalities proposed are: Mymensingh, Faridpur, Shariatpur, Gaibandha, Netrokona, Kurigram, Jagannathpur, Derai, Benapole, and Tarabo. These municipalities are selected mainly because there are no fully operational medical colleges and no 300-bed hospitals. In addition, these municipalities are in poorer and underserved districts mainly in the northern part of Bangladesh. The increase of PAAs for Dhaka North City Corporation and Dhaka South City Corporation are due to expansion of these city corporations which will result in 16 new unions and six new regions. Furthermore, there are insufficient health facilities and no union health and family welfare center at present. Lastly, new PAAs for Narayanganj and Gazipur are due to rapid expansion and the request of the city corporations.

3. The project will cover all city corporations in Bangladesh as a ‘critical mass’ for a national urban primary health care (PHC) project. Selection of municipalities to participate in the project observes the following criteria:

(i) municipalities with inadequate/poor PHC services;
(ii) municipalities without medical college hospitals or large health service facilities;
(iii) municipalities with high concentrations of poor population;
(iv) municipalities with leaders committed to the principles and approach of partnership and willing to participate in the project as evidenced by donation of land in strategic areas and willingness to accept conditions to assume project responsibilities after the project ends;
(v) municipalities with low social indicators, such as for maternal and child health, family planning, and nutrition;
(vi) municipalities with *haor* and growing population with limited health facilities;
(vii) rapidly growing industrial areas; and
(viii) municipalities willing to (a) deploy staff to take up positions in the project implementation unit (in line with their expertise), (b) absorb new staff hired by the project implementation unit after the end of the project, (c) contribute 1% of their revenues into Urban Primary Health Care Sustainability Fund.

4. Municipalities exhibit a wide variation in terms of their economy, population size, distribution of their residents among the different economic quintiles, etc. To make best use of the limited resources available for urban PHC and ensure value for money, the population size of the proposed partnership areas is an important parameter to consider. Also, to ensure that project benefits reach the maximum number of poor population, the poverty ranking of different districts should be another important consideration. Moreover, the management capacity of local government authorities and the commitment of the leaders (mayors, councilors, and other decision makers) is of paramount importance. Table A13.1 shows the estimated population, number of households and wards, as well as the number of partnership areas and wards covered in the city corporations and municipalities proposed for inclusion in the project.

5. Municipalities also vary in the concentration of public health facilities, teaching hospitals, and other private and charitable health facilities. Considering the accessibility issue, it has been recommended that new areas should consider the inclusion of municipalities which (i) lack or have poor PHC services for their residents and (ii) have no medical college hospitals or large health service facilities. Table A13.1 shows the estimated population, number of households and wards, as well as the number of partnership areas and wards covered in the city corporations and municipalities proposed for inclusion in the project.

Table A13.1: City Corporations and Municipalities Included under the Project

	Name of CC/Municipality	Estimated Population, 2018*	No. of Households, 2018**	No. of Wards	PAs		
					Existing	Additional	No. of Wards Covered
1	Dhaka South City Corporation (DSCC)	2,799,064	636,151	57	5	3	39 (existing=31)
2	Dhaka North City Corporation (DNCC)	3,382,345	768,715	36	5	2	22 (existing=17)
3	Narayanganj City Corporation (NCC)	514,232	116,871	27	1	1	11
4	Sylhet City Corporation	660,347	150,079	27	1	0	21
5	Barishal City Corporation	434,357	98,718	30	1	0	23
6	Rajshahi City Corporation	429,702	97,660	40	2	0	20
7	Rangpur City Corporation	366,600	83,318	16	1	0	16
8	Khulna City Corporation	350,627	79,688	38	2	0	17
9	Gazipur City Corporation	2,760,030	627,280	37	2	1	37
10	Cumilla City Corporation	367,726	83,574	24	1	0	24
11	Chattogram City Corporation	3,123,968	709,993	41	0	2	TBD
12	Kishoreganj Municipality	130,677	29,699	9	1	0	9
13	Gopalganj Municipality	61,789	14,043	9	1	0	9
14	Sirajganj Municipality	158,016	35,913	15	1	0	15
15	Kushtia Municipality	119,912	27,253	15	1	0	13
16	Mymensingh Municipality***	283,639	24,467	9	0	1	TBD
17	Faridpur Municipality***	140,616	29,275	9	0	1	TBD
18	Shariatpur Municipality***	56,249	19,521	9	0	1	TBD
19	Gaibandha Municipality***	74,536	14,223	9	0	1	TBD
20	Kurigram Municipality***	85,895	19,521	9	0	1	5
21	Netrokona Municipality***	128,812	18,500	9	0	1	TBD
22	Jagannathpur Municipality***	45,315	16,940	9	0	1	TBD
23	Derai Municipality***	32,760	11,252	9	0	1	TBD
24	Benapole Municipality***	36,524	7,048	12	0	1	TBD
26	Tarabo Municipality***	219,981	49,996	9	0	1	TBD
		16,763,719	3,769,697	514	25	19	TBD
	* 2018 population was estimated based on exponential growth rate projected from Census 2001 and 2011.						
	** Household numbers were estimated considering a family size of 4.4 (Census 2011 report).						
	*** New municipalities included						

ANNEX 14
REACHING THE URBAN POOR

A. Indicators to Determine the Poor and the Ultra Poor in Urban Areas

1. Based on the experiences of the first and second phases of the Urban Primary Health Care Project as well as the third phase (Urban Primary Health Care Services Delivery Project), the work of partner service providers, and consultations with various stakeholders, it is proposed to coordinate with other institutions to critically review the following criteria for identifying the urban poor in the next phase of the project. The criteria can be based on a combination of living conditions, nature of employment, monthly income, house rent, and food intake. The definition of "poor" and "ultra poor" will be further confirmed in coordination with local development partners, and reviewed and updated at regular intervals to further fine-tune efficient pro-poor targeting.

Table A14.1: Operational Definition of "Poor" and "Ultra Poor"[a]

	Status of Indicators	
Indicators	**Ultra Poor**	**Poor**
Living conditions	People living in very poor slums (i.e., shanties), on the streets, near factories or waste dumps, riverbeds or hillsides; floating population	People living in ordinary slums
Nature of employment	Casual and informal sector workers: garment workers; hawkers; rickshaw and rickshaw van pullers; other manual car pullers; garbage or waste collectors; street sweepers; latrine cleaners; day laborers; maid servants; beggars; sellers of food or cigarettes on the street; disabled people; the unemployed; other vulnerable groups, e.g., sex workers	Casual and informal sector workers: temporary drivers, small traders, taxi/bus/private car drivers, factory workers, shopkeepers, tailors, small businessmen
Monthly income (average per household member)	Up to Tk1,000 (to be updated based on Household Income and Expenditure Survey (HIES 2010)	Tk1,000-1,500 (to be updated based on HIES 2010)
Rental status	Rent up to Tk1,000	Rent over Tk1,000
Meal per day and cooking facilities	Average one meal or two inadequate meals per day; sharing cooking stove with other families	Two adequate or three inadequate meals per day, or three adequate meals per day
Other family characteristics	Widows, households headed by females, migrants from rural areas in the last 2 years	Widows, households headed by women, migrants from rural areas in the last 2 years

[a] Developed and used by the project in coordination with other implementing agencies.
Source: Asian Development Bank.

B. Mechanism to Increase Access to Health Services by the Poor

2. **Baseline survey of the project area.** A baseline survey will be conducted to identify poor households in the project area. Poor households will be identified based on the social and economic indicators above. These households will be given entitlement health cards ("red cards"), giving them free access to health services under the project. The survey of the poor households will be updated annually. Participatory appraisal will be conducted at the community level to assess the availability of health services, access to health services by the poor, and the social, financial, and physical barriers to their use by the poor.

3. The project management unit will assist nongovernment organizations (NGOs) in better identification of the poor, regular updating of the red card system on an annual basis, and closely aligning with partner implementing agencies to improve outreach and targeting of the poor. The project will use the "Simple Poverty Scorecard for Identification of the Ultra Poor and Poor" and its guidelines developed by the Urban Primary Health Care Services Delivery Project in 2014.

4. **Location of health facilities and mini-clinics.** To facilitate their use by the poor, health facilities will be located in slums or close to slums or poor populations. Where land is scarce and health facilities cannot be located in or near slums, mini-clinics will operate in slums. Mini-clinics' hours will be flexible to meet the needs of the poor. If necessary, they will be open during the evening. Geographic information system mapping of the poor populations, health facilities, and mini-clinics will be undertaken by the project management unit from project inception so that new health facilities will be constructed where poor populations will have easy geographic access. Annual updates of the geographic information system maps will be disseminated to public–private partnership service providers so that referral systems for nearby clinics can be facilitated. Moreover, the maps will be posted on information bulletin boards outside health facilities for the community's reference.

5. **Social mobilization.** At the beginning of the project, a launching or inception ceremony will be held in each ward to introduce the health center facilities. A comprehensive community social mobilization program will be designed to disseminate basic information on project services and motivate the poor to use the health facilities. The program will include audiovisual and other innovative methods. Neighborhood meetings in slums and low-income areas will be organized periodically to explain all services available, rates of services, and free services for the poor. Networking with other NGOs in the area will be encouraged to strengthen pro-poor targeting. Ward-level primary health care committees with male and female ward commissioners, local leaders, members of youth clubs, civil society, NGOs, partner NGOs, and representatives of the poor will develop awareness campaigns for the poor and monitor access to health services and their quality. The project will support grassroots activities against social prejudice and other barriers that discourage use of health facilities by the poor and minorities.

6. **Monitoring and record-keeping.** Partner NGOs will keep systematic records on the patients, by poverty and gender, and will prepare quarterly reports of health service use by the poor, children, women, and adolescents. Both aggregated data and quarterly reports (e.g., number of patients, expenditure, costing by each type of health service) will be uploaded to the health management information system and financial management information system, as appropriate.

7. **Capacity building.** Field staff of the partner NGOs responsible for social mobilization, health education, and community volunteers will be oriented on the project and pro-poor targeting.

Field staff and volunteers will receive training on mobilizing the poor and generating demand for health services among them.

8. **Piloting innovative and inclusive approaches towards universal health coverage.** To better reach the poor (and near poor) population towards achieving universal health coverage, some partnership areas will pilot various demand-side financing schemes, such as health service vouchers and health insurance, which would especially benefit the near poor against catastrophic out-of-pocket health expenditures. Another possible pilot approach would be mobile service delivery that is dispatched from partnership area nongovernment organizations to cover floating populations. These mobile clinics will have a regular schedule, and their sessions will be monitored for the performance incentive scheme as per the partnership area agreement.

C. Good Governance and Transparency to Ensure Efficient Pro-Poor Targeting

9. The project will ensure easy access to health service-related information by the general public and the urban poor. It will use information bulletin boards outside health facilities to provide information on user fees and availability of free services to the poor, outreach activities, community-based organizations, and other cost-effective means. The facility, ward, city, and municipality primary health care committees will include representatives of the poor urban slum dwellers and female ward members and will have quarterly meetings. The committees will review their respective jurisdictions' listing of poor households to ensure that the poor are being targeted efficiently, the annual physical and financial plans ensure adaptation to the local context, and the quarterly expenditure statements ensure public accountability. To make committees more effective, key stakeholders will be oriented and trained in project management to ensure good governance and transparency.

ANNEX 15
CLIMATE CHANGE AND HEALTH

A. Direct and Indirect Links Between Climate Change, Urban Infrastructure, and Public Health in Bangladesh

1. Bangladesh has made tremendous improvements in their economy and public health the past 30 years. From 1970 to 2015 the gross domestic product is growing at a rate of 6.6%, one of fastest in the South Asian region. Its gross national income has increased from $100 in 1973 to $1,190 per capita in 2015. Life expectancy had increased from 55 to 69 years old, and infant mortality from 133 to 37.5 and neo-natal mortality from 54.1 to 27 per 1,000 live births. It has also far greater immunization rate against diphtheria and measles than its richer neighbors. However, the threat of climate change could slowly erode these successes with the predicted inundation of coastal areas due to sea level rise, salinity intrusion of groundwater, more devastating cyclones, and severe droughts. Climate change is also predicted to impact human health by exacerbating existing disease burden on health systems and its capacity to adapt, with the elderly, children, and the poor as most vulnerable.

2. **Climate change**. Climate change refers to the significant variation in the mean state or variability of climate over a long period directly or indirectly to human activity that alters the composition of the global atmosphere. The concentration of greenhouse gases and aerosols in the atmosphere coupled with the changes in land cover have altered the global energy balance resulting in the warming over the past 50 years. Global warming has contributed to sea level rise, changes in wind pattern and tropical storms, extreme variability in temperatures, increase the risk of heat waves and droughts, and increase the frequency of heavy precipitation.[1]

3. **Existing and projected climate change and natural hazards**. Bangladesh has four seasons: pre-monsoon, monsoon, post-monsoon, and winter. Pre-monsoon occurs from March to May dominated with high temperature with occasional heavy rainfall. During the pre-monsoon, average maximum temperature is 36.7°C with some areas in the southwest reaching 40°C. Hot and humid with torrential rainfall characterizes monsoon season spanning from June to September. Bangladesh is one of wettest countries in the world receiving 1.5–5.8 meters of rain annually. A reduction in temperature, rainfall, and relative humidity occurs during post-monsoon which transitions to winter season from December to February, with average minimum temperatures dropping to 7.2°C in the northern districts maximum temperatures are reduced from 23.9°C to 31.1°C. Historical climatic records revealed an increasing trend in temperature of 1°C in May, 0.5°C in November from 1985–1998, greater variability in rainfall and temperature, the frequency of cyclone over the Bay of Bengal during the months of November and May.

4. To predict the future change in climate for Bangladesh the scientific community relies on downscaled climate global and regional models. These models provide the following insights (Intergovernmental Panel on Climate Change Third Assessment Report) for the country:

(iv) Mean temperatures are projected to increase between 1.4°C and 2.4°C by 2050 and 2100, respectively. This warming is expected to be more pronounced in the winter months (December–February). Average temperatures are expected to increase between 1 and 2°C by 2100.

[1] Intergovernmental Panel on Climate Change (2007). Fourth Assessment Report.

(v) The frequency of tropical cyclones in the Bay of Bengal may increase with peak intensity increase by 5% to 10%, and precipitation rates may increase by 20% to 30%".
(vi) Cyclone-induced storm surges are likely to be exacerbated by a potential rise in sea level of over 27 cm by 2050.
(vii) Sea-level rise is projected for Bangladesh suggests an increase of 30–100 cm by 2100.
(viii) Run-off is projected to increase, longer rainy days is expected to increase, and increase in peak rainfall intensity.

5. Bangladesh's location and topography make it as one of the most climate-vulnerable countries in the world. Located between the Himalayas and Bay of Bengal with an average elevation of only 4–5 meters above mean sea level, the country is regularly inundated with seasonal floods at times submerging 70% of the country under flood waters. The Bay of Bengal that defines the southern boundary of the country is located at the northern tip of the Indian Ocean with an inverted shaped funnel generating long tidal wave surges brought by cyclonic storms. Bangladesh is the most disaster-prone country (World Bank, 2005) accounting for 60% of the worldwide deaths cause by cyclones, an estimated 1 million people are affected by floods and riverbank erosion annually and up to two-thirds of the population experiences floods every 3 to 5 years, devastating seasonal droughts in the northern district decimate crops, and the northern and eastern districts are susceptible to destructive earthquakes.

6. According to the Bangladesh Climate Cell,[1] the country is already experiencing climate change and has observed hotter summers, more erratic rainfall patterns, heavier rainfall over a shorter period of time causing water logging and landslides, drier summer months, crop failures, salinity intrusion due to sea level rise, and increase in mortality and morbidity from extreme heat and cold waves, and outbreaks of dengue, malaria, and diarrhea.

1. Impacts of Climate Change on Human Health

7. There are three exposure pathways how extreme climate variability and change affects human health, these are: (i) direct exposure from extreme weather including heat, drought, and rainfall; (ii) indirect exposure mediated through natural systems like disease vectors, water-borne diseases, and air pollution; and (iii) indirect exposure mediated through human systems like occupational impacts, undernutrition, and mental stress.[2]

8. **Direct impacts of climate change on health outcomes.** Exposure from heat, cold, flood, and cyclones have claimed thousands of lives in Bangladesh. Seasonal flooding has affected more than 270 million individuals from 1970 to 2002[3] and caused 700,000 deaths from 1960–2009.[4] In 1988, 6% of recorded deaths and 5% of the total patients were flood-related. The coast of Bangladesh is regularly hit by devastating cyclones, accounting for the 60% of the total worldwide deaths from cyclones the past 20 years.[5] Noteworthy of these cyclones are Sidr and Aila. Tropical cyclone Sidr, considered as one of the worst natural disasters in Bangladesh, made landfall along the south-west coast in November 2007 generated 6 m storm surges and peak wind

[1] Climate Change Cell (2008). " Bangladesh Reducing Development Risks in Changing Climate". Department of Environment of GoB, United Nations Development Programme (UNDP), Department for International Development (DFID), Comprehensive Disaster Management Programme, Dhaka, Bangladesh.
[2] IPCCC AR5 Chapter 11. Human Health: Impacts, Adaptation and Co-Benefits.
[3] Gapminder.org based on data from Center for Research on the Epidemiology of Disasters (CRED) EM-DAT: The OFDA/CRED International Disaster Database. Université Catholique de Louvain – Brussels – Belgium.
[4] World Health Organization (2012).
[5] World Bank (2005).

speed of 260 kph destroying embankments, roads, bridges, and sanitation facilities; flooding of coastal areas, and contamination drinking water supply with saline water and debris. An estimated 1 million households were severely affected, large-scale evacuation ensued and recorded 3,406 deaths and 55,000 physically injured persons. An outbreak of communicable diseases followed, afflicting thousands of children under 5 years old with diarrhea, dysentery, acute respiratory infection, and pneumonia.

9. **Indirect impacts of climate change on health outcomes (ecosystem-mediated).** Changes in temperature, rainfall, and relative humidity are principal drivers on the prevalence of vector-borne diseases such as malaria, kala-azar, and dengue fever in Bangladesh. Changes in weather parameters are positively related with the number of dengue incidence while malaria tends to decrease with decreasing temperature. The Bangladesh Department of Environment's Climate Change Cell correlated the meteorological data with the upazila health complex data and revealed that (i) the annual and seasonal variation of temperature and rainfall on saline-intruded, flood, and drought-prone areas are positively correlated with the occurrence of diarrhea, skin disease, and kala-azar; and (ii) diurnal temperature difference are positively correlated to diarrhea. Not until after year 2000[6] was dengue became prevalent in the country and now considered endemic in the urban areas[7] like Dhaka where the environmental conditions are suitable to outbreaks. Outbreaks of dengue are reported frequently[8] and are highly correlated to seasonal variation in temperature and humidity which peaks in July and decreases in September.[9]

10. Kala-azar or black fever caused by the protozoan *Leishmania* parasites which are transmitted by the bite of infected female sandflies is one of the major vector-borne diseases in Bangladesh accounting for 60% of the total cases worldwide from 2004–2008. Usually occurring in rural areas with heavy annual rainfall, humidity of more than 70%, temperature range from 15°C–38°C, abundant vegetation, sub- soil water and alluvial soil.[10] The spread of Kala-azar is highly sensitive to climate as changes in temperature, rainfall, and humidity affects (i) distribution, survival, and population size of vectors and reservoir hosts; (ii) development cycle of the leishmania allowing transmission in new areas; and (iii) drought, famine, and flood resulting to displacement and migration of people to areas with transmission of *Leishmania*, and poor nutrition could compromise their immunity.

11. Substantial studies have been conducted on the effect of climate change and the spread of malaria. In Bangladesh, 13 districts[11] along the east and northeast borders have a high prevalence of malaria mainly due to Plasmodium falciparum parasite[12] carried by *Anopheles dirus, A. minimus, A. philippinensis,* and *A. sundaicus* [13] mosquitoes. Changes in temperature, rainfall, and humidity affect the mosquito population and the development of the Plasmodium

[6] The dengue virus strain was likely introduced from Thailand. The ban on dichlorodiphenyltrichloroethane (DDT) spraying, climatic, sociodemographic, and lifestyle are contributing factors.
[7] World Health Organization (2008). Climate Dengue Status in South East Asia Region: An Epidemiological Perspective. www.searo.who.int/.../Dengue_dengue-SEAR-2008.pdf
[8] Sharmin R, Tabassum S. Mamun KZ, Nessa A, Jahan M (2013). "Dengue infection in Dhaka City, Bangladesh." https://www.ncbi.nlm.nih.gov/pubmed/24292312
[9] Esnamul, Hasib and Prita Chathoth (2016). "Health Impact of Climate Change in Bangladesh: A Summary." s. http://www.scirp.org/journal/cus http://dx.doi.org/10.4236/cus.2016.41001
[10] WHO (2017). Leishmaniasis Fact Sheet
[11] Kurigam, Sherpur, Mymensingh, Netrakona, Sunamganj, Habiganj, Sylhet, Moulribazar, Chattogram, Coxsbazar, Khagrachari, Ragamati, and Baudarban
[12] Malaria Atlas Project: Bangadesh. http://www.map.ox.ac.uk/explore/countries/bgd/ http://www.map.ox.ac.uk/explore/countries/bgd/
[13] M. Elias (1996). "Larval habitat of Anopheles philippinensis: a vector of malaria in Bangladesh." http://apps.who.int/iris/bitstream/10665/54018/1/bulletin_1996_74(4)_447-450.pdf

parasite. High temperature, particularly near the physiological limit of mosquito, can decrease malaria transmission and conversely, at a lower temperature a slight increase result to a dramatic spike in the mosquito population and increases the risk of malaria transmission.

12. **Role of health care and essential public infrastructure**. Public health care and infrastructure can moderate health impacts by addressing human exposure to climate change and improve adaptation capability. Disaster preparedness can reduce mortality and morbidity related to the cyclone, storm surges, and flooding as the demonstrated in the establishment of cyclone centers on the coastal area of Bangladesh. The status of physical infrastructures particularly in urban centers like power and water supply, waste management, and sanitation influences the health risk from climate change. Public health and physical infrastructure are an integral part to improve the overall health status and overall resilience. In Cuba, with a well-developed public health care system, the prevalence of dengue continued to persist due to the lack of potable water supply forcing people to use containers that provided breeding grounds for *Aedes aegypti*. The city of New York saw an increase in heat-related mortality in 2012 when it suffered power failures during the heat wave.

13. Public health care[14] has a crucial role in reducing the exposure to climate change through (i) public education and awareness; (ii) early alert systems—impending weather extremes, infectious disease outbreaks; (iii) disaster preparedness, including increasing the health system's 'surge' capacity to respond to emergencies; (iv) enhanced infectious disease control programs—food safety, vaccine programs, vector control, case detection and treatment; (v) improved surveillance—risk indicators (e.g., mosquito numbers, aeroallergen concentration)—health outcomes (e.g., infectious diseases outbreaks, rural suicides, seasonal asthma peaks); and (vi) appropriate health workforce training, including mid-career development (e.g., updated understanding of climatic influences on health, training in public health).

B. Enhancing Climate Resilience Urban Primary Health Care

14. The projected climate variability and change pose serious risks to the human health as more frequent and destructive cyclones are expected to hit the southwestern coastal region of Bangladesh, bringing powerful winds, storm surges, flooding, and groundwater salt intrusion causing deaths and injuries from drowning, vector-, food-, and water-borne diseases. More intensive heat waves will increase the risk from heat strain and stroke. The health results from exposure to extreme weather and changing climate could erode the previous accomplishments in health status and place an additional burden on the existing health care systems, including primary care.

15. As primary health care is the first line of health care, primary health facilities and their staff will inevitably be first responders to climate change. The role and responsibility of local governments, especially in highly and densely populated urban areas, to effectively coordinate climate change adaptation and mitigation measures becomes more pressing. Urban ward councils and urban residents would benefit from greater awareness to become active participants in addressing climate change. Under the Urban Primary Health Care Services Delivery Project (UPHCSDP) (2012–2018), the primary health care center (PHCC) and comprehensive reproductive health care center (CRHCC) infrastructures are at risk from climate change and extreme weather. Designed to cater to the needs of the poor and be accessible to urban slums, the centers are located in available government lands without the benefit of risk assessment and are generally located in hazard prone areas. The partnership area NGOs (PANGOs) that operate the centers, lack the budgetary provisions and trained staff to handle disaster risk and response

[14] Blashki, G. "Climate change and primary health care." http://www.bvsde.paho.org/bvsacd/cd68/GBlashki.pdf

and the adverse effects of climate change both on the partnership area and the health infrastructure itself. The project which started constructing these centers almost 20 years ago is now faced with maintaining old structures that are more vulnerable to extreme weather.

16. Preparing the CRHCC and PHCC to be dynamically and effectively responding to climate change will require investments in personnel, infrastructure, and service coordination. The two main challenges brought by extreme weather events to urban primary health are potential service disruption due to failures of the infrastructure and the deterioration of the organization and supplies due to surge of patients that can overwhelm design capacity. These facilities are part of a bigger set of critical facilities in the urban areas where even a slight disruption have great implications. These critical facilities include cyclone shelters, power generation, and water and electric utilities. The delivery and operating theater of the CRHCCs and limited curative care (basic first aid, emergency care, minor infection, primary eye care, and disaster management) of CRHCCs, PHCCs, and satellite clinics should remain operational even under extreme weather and utilities failures. In some cases, like in sparsely populated areas, the centers may even serve as safe havens during and following disasters. Existing facilities must be retrofitted, and current prototype design revisited to ensure the infrastructure capabilities, redundancies, and disaster preparedness and response are addressed.

17. **Framework for building climate resilience of urban primary health Care**. Figure A15.1 presents the framework adopted in assessing the climate change risk and vulnerability of the UPHCSDP infrastructure and health services and measures to build resilience. The assessment was guided by ADB's Climate Risk Management Framework[15] but divided into two main streams: climate risk assessment of 152 existing CRHCCs and PHCCs which makes use of the UPHCSDP facility map and the Bangladesh Multi-Hazard Risk and Vulnerability Assessment, Modeling and Mapping Atlas prepared by the Bangladesh Department of Disaster Management pursuant to the Hyogo Framework for Action to identify the country's flood, storm-surge, earthquake, tsunami, landslide, drought-prone areas and assess exposure of population, houses, critical facilities including health care, and infrastructures among others. Specific CRHCCs and PHCCs with at least medium exposure from any hazards were identified. A climate resilience checklist for health care facilities was developed from toolkits to identify vulnerabilities of the infrastructure, its operation, and health service delivery, and corresponding measures were designed based on site audit and discussions with PANGOs.

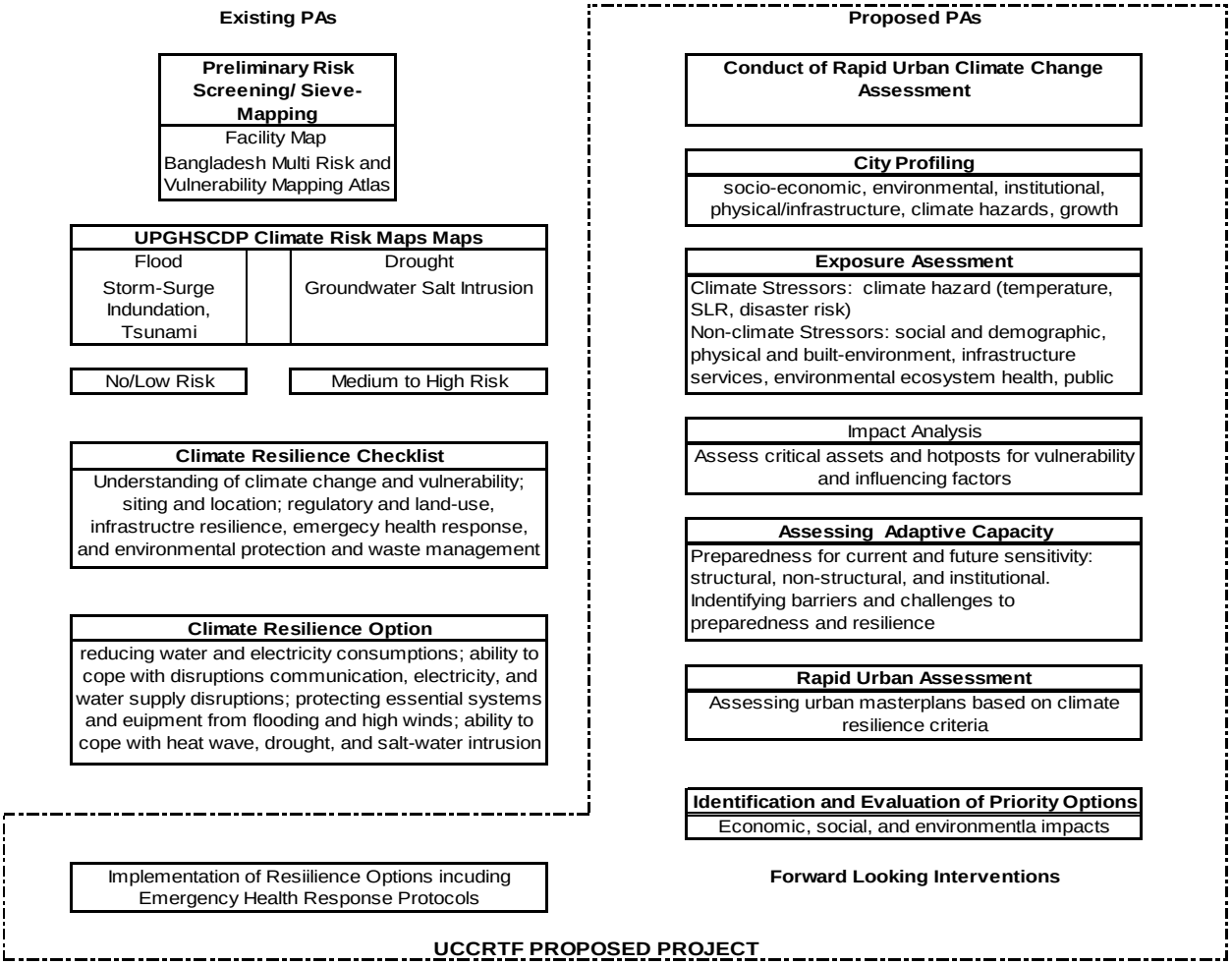
18. However, such approach is not applicable to the new partnership areas identified in the proposed additional financing of UPHCSDP (2018–2023) as the centers sites are still to be identified by the urban local bodies (ULBs). The conduct of rapid urban climate change assessment (RUCCA), a tool developed under "TA-8913 REG Subproject 1: Developing Integrated Urban Development Plans in Selected DMC Cities Incorporating Urban Climate Change Resilience Principles" is adopted. RUCCA follows the hazard-exposure-vulnerability investigation nexus but on a larger scale encompassing entire municipality. It considers the potential climate impacts, the areas of vulnerability and affected communities, the ULB's technical and administrative capacities, and overlay this information to identify vulnerabilities and formulate a set of action to address the later towards improving resilience. An impact assessment of climate change involves evaluating a municipality's profile in terms of socioeconomic, environmental, institutional, physical/infrastructure, climate hazard, and growth-trends against climatic and no-climatic stressors. Identified gaps, and weaknesses are further compared with the ULB's masterplans if there is conscientious effort to address them, based on climate resilience

[15] https://www.adb.org/sites/default/files/publication/148796/climate-risk-management-adb-projects.pdf.

principles, interventions are designed to address remaining issues to build the ULBs readiness and resilience to respond to climate change.

19. The proposed additional financing will directly benefit from the conduct of RUCCA through the generation of risk maps which will allow the ULBs to select better site for the new urban primary health care (UPHC) centers that avoid or minimize exposure to identified climate change risk. Unavoidable risk can be mitigated by site-adapting the health center's prototype design based on identified vulnerabilities similar to the options proposed for the existing centers. A broader benefit from the RUCCA is the strengthening of the ULB planning and implementation capabilities in general to become more resilient as it identified systemic adaptation projects, location-specific structural interventions, and strategic-regulations, institutional and financial interventions.

Figure A15.1:
Framework for Building the Climate Resilience of Urban Primary Health Care
Infrastructures and Health Services



20. **Preliminary risk screening of existing UPHC infrastructure exposures.** The UPHC infrastructure is facing numerous climate change and extreme weather risks. The CRHCCs and PHCCs by virtue of their location are exposed flood, storm surge, drought, tsunami, and saline intrusion of the aquifer. Understanding the nature of the PHC's vulnerability and exposure to

changing climate and extreme and natural hazards will allow the design and implementation of an effective adaptation and disaster risk management strategies and enhance their resilience. With 152 CRHCCs, PHCCs, and 226 satellite clinics distributed across 10 cities and four municipalities and handled by 25 PANGOs, each individual center is exposed to climate change and their capacities to cope with and adapt to climate change are factors that determine respective vulnerabilities. The country has very well built its resilience to catastrophic low-probability events like Sidr and flooding of Teesta River. The construction of cyclone centers is heralded as life savers, the climate adaptation of the Khulna Water Supply shows how ULBs can source have reliable source of water in the light of anticipated sea-level rise and salt water intrusion of the groundwater, while the construction of Teesta barrage in the 1990s has reduced flooding in central region of the country including Rangpur district that used to experience deep flooding. The UPHC's resilience should also address the slow, low intensity, and high-probability events like more frequent and prolonged power outages due to increase in temperature which puts burden on cooling, ventilation, and water supply systems of the center and the local utilities ability to sustain supply. The slow creeping salt water intrusion of the groundwater which has rendered deep wells useless unless deeper boreholes with more powerful pumps are installed requiring substantial resource not readily available. If these low-intensity events remain unattended, the UPHC's capacity to respond to more serious future disasters is diminished.

21. An overlay of available climate risk maps and the UPHCSDP facility map defined the preliminary risk screening. Risk maps developed by the Department of Disaster Management and compiled in an atlas provided probability-based risk and exposures on flood, storm surge inundation, tsunami, drought, and salt water intrusion. There are six existing CRHCCs and 40 PHCCs exposed to climate change risk with Khulna and Cumilla partnership areas the most at risk facing flood and salt water intrusion risks, and cyclone bearing high winds. Table A15.1 presents a summary of the preliminary risk screening:

Table A15.1: Summary of Preliminary Climate Change Risk Screening of Existing UPHCSDP Infrastructure

Partnership Area	Existing PHCCs and CRHCCs Exposed to Climate Risk			
	Flood	Drought/ Heat	Salt water Intrusion	Cyclone and High Winds
Dhaka South	PA1: PHCC-5, PHCC-6 PA:3 PHCC-1			
Narangyagonj	PHCC-1, PHCC-2, PHCC-3			
Rangpur	CRHCC, PHCC-1, PHCC-2			
Khulna	PA2: CRHCC (under construction)		PA1: CRHCC, PHCC-1, PHCC-2, PHCC-3, PHCC-4, PHCC-5, PHCC-6 PA2: CRHCC, PHCC-1, PHCC-2, PHCC-3, PHCC-4, PHCC-5	
Cumilla	CRHCC			CRHCC-PHCC-1, PHCC-2, PHCC-3, PHCC-4, PHCC-5
Barishal				CRHCC, PHCC-1, PHCC-2, PHCC-3, PHCC-4
Gazipur	CRHHC			
Rajshahi		PA1: CRHCC, PHCC1, PHCC2,		

		PHCC3, PHCC4, PHCC5 PA2:CRHCC, PHCC1, PHCC2, PHCC3, PHCC4, PHCC5		

Source: Asian Development Bank.

22. Annual floods are the most prevalent risk and vulnerability exposing numerous UPHC infrastructure annually particularly between the months of July and August and in extreme cases like what happened in 1998 and 2004 resulted in catastrophic damages in terms of lives and properties. Like the rest of country, the UPHC centers are mostly located in low lying flat lands with elevation no more than 10m above mean sea level and along major rivers. The succeeding Table provides the risk of flood by inundation depth for a flood event return period of 25 year for all existing UPHC infrastructure. An overlay of the UPHC location maps and the flood risk maps of the Department of Disaster Management, Ministry of Disaster Management and Relief revealed that of the 144 centers, 79 are free from flood risk representing 55%; 53 centers are at risk of very shallow inundation of less than 0.3 m or 37% of the total; nine centers or 6% are at risk of shallow inundation of less than 1 m; and only three centers all located in Rangpur are at risk of very deep inundation of more than 3.6 m of flood.

23. The divisions under threat from storm-induced surge are Barishal, Khulna, Chattogram, and Dhaka. These storm surges are generated by cyclones over the Bay of Bengal and the Indian Ocean barreling on a north western direction and making landfall on the south eastern region of the country can generate winds greater that 200 kph with destructive surges. In Barishal Division, the CRHCC, PHCC-1, PHCC-2, PHCC-3 (under construction), PHCC-4, and PHCC-4 (under construction) are exposed to very shallow <1 m storm surge inundation while PHCC-3 is under threat of medium inundation between 1.5–2.0 m with a return period of 25 years. The southern portion of Khulna Division is at risk of storm surge but not one of the UPHC infrastructures is at risk with all of them located north eastern section.

24. Bangladesh's long coastline and the active plate collision with subduction geologic nature underlying the Bay of Bengal and the Indian Ocean have experienced large-scale tectonic failures causing earthquakes exposing the southern region of country exposed to tsunamis. Barishal, Chattogram, and Khulna are expected to be inundated from a tsunami hazard of 100-year return period. However, not one of the UPHC centers in Khulna is at risk of inundation even with a tsunami hazard of 1,000 years.

25. Dry season can be very harsh in Bangladesh and the inadequacy and unevenness of rainfall distribution cause drought hazard particularly in the north western region particularly in Rajshahi and Rangpur Divisions covering the districts of Panchagarh, Thakurgaon, Dinajpur, Gaibandha, Joypurhat, Naogaon, Nawagganj, and Rajshahi. All UPHC centers in Rajshahi are exposed to this hazard.

26. According to World Bank, recent studies suggest that the coastal area of Bangladesh will become more vulnerable to salinity intrusion in a changing climate as continued sea-level rise is projected beyond 2100 even if greenhouse gas emissions are stabilized. The sea-level rise will result to increase the salinity of the rivers with potentially serious consequences resulting to shortages in water supply and irrigation water and decline of captured fisheries and biodiversity of the Sundarbans mangrove.

27. Bangladesh is regularly visited by tropical cyclones coming from the Bay of Bengal which is a common phenomenon within latitude 30° north and south of the equator. These cyclones have resulted in numerous disasters with wind speed, surge height, loss of life, and damage to crop and properties. The UPHC centers in Barishal and Khulna are in the forefront of cyclone paths.

28. **Vulnerability assessment of UPHC infrastructures and services**. To determine the vulnerability of the UPHC infrastructures and minimize the risk of climate change and extreme weather, a health center resilience checklist was developed. The checklist explores the following key resilience elements: (i) the UPHC center operators' understanding of climate change and vulnerabilities, (ii) siting and location, (iii) regulatory and land use, (iv) infrastructure resilience, (v) emergency health response, and (vi) environmental protection and management.

29. A total of 14 UPHC centers were surveyed in Cumilla (CRHCC, PHCC-1, PHCC-2, PHCC-3), Dhaka North City Corporation (PHCC-PA5), Kishoreganj (CRHCC, PHCC-1 and PHCC-2), Rajshahi (CRHCC-PA1/PHCC-1 PA1 and PHCC-1 PA2), Khulna (CRHCC and PHCC1) and Barishal (CRHCC-1). The following section describes the proposed activities based on the identified climate vulnerabilities of the assessed health centers.

C. Proposed Activities to Address Climate Change Impact

30. In order to address the impact of climate change, the proposed activities will need to include the following three aspects: (i) building appreciation, knowledge and capacity on climate change, risk, and vulnerability through training, workshop and international study tours; (ii) climate change vulnerability assessment and promotion of climate resilience; (iii) improving medical waste management capacity; and (iv) improving UPHC infrastructure resilience.

1. Building Appreciation, Knowledge and Capacity on Climate Change, Risk, and Vulnerability

a. International training and workshop in collaboration with World Health Organization Kobe Centre for city/municipal mayors and officials

31. ADB has supported UPHC projects in Bangladesh since 1998 with a principal aim to foster government-nongovernment organization contracting-out of primary health care services, emphasizing the poor. Bangladesh launched a National Urban Health Strategy in 2014, and efforts are underway nationally to devolve several responsibilities to local government. This will increase pressure to plan, deliver, and monitor health services and facilities in urban areas, as well as health outcomes and at the same time reinforce population-based or public health services and functions. These cover water, sanitation, communicable disease surveillance, health promotion and prevention programs (including reduction of noncommunicable disease (NCD) risk factors that fall outside the health sector), and the full spectrum of planning, response, recovery and building resilience for health emergencies and natural disasters (including impacts of climate change).

32. Decentralization-related reforms present opportunities and challenges for local governments to creatively expand health-urban planning linkages to improve the living environment, reduce risks for diseases, and to implement population-based health services (e.g. water, sanitation) and to ensure health care service delivery. Attending to fiscal flows, human resource planning and financing, and to intersectoral actions pose key issues and challenges to be resolved in order to achieve a healthy city vision.

33. This activity aims to partner with the World Health Organization (WHO) Kobe Centre (WKC) in building the capability of the ULB officials. WKC is the Knowledge Hub for the Commission on Social Determinants for Health (2005) on urbanization and health and developed, tested, and promoted the use of a set of tools and guidance measuring and addressing urban health inequities, intersectoral action, governance and health system development, urban health emergency management, as well as address emerging demographic and epidemiologic transitions such as NCDs and ageing of populations. WKC developed Urban HEART to assist municipal governments and ministries of health in systematically generating evidence to assess and respond to health conditions and inequity in urban settings. It combines a limited set of key indicators across sectors of government, with community engagement, to identify and prioritize health inequities at neighborhood level. It emphasizes the importance of prioritizing interventions and enables governments, central and local, to identify priorities for resource allocation. Urban HEART contributes to existing country initiatives that focus on urban health, community-based initiatives, Healthy Cities and Settings with the broader goal of encouraging an equity perspective in health and development work. The key target audience for this tool includes the mayor and city/municipal government, the Ministry of Local Government, Ministry of Health and Family Welfare, and other key partners in addressing the determinants of health, such as ministries of education, transport, housing, etc.

34. The activity comprises annual training workshop and study tour in Kobe, Japan during 2018–2020 for a group of mayors, senior city corporation, and municipal health decision makers, nongovernment organizations, and project officials. The team size is 12 participants. A total of 12 participants, comprising teams of 2–3 participants from 4–6 municipalities would be invited. In principle, a new cohort of participants would be invited each year. The latter is important to initiate a process to inform, using Urban HEART and similar approaches, the ability for mayors/municipal decision makers to lead development of efforts to increase population-based and primary health care services, along with equity (reaching the poor) that engage communities—a hallmark of the Sustainable Development Goals and often for political reasons, including accountability (both for elected officials, and of providers to health outcomes and government funding). Balancing time away from a country, the 4-day training workshop to be held in the month of May each year (tentative), will include lectures and small group exercises, as well as presentations by each team of participants about local initiatives and needs.

35. Topics for the workshop may include:

(i) Global, regional, and country trends in urbanization and population aging and their implications for health and sustainable development;
(ii) Exchange of local government initiatives to address environmental and population health challenges;
(iii) WHO initiatives on universal health coverage, urban health, and aging, including tools to support analysis, planning, implementation, and monitoring and evaluation;
(iv) NCD prevention strategies—the link between environmental pollution and population aging;
(v) Urban planning/design and health;
(vi) Multisectoral strategies to generate health co-benefits for the reduction of NCDs;
(vii) Role of primary health care in promoting awareness about the environmental determinants of health, as well as in advancing urban health coverage for ageing populations; and
(viii) Good practices and lessons learned in Japan.

36. The study tour will be complementary to the training workshop and will be integrated into the 4-day workshop schedule. These will be 0.5–1-day tour to field sites in Hyogo Prefecture. This will include courtesy visits to local officials, such as the governor's and mayors' offices. The study tours would provide an opportunity for participants to meet with local officials and directly observe good practices in Japan, including for air pollution control, waste management, transport/mobility, sustainable energy, NCD prevention, and urban models of integrated health and social care delivery.

37. The WKC will lead the organization and implementation of the training workshop and study tour, in consultation with ADB, and with technical inputs from the WHO Geneva Department of Public Health and Environment, the WHO Bangladesh Country Office, and other relevant WHO offices, as appropriate.

38. Below is a sample program for the training workshop and study tour—it is only meant to be indicative. The principal venue will be the WKC.

Table A15.2.
Training Workshop for City and Municipal Mayors and Officials in Kobe, Japan

Activity/Topic	Objectives
Day 1 Monday (morning, pre-workshop) Briefing and coordination meeting among organizers.	1. Review schedule and roles and responsibilities for the week 2. Housekeeping matters
Day 1 Monday (afternoon only) 1. Opening remarks 2. Overview of the week-long schedule of activities, objectives and expectations 3. Lecture on trends in urbanization and population ageing and their implications for health and sustainable development 4. City (team) presentations of local initiatives and major challenges 5. Courtesy visit to local senior officials (e.g. Mayor's office) 6. Welcome reception	1. Understand the objectives of the training workshop and study tour. 2. Understand global, regional and national trends in urbanization and population ageing and their implications for health and sustainable development. 3. Understand shared challenges among the municipalities. 4. Learn about other municipalities' initiatives to address urban health.
Day 2 Tuesday 1. Lecture on WHO initiatives on urban health 2. **Study tour** of municipal offices and field sites related to sustainable energy, urban planning, transport initiatives and emergency preparedness	1. Learn about WHO initiatives on urban health 2. Learn about the priorities for local decision makers in ensuring healthy and sustainable urban development 3. Learn about the latest technology and interventions used in Japan to address the environmental challenges to health
Day 3 Wednesday 1. Lecture on WHO initiatives on UHC and ageing 2. **Study tour** of municipal offices and field sites related to community-based care and primary health care	1. Learn about WHO initiatives on UHC and ageing 2. Learn about the priorities for local decision makers in ensuring healthy and sustainable urban development 3. Learn about the latest technology and interventions used in Japan to address population ageing challenges to health
Day 4 Thursday 1. Lecture on the role of primary health care to promote UHC in the context of urbanization and population ageing	1. Understand the role of primary health care in supporting sustainable health development

2. Lecture on multisectoral strategies to generate health co-benefits for the reduction of NCDs in urban areas 3. Lecture on WHO tools to support analysis, planning, implementation, and monitoring and evaluation 4. Small group exercises and presentations on applying the tools to their local context 5. Reflections and evaluation of the workshop by participants 6. Closing session	2. Understand the health co-benefits of multisectoral action for health, including air pollution control 3. Learn about relevant WHO tools and other technical support available from WHO 4. Apply their knowledge about the issues in their local context to consider how the WHO tools might be applied in their municipality
Day 5 Friday (morning, post-workshop) Debriefing session among organizers	1. Review participants' evaluation results 2. Develop recommendations for next year's training/workshop 3. Agree on key contents of the after-action report

Source: Asian Development Bank.

39. Activities (per year, to be repeated annually during 2018–2020) include:

(i) Content development of the training workshop and study tour, including developing (and updating in subsequent years) the curriculum and workshop materials, identifying and coordinating with appropriate speakers, and identifying appropriate tour sites.
(ii) Logistical coordination for the training workshop and study tour, including hiring a professional conference organizer to make workshop and study tour arrangements.
(iii) Travel support to invited speakers, including visa arrangements, if necessary.
(iv) Implementation of the 4-day workshop and study tour.
(v) Debriefing immediately after the workshop and study tour.
(vi) Production of an after-action report of the workshop and study tour.

b. In-country pre-workshop preparation and follow-up activities

40. **Pre-workshop preparation by participants.** To achieve optimal outcomes at the meeting, participants, before coming to the meeting, will need to:

(i) Identify desired learning objectives and linkages to Bangladesh-based institutions and resources to link up after the training workshop and study tour and for harmonization of learning.
(ii) Prepare a brief set of issues addressing urban health issues.
(iii) Identify all programs and initiatives that could generate synergies with Urban HEART and related tools (for follow up upon return).

41. **Follow-up plan.** It is suggested to include in-country follow-up in Bangladesh. Priority would be given to connecting the participants to the national capacity development programs and learning networks, and to WHO-supported Urban HEART and related processes to revitalize Healthy Cities and other initiatives addressing urban health, intersectoral action, social determinants of health to build local health systems in urban areas.

42. The total budget allocated for both in-country pre-workshop preparation and follow-up support by WHO Bangladesh is $100,000. The indicative activities include:

(i) design and conduct of tailored flagship courses on an annual basis on urban health coverage and health systems strengthening in urban settings;
(ii) conduct urban health coverage awareness and tailored communication activities for local health managers and communities;
(iii) improve coordination among implementing service delivery partners (nongovernment organizations and other parties); and
(iv) carry out equity analyses through the application of the Health Equity Analysis Tool and others.

c. Climate change appreciation training for urban local bodies, project management unit, and service providers

43. All but one of the 14 UPHC centers assessed registered poorly on their understanding of climate change risks and vulnerabilities facing their centers and partnership areas. Majority of the PANGO and project implementation unit (PIUs) interviewed were not aware of any risk and vulnerability assessment prepared at the city, municipal, or partnership area levels. The project management unit (PMU) has little understanding of existing natural hazards than can be exacerbated by climate change facing the network of centers that were established the past 18 years under the project. Only the Khulna PANGO[16] could demonstrate clear understanding of the climate risk and able to elucidate their role in disaster risk reduction being an integral part of the Khulna City Corporation's disaster risk management. This PANGO has a defined cyclone response protocol to include the suspension of staff leave privileges, pre-position of medical supplies and staff across the partnership area, and post-cyclone monitoring and reporting. Official cyclone warning and advisories are issued by the Department of Health while the other PANGO and PIUs rely on bulletins and weather warnings from the mass media.

44. This gap needs to be addressed in the coming project as good understanding of the challenges posed by climate change is essential for rational planning and decision-making in upgrading the current infrastructure prototype design and retrofitting the existing centers and ensure structural integrity and continued health service delivery during extreme weather. A good understanding of the locational and climate risks facing the ULBs will allow them to shape the UPHC effectively interact with the community it serves and how it can shift personnel and medical resources during extreme weather and post-response. The modular training program indicated in Table A15.3 will be conducted in collaboration with the Bangladesh Climate Change Cell and managed by the TA firm.

Table A15.3:
Training on Climate Change for UPHC PIU, PANGO, and ULB Department Heads

3-Day Climate Change and Bangladesh Training Administered by the Bangladesh Climate Change Cell	
Objective: To facilitate participants' learning and uptake, the course was divided into the following modules	
Module 1 Climate Change: Basic Concepts. The first module addresses the key issues and concerns with regard to climate change, with current scientific knowledge and understanding on: how is the climate changing? What is causing the climate to change? What are the impacts of this changing climate? What are primary physical effects of the climate impacts? What can happen where? Who are likely to be affected most? ***Module 2 International Processes to address Climate Issues, Concerns***. This module provides a	***Module 5 Planning Process and Climate Change: Drawing on Local Knowledge and Building Participation***. Development planning processes need to recognize and build in considerations to tackle additional challenges posed by adverse impacts of climate change and climate variability on the setting and achievement of goals and targets. Planning at all levels, across different sectors, organizations need to build participation of all stakeholders, especially those vulnerable, to identify and incorporate climate change considerations, incorporating local knowledge where relevant. This

[16] Srizony Bangladesh.

brief walk through history of the international process evolving to address the climate issues and concerns. More specifically, the UN Framework Convention on Climate Change and the Kyoto Protocol will be discussed, but first building upon the historic landmarks, the story for mitigation so far, and how adaptation is being recognized over time. Also, the role of Bangladesh in the international process is highlighted to put relevance and perspective for participants. ***Module 3 Bangladesh: Impacts of Climate Change and Climate Variability***. This module draws on evidence, documents, scientific studies and reports as well as local perceptions and knowledge on climate change and climate variability regarding Bangladesh. This module also outlines possible impacts and concerns for different sectors, including key risks and vulnerability aspects. ***Module 4 Climate Change and Sustainable Development.*** Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs. Impacts of current and future changes in the climate challenge our national efforts to achieve sustainable development goals and targets. The module describes both current and possible scenarios for the future regarding climate change and climate variability, highlighting the economic, social and environmental burden associated with these. Planning sustainable development and managing the process requires the integration of risks and challenges that may well overturn the realization of goals and targets. Climate challenges the sustainable development process, particularly in Bangladesh. What are the challenges? How can we prepare to respond to the challenges?	module will outline how Participatory Action Plan Development (PAPD) can integrate climate related risks and responses to overcome them. ***Module 6 National Efforts Addressing Climate Change***. Climate change is a global issue with significant local concerns. Bangladesh, like other countries need to recognize how climate change affects national priorities and performances toward achievement of goals and aspiration. This module outlines key in-country processes, programs and activities that focus on addressing climate issues and concerns. Current knowledge on these efforts will also be shared, providing guidance on who is doing what. ***Module 7 Toward a National Framework on Adaptation to Climate Change***. For any country, adaptation to climate change will require systematic and holistic approaches in its assessment, planning and policymaking processes. What key aspects should be considered while contemplating a national Framework for Adaptation to Climate Change? A National Framework would provide guidance to different actors and institutions on their respective role and responsibility. This module will outline synergies and inter-relationships across different sectors, stakeholder groups which need to be considered in this respect. ***Module 8 Way Ahead: How do you address Climate Change?*** Government organizations and respective post-holders need to identify climate change related threats and challenges relevant to cope with their work and mandates. What key considerations need to be taken on board to initiate a process of responding to climate change? What can you do? How can you engage or facilitate? The module attempts to provide guidance on how one can approach this vital step in addressing climate change concerns.
Target Participants: 120 ULB Department Heads[17], 4 PMU[18], 48 PIU[19] (2pax X 24), and 120 service providers.[20] Quarterly with 40 participants per batch. **Estimated Cost per Person: BDT12,000 Total Training Cost: 292pax X 12,000 = BDT3.5M (US$45,000)**	

Source: Asian Development Bank.

d. Training on water and electricity conservation

45. Key UPHC staff will undergo separate 1-day training on water and electricity conservation to be administered by the Dhaka Water Supply and Sewerage Authority (WASA) and Dhaka Power Distribution Company, Ltd. (DPDC). These agencies regularly conduct training on good practices at their own training facilities. The main objective of the conservation training is how to reduce the water and electricity usage of the centers without affecting the primary health care delivery.

[17] Engineering, Health, Waste Management, WASA, and Department of Public Health Engineering.
[18] Project director, deputy project director, two senior project officers.
[19] Program manager and officer.
[20] Project manager, clinic manager, and paramedic.

46. The water conservation training will cover the following: (i) how to conduct water audit of current use to include installation of water meters and record-keeping; (ii) identification of conservation opportunities (fixing drips and unnecessary flows, best practices in cleaning and laundry); and those requiring engineering/equipment solutions (toilets, bathrooms, and sterilizers); (iii) determine cost of opportunities and potential return on investment; (iv) prioritize water conservation opportunities; (v) develop a phased plan based on available resources; vi) plan implementation and documentation. Each PANGO will prepare a water conservation program based on the lessons learned from the training to be reviewed and approved by the PMU for implementation.

47. The energy conservation program training will cover: i) how to conduct energy audit to identify areas that need maintenance, where patient comfort complaints are high, and where potential energy cost savings can be realized; ii) identify opportunities for energy reduction like cooling, equipment maintenance, improve natural lighting, replacement of old (>10 years old) equipment like airconditioners and refrigerators and building envelope to minimize building heat load; iii) prioritize electricity conservation opportunities; iv) develop a phased plan based on available resources and potential savings, and v) plan implementation.

Table A15.4: Training on Water and Electricity Conservation

Item	Cost
Water Conservation Target Participants: 292 [120 ULB Department Heads,[21] 4 PMU,[22] 48 PIU[23] (2pax X 24), and 120 service providers[24] Estimated Cost per Person: BDT5,000 (total BDT1.5M)	$19,000
Electricity Conservation Target Participants: 292 [120 ULB Department Heads,[25] 4 PMU,[26] 48 PIU[27] (2pax X 24), and 120 service providers[27] Estimated Cost per Person: BDT5,000 (total BDT1.5M)	$19,000
Total	**$38,000**

Source: Asian Development Bank.

e. Training on disaster and emergency response and management

48. Assessment of the contract service providers revealed that only Barishal service provider has prepared an operating procedure on how to respond to cyclones. The centers assessed generally have limited competency to prepare the response protocols on how to deal with flood, cyclone, heat wave, and outbreaks of diseases that follow such events.

49. There is a need to define the roles and responsibilities of the service providers in disaster management. Coordination between the City Corporation Disaster Management Committees and the PMU is an important first step learning from Barishal service provider's experience which would include:

(i) dissemination of special bulletins particularly on flood and cyclone;

[21] Engineering, Health, Waste Management, WASA, and Department of Public Health Engineering.
[22] Project director, deputy project director, two senior project officers.
[23] Program manager and officer.
[24] Project manager, clinic manager, and paramedic.
[25] Engineering, Health, Waste Management, WASA, and Department of Public Health Engineering.
[26] Project director, deputy project director, two senior project officers.
[27] Program manager and officer.
[27] Project manager, clinic manager, and paramedic.

(ii) mobilization drills;
(iii) identification of safe centers and shelter places where temporary clinics may be operated by the UPHC;
(iv) define the staffing, roles, and materials needed in the emergency operation centers;
(v) data collection on damages;
(vi) serve as conduit for the distribution of relief materials;
(vii) hazard-mapping; and
(viii) risk communication.

6. Based on the result of the coordination, the PMU consultants to be headed by the environmental specialist draft disaster-specific response protocols to be implemented by the service providers. These protocols will be prepared in close coordination with a qualified, internationally recognized agency/organization with the objective of establishing an ad-hoc emergency medical services team in each of the CRHCC and mobilized immediately before, during, and after disasters as part of the service providers' Disaster Risk Management Service. The ad-hoc team will undergo training on the following: (i) assessment to identify priority interventions; (ii) best practices (planning, policy, standard operating procedures) in emergencies; and (iii) simulations and table-to exercises on health emergencies.

Table A15.5: Training on Disaster and Emergency Response and Management

Item	Cost
Target Participants: 24 ULB Department Heads,[28] 4 PMU,[29] 48 PIU[30] (2pax X 24), and 120 service providers[31] (total 206) Estimated Cost per Person: BDT5,000/day Duration: 1 week in 3 batches	$100,000
Total	**$100,000**

Source: Asian Development Bank.

f. Training/workshop on Expanded Program on Immunization/disease surveillance/outbreak response

7. Effective Expanded Program on Immunization, disease surveillance and outbreak response play a critical role in strengthening climate resilience in urban areas. To a certain extent, the health departments are filling the roles and responsibilities in these areas. Nevertheless, additional effort is required to enhance the capacity and competency of the health departments in meeting the requirements.

8. Trainings/workshops and related activities will be conducted by a qualified, internationally recognized agency/organization. A detailed program will be prepared and executed during project implementation based on the needs of the target audiences consisting of ULBs, CRHCCs, and PHCCs personnel.

9. Total budget allocated is $100,000.

[28] Health Department.
[29] Project director, deputy project director, two senior project officers.
[30] Program manager.
[31] Clinic manager.

2. Climate Change Vulnerability Assessment and Promotion of Climate Resilience

10. The resilience checklist revealed a weakness in the UPHC system in general where the entire project administration—PMU, PIU, ULB Health Departments, and existing public–private partnership service providers only possess anecdotal knowledge on the climate hazards and partnership area's climate vulnerabilities. Discussions with the PMU, service provider project manager, and PIUs initially posited the risk of flooding, heat wave, and cyclone were present. However, not a single center was exposed serious enough to cause mitigation. The site visits revealed otherwise, the CRHCC in Gazipur related that last year's heat wave generated a spike in health-related illnesses at magnitude almost reaching capacity threshold. The PHCC-1 PA2 in Rajshahi was regularly inundated with flood being located less than 100 m from the banks of the Padma River and outside the road embankment. Khulna's CRHCC and PHCC-1 access roads are seasonally inundated with a foot of flood. All deep wells of the UPHC centers in Khulna which cost thousands of dollars to install are now un-operational due to the deepening of the groundwater level and salt water intrusion.

11. Identifying climate risks and partnership area vulnerabilities is an important step in defining UPHC delivery resilience. Under the additional financing, it is recommended that a climate risk and vulnerability assessment (CRVA) is conducted on both existing and proposed partnership areas. The CRVA will allow the ULBs through the PMU how to shift resources during extreme weather events including the preparation of necessary threat-specific response protocols and post-disaster response on the catchment slums that may need emergency services. This will also relieve pressure on health facilities or serve as an effective conduit in providing essential community services like food, water, and basic shelter. The CRVA will provide important insights on how to improve non-structural renovations on existing centers and adaptation measures in the structural design of new centers.

12. For the new partnership areas, the proposed additional financing will adopt the RUCCA tool developed under "TA-8913 REG Subproject 1: Developing Integrated Urban Development Plans in Selected DMC Cities Incorporating Urban Climate Change Resilience Principles". This provides an opportunity to the proposed additional financing to utilize key findings and recommendations from the RUCCA and screen nominated sites for CRHCCs and PHCCs to avoid high climate risk areas and revisit the building design to improve coping measures and improve resilience. The RUCCA also offers ULBs a list of key infrastructure projects and their locations, land and water zoning concepts, and investment plan to enhance the climate resilience of the municipalities. The same approach will provide guidance on the location of the new centers, mainstream the structural and non-structural resilience measure in the building designs, and revisit the PANGO's contracts to incorporate needed health protocols.

13. Climate change expert, environmental engineers/planners, and economist will be engaged through an international consulting firm to develop the climate information and related products and carry out the CRVA for selected project health facilities. Climate resilience scope will cover the new partnership areas that TA-8913 REG has not covered.

3. Training on Medical Waste Management and Disposal

14. The safe management of both clinical and hazardous waste is paramount to addressing climate change and urban resilience. This requires proper management from the source up to the final disposal. The training related to medical waste shall aim to improve the management systems through capacity building for health personnel. Medical waste management systems,

including liquid hazardous waste, will be strengthened to meet national standards in health facilities and raising awareness.

15. Training could be conducted from individuals who are recruited through the consultant pool or through a reputable, recognized institute/agency. Training will be for 2 days and participants will be health personnel from the CRHCCs and PHCCs as well as ULBs. Altogether, 400 participants will be trained over a period of 2 years. The following areas will be trained:

(i) Introduction of Medical waste management;
(ii) Classification of Medical waste;
(iii) In-house Medical waste management;
(iv) Medical waste management: WHO guiding principle, strategy and policy;
(v) Composition of medical waste, consequences, risk and hazard;
(vi) Factors influencing external waste management, final disposal technology;
(vii) Occupational Hazards: Bio-Safety, Prevention and Management;
(viii) Medical Waste and Infection Control Measures;
(ix) Temporary Waste Storage & Transportation;
(x) Supervision and monitoring in medical waste management; and
(xi) Roles and responsibilities of concern personnel related to medical waste management.

16. Costing: 400 participants costing approximately $47,000.

4. Improving Urban Primary Health Care Infrastructure Resilience

17. The succeeding tables present packages of retrofitting available for the Urban Climate Change Resilience Trust Fund. These packages present a set of resilience measure to address vulnerability identified in the previous section. The measures are applicable to selected UPHC centers like electricity and water conservation. These measures could be scaled up and replicated in other centers.

a. Ability to cope with water interruption

18. None of the 14 centers assessed have redundant water source relying on either borehole or district water supply. No one is monitoring the water consumption, the PANGOs are confident the overhead water storage tanks, ranging from 2–3 x 1,000 liters, are adequate to supply their 24-hour demand. It was surprising that Rajshahi, the most drought-prone partnership area relying solely on boreholes has not experienced water shortage due to the productive groundwater resources, proximity to the Padma River, soil structure, and relatively small volume of water requirement to sustain the center's operation. The availability of a reliable water supply is more critical in Khulna where groundwater has been intruded with salt-water due to over-extraction and sea-level rise. Water harvesting system is important to provide a redundant water source and ease the pressure on the Khulna Water District. Available land for the construction of water harvesting is extremely limited particularly in the PHCCs, however, an overhead tank can be constructed in the driveway or parking area of the CRHCC and underneath can serve as an extension of the patient waiting area. It should be emphasized that harvested water will be used exclusively for facility washing and flushing toilets on the ground floor to avoid costly filtration and treatment to achieve proper water quality necessary for health care use.

Table A15.6: Water Harvesting System Construction in Khulna CRHCC

Item	Cost
Water Harvesting System: - Effective catchment/roof area (25%x100m^2 @ 90% reliability[32] requires 6.0 m^3 storage tank) - Pipes and fittings (45% of tank cost) - Concrete platform - Labor cost (30% of materials) - Price contingency (10%)	 $6,000($1,000/10,000 li x 6) $2,700(1,500*45%) $5,000 $4,110 $1,781
Total	**$19,591**

Source: Asian Development Bank.

b. Protecting essential systems and equipment from flood

19. Several existing CRHCCs are vulnerable to flood and at risk of inundation which may cause service disruption. Of the 14 sites assessed, all have electrical sockets are above historical flood level but six have electric generators at the ground level. Flood-proofing of essential systems and equipment like the relocation of generators to the rooftop or if not feasible due to a limitation in the building's load-bearing design, the center should resort to dry flood-proofing to include construction of barriers around generators, fuel storage, and water tanks. All operating theaters and emergency rooms should be transferred at least at the second floor. Elevators installed in the CRHCCs are also prone to damage from to flooding that requires expensive repair particularly the cabs. Flood-proofing of the elevators will include installation of floats in the elevator pits to prohibit the cab from descending to flooded areas. Ensure all controls are located at the roof top and implement proper maintenance like water proofing of all materials inside the elevator pit. During flood events, septic tank backflow particularly in the lower levels of the center may occur increasing the risk of water-borne diseases. A simple fix is the installation of backflow preventer on the main pipe leading to the septic tank.

Table A15.7: Protecting Essential Systems and Equipment from Flood

Items	Cost
Relocating generators and fuel storage on the rooftop of CRHCC in Rangpur, Khulna (PA2), Gazipur (PA2), and Cumilla	$20,000 (4x$5,000)
Dry-flood proofing of PHCCs (9 PHCCs at risk)	$18,000 (9x$2000)
Installation of backflow preventer (13 centers at risk of slight flooding)	$6,500 (13x$500)
Installation of floats in the elevator pits, water proofing of CRHCC at risk of flooding	$20,000 (4x$5,000)
Total	**$64,500**

Source: Asian Development Bank.

b. Water and electricity conservation

20. Improving energy and water efficiency through conservation measures is one of the first crucial steps in building resilience. The less energy and water required to operate the centers, the longer it can remain operational given the energy generation capacity from the generator and solar energy system, and fuel and water storage facilities. Not a single center assessed practice

[32] S. Khan, et al (2017). "Rainwater harvesting System: An Approach for Optimum Tank Size Design and Assessment of Efficiency. Bangladesh University of Engineering and Technology (BUET).

energy and water conservation programs simply because this was not part of the PANGO's terms of reference for the delivery of PHC services.

21. All centers still use the inefficient old ballasted tube lights that consume at least 43 watts. A direct replacement of the tubes with T8 LED tube and minor re-wiring conversion that consumes 14 watts will result to an annual electricity savings of 236 kWh annually. A 5-storey CRHCC and 3-storey PHCC have 240 and 160 individual tube lights consuming a 30,134 kWh and 20,089 kWh annually (8hrs/365 days) at average electricity tariff of 5Tk[33]/kWh translates to $1,800 and $1,200. Using T8 LED can reduce annual lighting cost to $586 and $390 for CRHCC and PHCC, respectively.

22. Record-keeping through the installation of electric and water meters on each floor, fixing leaks, installing automatic shut-off device on elevated water storage tanks, installing light dimmers, pulling the plugs to reduce phantom loads, replacement of energy efficient computers, monitors, laptops, high EER rated refrigerators and airconditioners can help reduce the electricity and water consumption.

Table A15.8: Electricity and Water Conservation

Items	Estimated Cost	Cost
CRHCCs and PHCCs exposed to climate risk		
Water Conservation Program 46 existing centers	$3,000*46	$138,000
Electricity Conservation: 46 existing centers Conversion to LED (6 CRHCCs 40 PHCCs) Replacement of high EER airconditioners and refrigerators in CRHCC.	 6x2,000 40x1,500 6 CRHCCs x 4 Air-conditioners @$1,000 x 2 refrigerators @ $500	 $12,000 $60,000 $25,000
Total		**$235,000**

Source: Asian Development Bank.

d. Installation of solar energy system

23. To provide redundant power source reduce reliance to electric utilities, all existing centers should have solar power generation units. Of the 14 centers assessed, six (43%) have solar panels installed. However, most are not operational. An assessment in UPHCSDP's project administration manual[34] was made on the design capacity of the SES which were set at 5 kW for CRHCCs and 2 kW for PHCCs at a cost of $3.25-5.29/Watt capacity. This estimate was misleading on two accounts, first is the under-estimation of the design capacity which was set at 5 kW and second is the limited available space at the rooftop in each center. Based on site visits, a CRHCC typically has 100 m^2 and PHCCs ha 18 m^2 available space on the rooftop. Based on solar irradiance figures for Dhaka with solar panels tilt angle of 67.2 degrees facing west-northwest can generate from 3.96-5.65 kWh/m2/day with an average of 4.58kW/m2/day,[35] the maximum solar energy than can be generated from the available space at the roof top of the CRHCC is 343kW/day (100m2x75%x4.58) and PHCCs is 61kW/day (18mx75%x4.58) which can at most supply facility lighting.

[33] $0.012 = Tk1.

[34] UPHCSDP (2012–2018) Project Administration Manual, Appendix 17. Green Clinics: Mitigating of Climate Change Impacts for Urban Primary Health Care Facilities.

[35] Solar electricity handbook/solar calculator.

Table A15.9. Solar Energy System

Items	Total Generating Capacity Day	Cost
Existing PHCCs exposed to climate change risk without SES 24 PHCCs (40 PHCCs x 60%)	24 x 61kW/day = 1,464kW	$600,000
Total		**$600,000**

Source: Asian Development Bank.

D. Summary of Urban Climate Change Resilience Trust Fund (UCCRTF) Investments to Enhance Climate Resilience of Urban Primary Health Care

24. A total of $2 million from UCCRTF grant will be required to enhance climate resilience of UPHC. The cost breakdown is presented in Table A15.10.

Table A15.10: Summary for UCCRTF Climate Change Investments

#	Items	Person-month	Rate per month (USD)	Amount (USD)	Subtotal (USD)	
1	**Consultants**					
	National Consultants					
	Structural/civil engineer	12	5,000	60,000		
	Electrical engineer	9	5,000	45,000		
	Medical Waste management expert	6	5,000	30,000		
	Climate change expert (infrastructure eng.)	9	5,000	45,000		
	Climate change expert (training)	9	5,000	45,000		
	Water supply expert	6	5,000	30,000		
	Procurement expert	9	5,000	45,000		
	Subtotal				**300,000**	
2	**National travel (including per diem)**					
	Travel and per diem			77,000		
	Subtotal				**77,000**	
3	**Workshop & training**					
	Training workshop, study tours on urban health-WHO Kobe Centre			273,000		
	In-country preparation and follow-up activities			100,000		
	National modular training - climate change appreciation			45,000		
	Training on water and electricity conservation			38,000		
	Training/ workshop on emergency health response			100,000		
	Training on medical waste management/disposal			47,000		
	Training on EPI/disease surveillance/outbreak response			100,000		
	Subtotal				**703,000**	
4	**Civil Works**					
	Package 1 - water harvesting			20,000		Khulna CRHCC
	Package 2 - flood protection			65,000		4 CRHCCs and 9 PHCCs (Rangpur, Khulna, Gazipur and Cumilla) [$10,500 per CRHCC, $2,500 per PHCC, total $64,500]
	Subtotal				**85,000**	
5	**Equipment**					
	Package 3 - water and electricity conservation			235,000		6 CRHCCs and 40 PHCCs [$8,600 per CRHCC, $4,600 per PHCC, total $235,600]
	Package 4 - solar energy system			600,000		24 existing PHCCs [$25,000 per facility, total $600,000]
	Subtotal				**835,000**	
6	**Contingency**			0	**0**	
	TOTAL				**2,000,000**	

Source: Asian Development Bank.

E. Proposed Institutional Arrangement, Schedule and Milestones to Implement Climate Resilience Activities

25. The UCCRTF grant will be administered by ADB and will be implemented as part of the proposed additional financing. The executing agency is the Local Government Division (LGD) of the Ministry of Local Government, Rural Development, and Cooperatives and the implementing agencies are the respective city corporations and municipalities. The LGD is responsible for key decision making in relation to the project and the PMU is responsible for day-to-day project implementation activities. The PMU is established within LGD and consists of a comprehensive team of staff/experts. The PMU is responsible for managing the implementation and progress monitoring and evaluation during the project.

26. Procurement and consultant recruitment under the grant will be in accordance with ADB's Procurement Guidelines (2015, as amended from time to time) and ADB's Guidelines on the Use of Consultants and its Borrowers (2013, as amended from time to time). International competitive bidding procedures will be used for civil works contracts estimated to cost $15 million or more, and supply contracts valued at $2 million or higher. Shopping will be used for contracts for procurement of works and equipment worth less than $100,000.

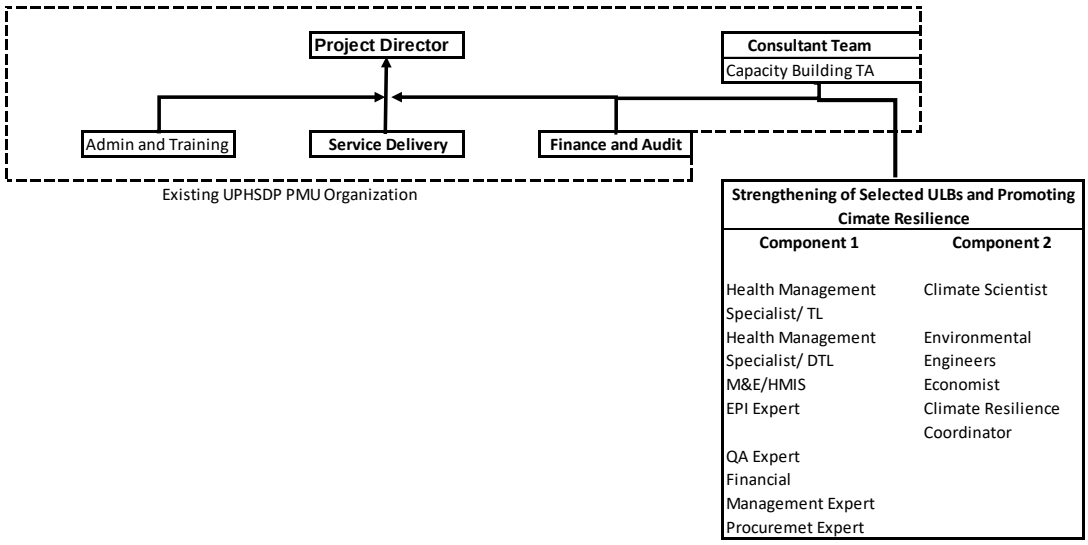
27. The proposed activities consist of four distinctive outputs: (i) climate risk and vulnerability assessment completed, (ii) climate resilient health care infrastructure and services introduced, (iii) medical waste management trainings conducted, and (iv) capacity building and education of UPHC on climate resilience strengthened.

28. The proposed activities to build appreciation, knowledge, and capacity on climate change, risk, and vulnerability will be supported by several institutions: (i) training for mayors and city/municipal officials will be collaborated with WKC, which will also include in-country preparation and follow-up activities; (ii) national training at different levels will be conducted in collaboration with the Bangladesh Climate Change Cell (training for ULBs, PMU, and service providers); (iii) water and electricity conservation will be in collaboration with Dhaka Water and Sewage Authority; and (iv) emergency health response and management, medical waste management, and Expanded Program on Immunization/disease surveillance/outbreak response will be supported by a qualified, recognized agency/organization.

29. To enhance ownership and sustainability on climate change resilience, the ULB strengthening consulting firm that will coordinate and manage the activities will be recruited and administered by the project. The infrastructure resilience measures will be done in coordination with Local Government Engineering Department (LGED) to perform the necessary civil and electrical-related assessment, design, procurement, construction, equipment installation, and overall supervision.

30. A team of individual consultants will kick-start activities by assessing and collecting requirements for the proposed infrastructure resilience activities for selected existing facilities. Based on these assessments, these consultants in coordination with LGED will prepare the tender documents. LGED will tender out the works and provide regular monitoring and oversight of the works.

Figure A15.2: Institutional Arrangement



Source: Asian Development Bank.

Figure A15.3: Implementation Schedule and Milestones

Items	2018				2019				2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
1. Training and workshop												
International training - WHO Kobe		■				■				■		
In-country preparation and follow-up activities	■		■		■		■		■		■	
National modular training - climate change appreciation			■	■	■	■	■	■				
Training on water and electricity conservation					■		■		■			
Training/ workshop emergency health response							■	■	■			
Training on medical waste management/ disposal						■	■					
Training/ workshop EPI/ disease surveillance/ outbreak response			■				■				■	
2. CRVA												
Review existing RUCCA	■	■	■	■								
Conduct RUCCA for new PAs	■	■	■	■								
Appoint consulting firm (funded by project)	■			■								
3. Civil works												
Water harvesting						■	■					
Flood protection					■	■	■	■				
4. Equipment supply/ installation												
Water and electricity conservation					■	■	■	■				
Solar energy system					■	■	■	■	■	■		

Source: Asian Development Bank.

F. Overall Climate Financing for Climate Change Mitigation and Adaptation.

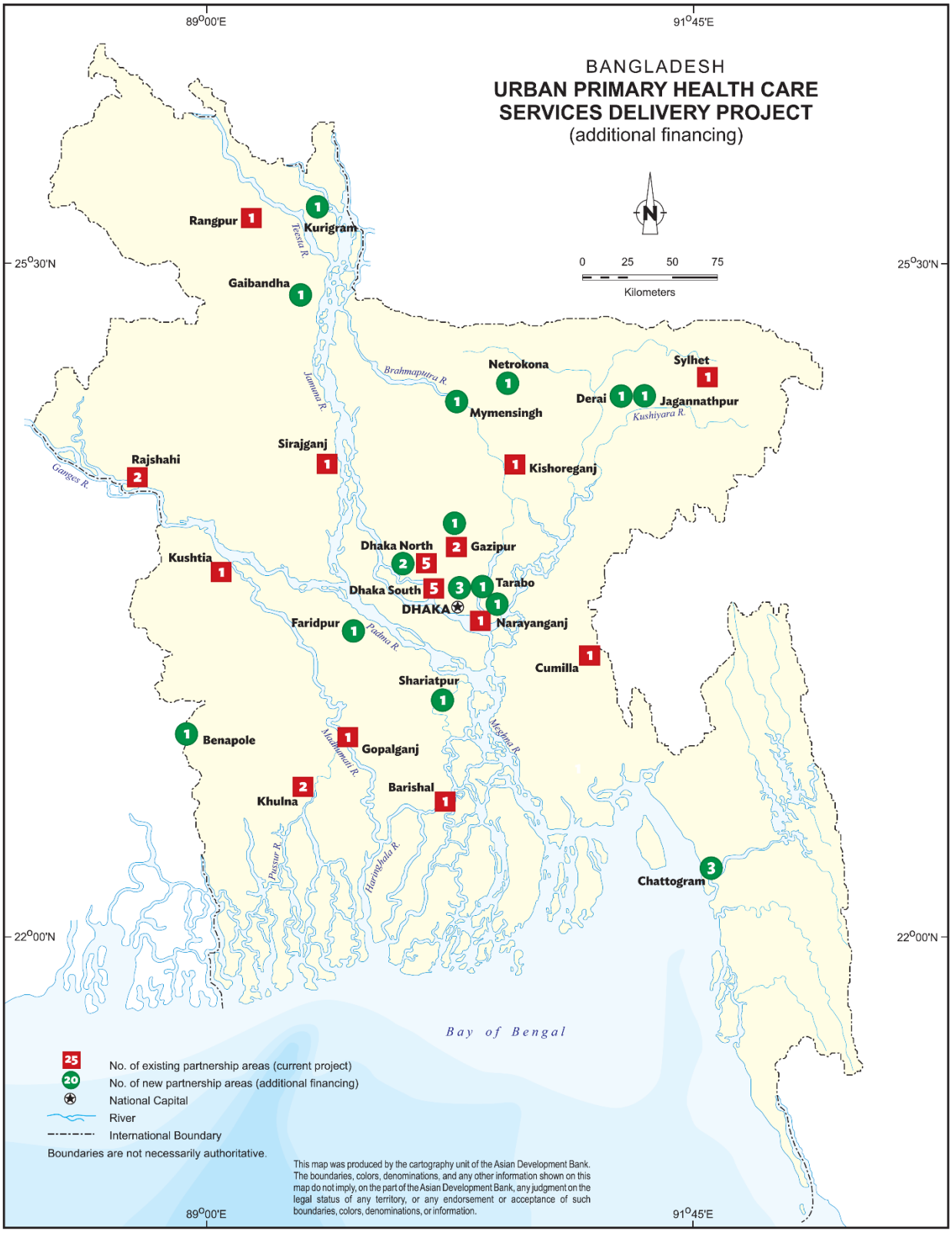
31. Climate change mitigation is estimated to cost $2.50 million and climate change adaptation is estimated to cost $6.42 million. ADB will finance 100% of mitigation and adaptation costs excluding taxes and duties.

Table A15.4: Cost Estimate of Climate Change Mitigation and Adaptation Activities

Activities	Health Facilities	Unit cost (BDT)	Total cost (BDT)	Total ($)	ADB Loan	UCCRTF Grant
Mitigation						
Solar panel PHCC – UPHCSDP-AF	39	520,000	20,280,000	250,370	250,370	
Solar panel CRHCC – UPHCSDP-AF	16	1,500,000	24,000,000	296,296	296,296	
Solar panel - UCCRTF	1			600,000		600,000
UPHCSDP-AF: Building design improvement, 5% of civil works investment (through environment friendly climate proof design, use of environment friendly building materials, promote natural lighting and ventilation)	1			1,150,000	1,150,000	
Training (UCCRTF: water and electricity conservation, climate change appreciation, partially WHO Kobe training; UPHCSDP-AF: Training on Operation and Maintenance)				200,000	10,000	190,000
Total (mitigation)				**2,496,666**	**1,706,666**	**790,000**
Adaptation						
UPHCSDP-AF: Sewage management deep well	39	3500000	136,500,000	1,685,185	1,685,185	
UPHCSDP-AF: Generators	16	1200000	19,200,000	237,037	237,037	
UPHCSDP-AF: Building design improvement, 15% of civil works investment (through environment friendly climate proof design, use of environment friendly building materials, promote natural lighting and ventilation)				3,450,000	3,450,000	
UCCRTF: flood protecting, water and electricity conservation	1		-	300,000		300,000
UPHCSDP-AF training: operation and maintenance, waste management	1		-	250,000	250,000	
UCCRTF training (excludes training related to mitigation)	1		-	503,000		503,000
Total (adaptation)			**-**	**6,425,222**	**5,622,222**	**803,000**

Source: Asian Development Bank.

ANNEX 16
MAP OF PARTNERSHIP AREAS



ANNEX 17
UNFPA PARTNERSHIP FOR URBAN PRIMARY HEALTH CARE SERVICES DELIVERY PROJECT (ADDITIONAL FINANCING) IN 9TH COUNTRY PROGRAM

A. Background

1. UNFPA has provided assistance to Urban Primary Health Care Services Delivery Project (UPHCSDP) in its 8th Country Program, under the Local Government Division LGD and through bilateral funding, to increase the quality and effectiveness of reproductive health services for the urban poor. During the UPHCSDP implementation period (2012–2018), UNFPA put strong focus on institutional strengthening through capacity building, advocacy activities, and awareness raising among the community to enhance reproductive health care-seeking behavior. UNFPA fund was disbursed to 25 partner nongovernment organizations of UPHCSDP in 10 city corporations and 4 municipalities following public–private partnership modality adopted by UPHCSDP. UNFPA has successfully accomplished all the activities planned as summarized below.

1. Strengthening Comprehensive Emergency Obstetric Care Activities for Urban Poor

2. **Capacity building of service providers through training.** To improve the quality of maternal, newborn, and child health services and confidence of the services providers UNFPA has provided emergency obstetric care/midwifery training to 15 Nurses of the comprehensive reproductive health care center (CRHCC) in one batch through its technical officer of Maternal Health. UNFPA also provided basic training on cervical cancer screening through VIA (Visual Inspection by Acetic acid) method and clinical breast examination for medical officers and nurses of the CRHCCs. Total of 10 doctors and 20 nurses/paramedics have been trained in five batches. Refresher training on cervical cancer screening through VIA method and clinical breast examination were provided to six medical officers and 12 nurses/paramedics in three batches. The project also jointly observed national days like Safe Motherhood Days, World Population Days through organizing rally, health education sessions, seminars, etc.

3. **Strengthening capacity of SDPs (CHRCCs) by providing necessary equipment, facilitate MIS, and QA system of UPHCSDP.** UNFPA has procured total four ambulances and some other major equipment for CRHCCs. The project also assisted through printing of different cards including Red Cards, registers for EOC services at the CHRCCs. The project procured medical equipment for screening of cervical cancers and treatment (Cryo Surgery). UNFPA has established cervical cancer screening through the CRHCCs by providing training, equipment and motivational work. Strengthening MIS system related to EmOC services like reporting, linking with national MIS and dissemination were supported and assisted.

4. **Addressing morbidities like detection of cancers of reproductive organs, referral of fistulae clients.** UNFPA has provided orientation of service providers of the CRHCCs and PHCCs and awareness creation in community on prevention, treatment and rehabilitation of fistulae clients and established a system of referral. Orientation on reproductive health issues including maternal morbidity issues (cervical cancer, fistulae, PPH, obstructed labor) for community focusing on urban slums. UNFPA also provided incentives to service providers of CHRCCs and PHCCs and field workers for providing comprehensive Maternal Health care services in urban slums.

2. Increase Family Planning Services in Urban Areas Focusing on Slums

5. **Increasing awareness on family planning among urban poor through campaign activities and networking with national family planning campaign programs.** UNFPA provided continuous support to strengthen Post-Partum Family Planning services at CRHCCs and UPHCSDP catchment areas focusing on slums through multiple advocacy and campaign activities. Built capacity and shared knowledge for the program managers and service providers (local workshop/seminars), facilitated training and participation at International Urban Health Conference- 2015, Family Planning LAPM Training, observed Int./National days (WPD, WAD, IYD, etc.). The project developed and displayed IEC materials for service delivery and strengthened BCC activities at community level focusing on slums for FP services.

6. **Strengthening capacity of service providers of city corporations, municipalities, and partner nongovernment organizations of UPHCSDP in family planning service provision through family planning training.** UNFPA has provided basic training on clinical contraception to 24 Medical Officers in five batches as well as provided refresher training to 12 medical officers in two batches. The project also provided basic training on clinical contraception for nurses/paramedics to 40 Nurses in four batches as well as refresher training to 20 nurses/paramedics in two batches on the same.

7. **Capacity building of SDPs (CHRCCs and PHCCs) in family planning service provision by supplying equipment and instruments.** UNFPA has procured NSV/family planning kits and other equipment for seven new centers, printed different forms, cards, and registers on family planning issues.

8. **Quality assurance of family planning services.** The project developed QA modality and monitoring and evaluation system including couple registration at UPHCSDP working areas. Provided continuous supervision and monitoring support to the services providers and field workers of CRHCCs and PHCCs.

3. Strengthening Adolescent Sexual and Reproductive Health Services

9. **Strengthening youth-friendly services in CHRCCs.** Developed capacity building of service providers on adolescent sexual and reproductive health (ASRH) services like adolescent health, menstrual hygiene, awareness on sexually-transmitted infection (STI)/reproductive tract infection/HIV/AIDS, prevention of early marriage and child bearing, etc. Provided support to increase availability of information materials at the centers.

10. **Awareness programs on family planning and reproductive health at the community level.** Provided capacity building of peers, increase awareness of adolescents, families, and communities on ASRH issues.

11. Linking adolescent and youth forums/institutions. UNFPA has worked through developing networking, linking with schools and youth clubs with the CRHCCs and PHCCs for ASRH issues and provided IGA training for disadvantaged adolescents.

B. Planned Activities with UNFPA Fund for UPHCSDP-AF (2018–2023)

12. The United Nations Development Assistant Framework (UNDAF), 2017–2020 responds to imperatives of the 2030 Agenda for Sustainable Development and will address the Sustainable Development Goals through its programming elements—human rights, gender equality and women's empowerment, sustainable development and resilience, leave no one behind and accountability, i.e., a commitment to meeting the needs of the most vulnerable and marginalized

first to achieve inclusive delivery of equal, equitable, and quality services for all. The strategic priority areas of new country program of UNFPA are aligned with 2030 Agenda and Sustainable Development Goals.

13. Under UPHCSDP, the LGD has filled a vacuum created by lack of urban public primary health infrastructure and limited primary health services. The next phase—the proposed additional financing—builds on the lessons and experience of the past two project phases and the ongoing third phase (UPHCSDP), which is expected to complete on 31 March 2018. The additional financing phase is expected to start on 1 April 2018 for 5 years with financial support primarily by ADB and Government of Bangladesh.

14. UNFPA is delighted to have contributed to the joint effort of ADB, UNFPA, and Government of Bangladesh to implement Urban Primary Health Care Project since its inception in 1998. UNFPA is honored to be involved with the next phase of UPHCSDP through in-kind technical support with a fulltime urban health specialist and some other modest resources to assist fulfilling the objectives of LGD in some specific areas. The suggested activities would be under three broad headings:

(i) Capacity Building

a. Provides technical assistance for implementation of SRH interventions in Comprehensive Reproductive Healthcare Centre (CRHCC) and Primary Healthcare Centre (PHCC) under the brand name of *Nagar Sastho Kendro* with special attention to equity issues. Sexual and Reproductive Health interventions include maternal health, newborn and child health, family planning, nutrition, prevention of child marriage and early pregnancy, reproductive tract infection/STI and HIV. Through effective implementation of the SRH intervention UNFPA will contribute to the reduction of GBV, unwanted pregnancies, unsafe abortions, maternal and child mortality and the spread of HIV and other sexually transmitted infections in the target areas especially urban slums.
b. UNFPA will provide support to improve coordination with different stakeholders, supervision and monitoring of the activities at service delivery and developing referral linkages.
c. Provide technical support in capacity building of the service providers of CRHCCs and PHCCs on SRHR issues.
d. Ensures the institutionalization of the capacity being developed.

(ii) Policy Advocacy and Partnership

a. Foster partnership with MOHFW and ensure CRHCC and PHC benefit from broader national SRHR interventions and initiatives
b. Continue policy advocacy and work with media and key influencing entities including parliamentarians in sustaining their interest for the cause of urban poor.
c. Promote SRHR in garment factories in urban areas – promoting health of girls and women in garment industries by providing technical assistance to factories
d. Support community mobilization efforts in urban slums for improving skilled birth attendance at delivery; promoting uptake of family planning

and addressing obstetric/gynecologic morbidities (cervical cancer, fistulae including STIs and HIV. Working with BBC media action and other community level advocacy events on broad areas of SRHR.

e. Maintains collaborative relationships with the project counterparts/stakeholders at all levels, like Ministry of Local Government, City corporations/municipalities, NGOs and civil society organizations involved with the implementation of UPHCSDP

f. Keeps close rapport with the City Corporation and Municipality authorities including the functionaries of other Ministries to ensure their effective participation in all stages of project management (from planning and implementation to monitoring and evaluation), in liaison with UNFPA District Field Officers based at district offices.

(iii) Knowledge Management

a. Support MOLGRD in the analysis of data from the UPHCSDP project to understand equity gaps.

b. Assist and support to generate new evidence through small-scale implementation research.

c. Monitoring, evaluation, and reporting (e.g., tracking the progress of the indicators; preparation of project reports capturing results, lessons learned, and best practices).

Table A17.1: Component-Wise Budget (in-kind) of UNFPA for UPHCSDP-AF (2018–2023)

No	Personnel	Activities	% of time	Budget/ per year ($)	Total ($)
1	Urban Health Specialist	Provide technical assistance for implementation of SRH interventions in CRHCCs and PHCs	100%	60,000	300,000
2	MNH Experts (UNFPA)	Technical support to broader national SRHR interventions and initiatives	10%	30,000	150,000
3	M&E Officer & other Consultant (UNFPA)	Support MoLGRD in the analysis of data	10%	60,000	300,000
4	Media & Communication Officer (UNFPA)	Policy advocacy and work with media and key influencing entities	10%	50,000	250,000
5	BBC Media Action	Support community mobilization efforts in urban slums	-	-	300,000
6	Technical Expert (UNFPA)	Promote SRHR in garment factories in urban areas	-	-	200,000
Total					**1,500,000**

Source: UNFPA.

ANNEX 18
RESETTLEMENT, TRIBES, MINOR RACES, ETHNIC SECTS, AND COMMUNITY PEOPLES PLANNING FRAMEWORK

I. INTRODUCTION

A. Project Background and Description

1. This Resettlement, Tribes, Minor Races, Ethnic Sects and Community Peoples Planning Framework (henceforth "Social Safeguards Planning Framework" or "SSPF") is proposed to deal with social safeguard issues and impacts that may arise during the implementation of the additional financing of the Urban Primary Health Care Services Delivery Project, as well as the social development concerns that the project could address within its scope of works. The National Urban Health Strategy has been formulated and approved in 2014 by MOLGRDC considering overall national goals and policies the necessity of a well-planned strategy for an urban health system. The draft action plan of national urban health strategy has been prepared by PMU and ADB in consultation with all relevant development partners. The project is designed to help the Bangladesh urban primary health sector and additional financing will mainly focus on strengthening the local health system and capacity which would ultimately result the sustainability of this project.

2. The provisions of this SSPF are proposed in view of the ADB's SPS 2009 that requires the borrowers to assess potential social safeguard issues and impacts in project preparation, and adopt and implement appropriate measures to mitigate them, in compliance with the specified policies. Due to the nature of the project, there will be no direct or indirect impact on land, structures or livelihood. Moreover, there will be no direct impact on tribal people or communities. Additional financing will continue momentum of the ongoing project, provide support to ongoing 25 partnership areas including 20 new partnership areas where there are no medical colleges and hospitals, strengthen existing PMU, construct health facilities and improve PHC with a more integrated and long-term perspective where the focus would be on strengthening local health system, capacities which would ultimately result in sustainable urban PHC to be owned and continued by the urban local bodies. Once the subproject sites are decided, the proposed SSPF will provide the basis to select the exact site, assess the social safeguard issues and impacts, and prepare the necessary plans to mitigate the adverse impacts if there are any.

3. Poverty reduction is one of the key agenda in the development objectives of the Government of Bangladesh (GOB). All efforts have been targeted to reduce poverty and increase facilities for productive environment for the country's population. With continued efforts, poverty in recent years shows a considerable decline but number of poor people is high in both the rural and urban areas. Increased number of the poor people in the urban areas is mainly due to the migration of poor people from the rural to the urban areas, because of the insecurity from the lack of employment and resources. Poor health of this increasingly high urban poor population due to their low or no capacity in accessing health services remains as an impediment to fight poverty. The urban poor cannot afford costly medical services of private clinics and hospitals and timely medical services of reputed Govt. hospitals available in the urban areas. Knowledge about the health matters of the urban slum dwellers and their access to essential basic health services are low. A considerable number of children living in urban slums are deprived of education and health care, and vulnerable to violence, abuse and exploitation. On the other hand, high rate of mortality and morbidity exists among slum dwelling women who remain neglected in terms of meeting their basic health needs and ensuring their rights. Lack of access to primary treatment makes the sick poor women and children vulnerable to complicated diseases and sometimes this cost them their

lives. Frequent sickness compels the poor especially the women lose their workdays that sustain them in poverty.

4. GOB has, therefore, undertook strategies to address the issues of improving the health status of the urban population. The strategies aim to improve access to and utilization of efficient, effective and sustainable Primary Health Care (PHC) services. Treatment of poor pregnant women, taking care of delivery cases of women, and protecting children from common infectious diseases are the major targets of the government. With this intention, the first Urban Primary Health Care Project (UPHCP) was implemented with assistance from the Asian Development Bank (ADB) and the Second UPHCP (UPHCP-II) with assistance from the ADB and the governments of United Kingdom and Sweden. The ADB supported UPHCP is one of the largest public-private partnerships in the delivery of PHC in South Asia. The first UPHCP in Bangladesh was implemented from March 1998 to June 2005 (covered four city corporations (CCs) – Dhaka, Chittagong, Khulna, and Rajshahi). The second UPHCP commenced in July 2005 and completed in 2012 (covered six city corporations – Dhaka, Chittagong, Rajshahi, Khulna, Barisal, and Sylhet; and five municipalities – Bogra, Comilla, Sirajganj, Savar and Madhabdi). The third phase Urban Primary Health Care Services Delivery Project (UPHCSDP) (2012-2018) covers 10 CCs (Dhaka South, Dhaka North, Rajshahi, Khulna, Barishal, Sylhet, Cumilla, Rangpur, Narayanganj, and Gazipur) and four municipalities (Sirajganj, Kushtia, Kishoreganj, and Gopalganj). In addition, ADB is extending its support for the next five years (2018-2023) for continuing urban PHC in Bangladesh with UNFPA parallel cofinancing.

5. Through its large focus on women's health, the project will create an enabling environment for ensuring greater gender equity. The poor women and children of urban areas will be able to access PHC that prevents their illnesses from turning into serious diseases. PHC will keep poor urban people free from common sickness and hence keep them physically fit for working and earning money. Hence the urban primary health care project will mitigate poverty of urban people. The Local Government Division (LGD) under the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC) is the executing agency (EA) on behalf of GOB.

B. Rationale and Purpose of this Framework

6. The ULBs will select lands for subprojects that are vacant in all respect including residential, commercial and income generation purposes. ULBs will also confirm positive attitudes of the communities especially those neighboring the subproject areas and consider their suggestions and options in the construction and operation of the Health Care Centers (HCCs) under the project. However, in case of any unavoidable circumstances, ULBs will minimize the social and resettlement impacts and undertake measures to mitigate the unavoidable impacts. The ULBs have been in the process to identify and locate lands for construction of infrastructures for existing and new HCCs.

7. For the additional financing, ULBs have been able to locate the lands but without any clear demarcation of boundaries or the area of land allocated for construction. ULBs are also not aware if acquisition of land will be required for construction of infrastructure for the HCCs. As a result, exact impact could not be assessed, or any displaced persons be identified. As the assessment of impacts for land acquisition or other method of obtaining lands for infrastructure construction under the project is pending, LGD has prepared this SSPF for UPHCSDP outlining the process for site screening, consultation with communities including tribal groups and development of instruments for minimizing impacts, and mitigating unavoidable social impacts including resettlement.

8. This SSPF will guide resettlement planning activities for the interventions to be finalized after ADB's Board approval of the UPHCSDP. The SSPF is prepared in accordance with the ADB Safeguard Policy Statement (SPS), 2009 and Bangladesh Acquisition and Requisition of Immovable Property Ordinance 1982 (ARIPO).

C. Categorization: Involuntary Resettlement (IR) and Tribes, Minor Races, Ethnic Sects and Community Peoples

9. The overall project has been classified as category C for both Involuntary Resettlement Impact and Tribes, Minor Races, Ethnic Sects and Community Peoples Impact. However, as the specific locations of infrastructure are uncertain at the time of SSPF preparation, this SSPF has been prepared to guide subproject selection, screening and categorization, social and assessment, and preparation and implementation of resettlement plans of subprojects (if ADB's IR policy triggers), and to facilitate compliance with the requirements specified in Safeguard Requirements 2 of SPS. The classification is an ongoing process to be confirmed by ADB during detailed design (DD) and implementation. As this project covers solely urban areas, insignificant impact on tribes, minor races, ethnic sects and community peoples is expected.

D. Project Scope, Resettlement Impacts, and Tribes, Minor Races, Ethnic Sects and Community Peoples Plan

10. The ongoing project has 25 partnership agreement (PA) areas in 10 CCs and 4 municipalities. Twenty new PA areas in 10 municipalities and one city corporation will be added in additional financing phase. In two city corporations, namely Dhaka South and Dhaka North, due to expansion to 16 new unions and 6 regions, 5 new PA areas are proposed. Chattogram City Corporation is added for the additional financing phase. In Narayanganj and Gazipur, 2 new PA areas are proposed for each city corporation, due to rapid expansion and their request. Ten new municipalities are proposed to be covered under the new project, namely Mymensingh, Faridpur, Shariatpur, Gaibandha, Netrokona, Kurigram, Jagannathpur, Derai, Benapole, and Tarabo since there are no fully operational medical colleges and no 300-bed hospitals. In addition, these municipalities are in poorer and underserved districts.

Table A18.1: List of City Corporations and Municipalities to be covered by the Project

City Corporation/ Municipality	Number of Existing PAs	Proposed Number of PAs	Level of impact on IR and IP
Dhaka South City Corporation	5	8	No land, structures or livelihood will be affected as project will use government or donated land. No existence of tribal communities. Existing PAs are operating either on ULB's new constructed premises or rented premises.
Dhaka North City Corporation	5	7	Same as above
Rajshahi City Corporation	2	2	Same as above
Khulna City Corporation	2	2	Same as above
Barishal City Corporation	1	1	Same as above
Sylhet City Corporation	1	1	Same as above
Cumilla City Corporation	1	1	Same as above
Rangpur City Corporation	1	1	Same as above
Sirajganj Municipality	1	1	Same as above
Kushtia Municipality	1	1	Same as above
Kishoreganj Municipality	1	1	Same as above
Gopalganj Municipality	1	1	Same as above
Narayanganj City Corporation	1	2	Same as above

City Corporation/ Municipality	Number of Existing PAs	Proposed Number of PAs	Level of impact on IR and IP
Gazipur City Corporation	2	3	Same as above
Chattogram City Corporation		3	Same as above
Mymensingh Municipality		1	Same as above
Faridpur Municipality		1	Same as above
Shariatpur Municipality		1	Same as above
Gaibandha Municipality		1	Same as above
Kurigram Municipality		1	Same as above
Netrokona Municipality		1	Same as above
Jagannathpur Municipality		1	Same as above
Derai Municipality		1	Same as above
Benapole Municipality		1	Same as above
Tarabo Municipality		1	Same as above
Total	**25**	**45**	

Source: Project Management Unit and Asian Development Bank.

11. In all cases, the additional lands for the extension or new constructions will be free from encumbrances and no tribes, minor races, ethnic sects and community peoples will be affected in their language, culture and livelihoods. However, any SEC peoples in the catchments of the existing and proposed HCCs will be benefitted equally with those of the mainstream population. Special attention will be given in identification and selection of sites so that minimal number of tribes, minor races, ethnic sects and community peoples are affected. Implementation of the UPHCSDP will involve additional land for horizontal extension of existing structures and construction of new structures for the CRHCCs and PHCCs. Vertical extension of existing HCC structures will not involve any additional land in their premises. LGD will select lands to undertake construction of infrastructures for HCCs on lands owned by the urban local bodies (ULB) including city corporations and municipalities or other public lands. In cases of unavailability of public lands, ULBs will opt to obtain private lands through acquisition, direct purchase or voluntary donation by the owners.

II. OBJECTIVES, POLICY FRAMEWORK, AND ENTITLEMENTS

A. Objectives

12. A total of 11 city corporations and 14 municipalities will be covered with this additional financing which includes 25 existing partnership areas in 10 city corporations, 4 municipalities and 20 new partnership areas in 10 new municipalities, 4 existing city corporations and one new city corporation. No land, structures or livelihood has been affected in the existing facilities and same will follow the same modality for the new 20 PAs. Hence, the overall project is classified as Category C for involuntary resettlement (IR) and tribes, minor races, ethnic sects and community peoples based on the ADB SPS 2009. No tribal communities or tribal people will be affected by the project.

13. This SSPF is prepared in compliance with the Bangladesh ARIPO (Ordinance II of 1982 with amendments up to 1994) and ADB's specific requirements under SPS. The SSPF provides the principles and guidelines for selection of construction sites, eligibility for displaced person (DP), entitlements, legal and institutional framework, modes of compensation and rehabilitation, participation and consultation procedures, and grievance redress mechanisms which will be employed to compensate, resettle and rehabilitate the livelihoods and living standards of the development partners which are agreed by the GOB and the ADB. It also provides specific guidance on the ADB requirements for planning and implementing land acquisition and resettlement (LAR) under UPHCSDP and uses ADB terminologies. The ADB SPS 2009 stipulates

that development projects planned and implemented in areas inhabited by tribes, minor races, ethnic sects and community peoples, should ensure that these people are not adversely affected, and that they receive culturally compatible social and economic benefits. In compliance with these stipulations, the basic objectives of SSPF are:

(i) Screen all development and construction interventions to determine presence of tribes, minor races, ethnic sects and community peoples and, if so, ensure their direct participation in selection, design and implementation of the project's activities.
(ii) Adopt socially and culturally appropriate measures to mitigate the unavoidable adverse impacts.
(iii) Wherever feasible, adopt special measures—in addition to those for impact mitigation—to reinforce and promote any available opportunities for socioeconomic development of the affected tribes, minor races, ethnic sects and community peoples.
(iv) Finally, no facility site should be selected, even at the preliminary stage, based only on official land records, which may not represent ground reality in terms of current uses and users.

14. The basic objectives of the SSPF are to guide the EA in (i) properly selecting sites through social screening, (ii) minimizing social impacts and assessing unavoidable impacts using appropriate methods, (iii) properly identifying, compensating, and restoring the livelihoods of the development partners, (iv) serve as a binding document to ensure payment of compensation and assistance to the development partners, and (vi) provide direction in preparing, updating, implementing, and monitoring Resettlement Plans (RPs).[1]

B. Legal Framework in Bangladesh

15. Land for development projects undertaken by GOB is obtained through legal acquisition. The principal legal instrument governing land acquisition in Bangladesh is the ARIPO 1982 (Ordinance II with amendments up to 1994). The Ordinance states that compensation be paid for (i) land and assets permanently acquired (including houses, trees, and standing crops,); and (ii) any other impacts caused by such acquisition. The Ordinance provides certain safeguards for the owners and has provision for payment of —fair value for the property acquired. The Deputy Commissioners (DC) determine (i) market value of acquired assets on the date of notice of acquisition (based on the average of the registered values of similar properties bought and/or sold in the area over the preceding 12 months); and (ii) 50% premium on the assessed value (other than crops) due to compulsory acquisition. The DC payments or —award to owners is commonly called cash compensation under law (CCL). The value thus paid is invariably less than the —market value as owners customarily report undervalued land transaction prices in order to pay lower stamp duty and registration fees. As a result, compensation for land paid by DC, including premium, remains less than the replacement cost at current market price or replacement value (RV).[2] If the acquired land contains standing crops cultivated by tenant contract farmers/ share croppers (*bargadar*), the law requires that part of the compensation money to be paid in cash to

[1] RP would be prepared if any of the subprojects includes IR impacts that are not deemed significant. The IR impacts of an ADB-supported project are considered significant if 200 or more persons will experience major impacts, which are defined as (i) being physically displaced from housing, or (ii) losing 10% or more of their productive assets (income generating).

[2] There is provision for Arbitration Appellate Tribunal on compensation assessment by the DC, but the law allows only 10 percent enhancements on the DC—award.

the tenants with registered deeds only. Places of worship, graveyard, and cremation grounds are not to be acquired for any purpose. The Ordinance requires that all the acquired movable properties on the acquired land will be auctioned publicly by the project executing agencies requiring the land.

16. Under the 1982 Ordinance, the Government of Bangladesh is obliged to pay compensation only for the assets acquired. Further, the Ordinance does not deal with social and economic impacts because of land acquisition. For instance, the Ordinance does not cover project-affected persons without titles such as informal settlers (squatters), occupiers, informal tenants, and lease-holders (without registration document). Further, the Ordinance has no provision for resettlement of affected households and businesses or any assistance for restoration of livelihoods of the affected persons.

17. In Bangladesh, “indigenous people” are treated as “tribals” in official documents, though in the Act 12 of 1995 and Rules 6, 34, 45, 50 of Chittagong Hill Tracts (CHT) Regulation (1900), they are documented as “indigenous peoples” or “aboriginal” as per section 97 of the SAT Act (1950). In Bangladesh, there are about 50 different tribes, minor races, ethnic sects and community peoples living in the plain lands and hill areas. Though they claim that their population is over 3 million, according to the survey of 2011, the country’s tribes, minor races, ethnic sects and community peoples is around 1,586,141, which is 1.8% of total population of the country. The Constitution of Bangladesh ensures affirmative action for tribes, minor races, ethnic sects and community peoples and prohibits discrimination on grounds of race, religion or place of birth. The Bangladesh Indigenous Peoples Forum (BIPF) urged the government to enact the Bangladesh Indigenous Peoples Rights Act (2015) which is being drafted by the Parliamentary Caucus on Indigenous Peoples and formulated by the National Human Rights Commission aiming to ensure economic, social, and cultural rights of tribes, minor races, ethnic sects and community peoples.

18. The total number of tribal groups is also a matter of much disagreement. The 1991 census mentions 29 groups. The recently adopted Small Ethnic Minority Cultural Institution Act (April 2010) mentions 27 different groups which is at present under revision and proposes 50 different groups. The Bangladesh Adivasi Forum mentions as many as 45 tribes, minor races, ethnic sects and community peoples’ groups in one of their publications (Solidarity, 2003). A proposed draft law, called Bangladesh Indigenous Peoples Rights Act, by Bangladesh Parliamentary Caucus on Tribal Peoples – a group of parliamentarians who advocate for the rights of the country’s tribal peoples – enlists as many as 59 distinct ethnic minority groups.

19. Although the tribal peoples are scattered all over Bangladesh, they are overwhelmingly concentrated in several geographical pockets; namely Northwest (Rajshahi and Dinajpur), Northeast (Sylhet), Central region (Dhaka and Mymensingh), South (Barishal and Patuakhali), with the most significant concentration in the south-eastern corner – the Chattogram Hill Tracts. The location of the various ethnic minority groups by region is broadly:

(i) Northwest region (Rajshahi division - includes Rajshahi, Naogaon, Chapainawabganj, Natore, Sirajganj, Pabna, Joypurhat, Dinajpur, Thakurgaon, Rangpur, Bogra and Gaibandha district): major adivasi communities are: Santal, Uraon/Oraon, Munda, Mahato, Paharia, Malo, Pahan, Rajbongshi, Rajooar, Karmakar and Teli).
(ii) Northeast region (Sylhet division - includes Sylhet, Sunamganj, Habiganj and Moulvibazar district: major adivasi communities are; Khasi, Patro, Monipuri, Garo, Tripura and tea garden communities).

(iii) Central region (Greater Mymensingh and Dhaka - includes Gazipur, Tangail, Sherpur, Jamalpur, Netrokona, Mymensingh): major adivasi communities are: Garo, Hajong, Koch, Banai, Rajbangshi, Dalu, Barman and Hodi.
(iv) Coastal region (Khulna, Chattogram and Barishal division - includes Patuakhali, Barguna, Chandpur, Chattogram, Coxsbazar, Khulna, Satkhira): major Adivasi communities are- Rakhhaine, Tripura, Munda and Ranbangshi.

C. ADB's Policy on Involuntary Resettlement and Indigenous People

1. ADB's Policy on Involuntary Resettlement

20. The ADB policy on involuntary resettlement is detailed as —Safeguard Requirement (SR)-2 in the ADB Safeguard Policy Statement (SPS) of June 2009. The SR 2 emphasizes ADB's efforts to assist its development member countries to pursue environmentally sustainable and inclusive economic growth. In addition, ADB is committed to ensuring the social and environmental sustainability of the projects it supports. In this context, the goal of the safeguards is to promote the sustainability of project outcomes by protecting the environment and people from project's potential adverse impacts.

21. The objectives of ADB's safeguards are to:

(i) Avoid adverse impacts of projects on the environment and affected people including tribes, minor races, ethnic sects and community peoples, where possible
(ii) Minimize, mitigate, and/or compensate for adverse project impacts on the environment and affected people when avoidance is not possible; and
(iii) Strengthen safeguard systems of the executing agency and develop their capacity to manage social risks.

22. The key principles of ADB's Involuntary Resettlement Policy and procedures relevant to the SSPF are:

(i) Assess past and current involuntary resettlement risks.
(ii) Undertake meaningful consultation and participation of all DPs
(iii) Separate consultation with tribal communities if affected directly or indirectly
(iv) Pay attention to vulnerable groups especially those below the poverty line, the landless, the elderly, women and children, and tribes, minor races, ethnic sects and community peoples, and those without legal lease to land
(v) Establish a grievance redress mechanism to receive and facilitate resolution of the affected persons concerns.
(vi) Support the social and cultural institutions of displaced persons and their host population.
(vii) Improve, or at least restore, the livelihoods of all displaced persons through:
    a) land-based resettlement strategies when affected livelihoods are land based where possible.
    b) prompt replacement of assets with access to assets of equal or higher value,
    c) prompt compensation at full replacement cost for assets that cannot be restored; and
    d) additional revenues and services through benefit sharing schemes where possible.
(viii) Provide DPs with the following:

a) secured tenure to relocation land;
b) better housing at resettlement sites with comparable access to employment and production opportunities;
c) integration of resettled persons economically and socially into their host communities; and
d) extension of project benefits to host communities.

(ix) Provide DPs with transitional support and development assistance, such as land development, credit facilities, training, or employment opportunities;
(x) Provide civic infrastructure and community services, as required.
(xi) Improve the standards of living of the displaced poor and other vulnerable groups, including women, to at least national minimum standards.
(xii) Develop procedures in a transparent, consistent, and equitable manner if land acquisition is through negotiated.
(xiii) Ensure that displaced persons without leases to land or any recognizable legal rights to land are eligible for resettlement assistance and compensation for loss of non-land assets.
(xiv) Prepare a resettlement plan elaborating displaced persons 'entitlements, the income and livelihood restoration strategy, institutional arrangements, monitoring and reporting framework, budget, and time-bound implementation schedule.
(xv) Disclose a draft resettlement plan, including documentation of the consultation process in a timely manner, before project appraisal, in an accessible place and a form and language(s) understandable to affected persons and other stakeholders. Disclose the safeguard documents to tribal communities in their local languages. Disclose the final resettlement plan and its updates to affected persons and other stakeholders.
(xvi) Pay compensation and provide other resettlement entitlements before physical or economic displacement.
(xvii) Implement the resettlement plan under close supervision throughout project implementation.
(xviii) Monitor and assess resettlement outcomes, their impacts on the standards of living of displaced persons.

D. ADB Policy vis-à-vis Voluntary Donation of Land

23. Direct purchase and voluntary donation of land for project purpose will not trigger SR-2 of SPS 2009 on involuntary resettlement. Direct purchase should be executed on willing buyer and willing seller basis and voluntary donation should be executed with full knowledge of the donor without application of any force or threat. Certain safeguards to be ensured for such process of obtaining lands for infrastructure construction under the project. Such safeguards include:

(i) full consultation with landowners and any non-titled affected people on site selection;
(ii) ensuring that voluntary donations do not severely affect the living standards of affected people, and are linked directly to benefits for the affected people, with community sanctioned measures to replace any losses that are agreed to through verbal and written records by affected people;
(iii) any voluntary donation will be confirmed through verbal and written records and verified by an independent third party such as a designated non-government organization or legal authority; and
(iv) having adequate grievance redress mechanisms in place.

E. Project's Social Safeguard and Resettlement Policy

24. ULBs will select sites, and design and construct infrastructure for HCCs with an emphasis on avoiding or minimizing use of additional private and public lands, and minimizing disruptions to business/trading activities where the works are concerned with vertical extensions of existing structures. The social and resettlement policy for the project has been designed to deal with acquisition of land using power of eminent domain, direct purchase and/or voluntary donation. Land acquisition for the project will be governed by Bangladesh ARIPO II of 1982 and ADB SPS 2009 and in such cases resettlement plans will be prepared following the SPS requirements as incorporated in this framework.

25. Where subprojects involve vertical extension of the existing facilities without a need for additional lands, ULBs will:

(i) Plan and carry out the construction activities to avoid or minimize disruptions to health services from the concerned HCCs and any livelihood activities. Conduct separate consultations with tribal communities.

(ii) Arrange alternative temporary locations (on rental basis) or bring in structural measures to allow the HCC operatives (doctors, nurses, attendants and others) in the same space including safety arrangements for HCC operatives and visiting health service seekers (children and mothers) and avoid peak business hour of the HCCs for construction activities.

26. ULBs will be using their own land, other public land or lands arranged through voluntary donation or direct purchase. In case of unavailability of land under all these means, ULBs may opt to obtain land through acquisition. In such cases, resettlement plans will be prepared following the SPS requirements as incorporated in this framework. The following principles and guidelines will also apply in obtaining lands for construction of new infrastructures:

1. Land Acquisition Using ARIPO II of 1982

27. Land acquisition will be the last option for obtaining lands for construction of new infrastructures for upgrading existing and establishments of new HCCs. The resettlement policy for the project, in case of land acquisition, will (a) cover all displaced persons irrespective of their title to land, (b) compensation for lost assets at full replacement cost, and (c) restoration or enhancing the livelihoods of all categories of displaced persons. The households/persons displaced by the project interventions will receive cash compensation for land and other assets at full replacement cost as per market price at the time of dispossession. Additional measures will be taken to ensure minimum disruption during the project construction period.

28. Thus, households to be displaced physically and are affected economically will receive due compensation, relocation assistance, and allowances in accordance with the following guidelines and policy:

(i) Land acquisition, and other involuntary resettlement impacts will be avoided minimized exploring all viable alternative project designs.

(ii) Where unavoidable, a time-bound RP will be prepared, and DPs will be assisted in improving or at least regaining their pre-project standard of living.

(iii) Replacement value of land and other assets will be paid at current market price and titling cost will be included in the replacement value without any condition.

(iv) Consultation with DPs on compensation, disclosure of resettlement information to DPs, and participation of DPs in planning and implementing the project will be ensured.

(v) Vulnerable and severely affected DPs will be provided with special assistance.
(vi) Non-titled DPs (e.g., informal dwellers or squatters, DPs without registration details) will receive a livelihood allowance in lieu of land compensation and will be fully compensated for losses other than land.
(vii) Provision of income restoration and rehabilitation will be made.
(viii) The RP will be disclosed to the DPs in the local language which is Bangla.
(ix) Payment of compensation, resettlement assistance and rehabilitation measures will be fully provided prior to the contractor taking physical possession of the land and prior to the commencement of any construction activities on a particular package.
(x) Establishment of appropriate grievance redresses mechanisms to solve DPs' grievance if occurs.

2. Direct Purchase of Land

29. In the circumstances where ULBs do not have their own land, cannot find other public land, or arrange lands through voluntary donation by private owners, they will attempt purchase of lands through direct negotiation with potential private owners. ULBs will execute direct purchase of land according to the following guidelines:

(i) All purchases must be on a 'willing buyer and willing seller basis'.
(ii) Prices will be negotiated and paid transparently in the presence of community leaders and elected representatives at the Upazila and Union levels.
(iii) Records of negotiations with names and addresses of participants outside ULBs, and those of purchases including certified copies of registration deeds will accompany the funding requests made to PMU, LGD and will remain open to review by ADB and others interested in the matter.
(iv) Failure of negotiation will not result in expropriation and alternative sites will be selected for the project.
(v) There will be no coercion and the 'risk of asymmetry of information and bargaining power' will be duly addressed.
(vi) Negotiation will be monitored and documented by an independent external party.

3. Voluntary Donation of Land

30. Voluntary donation will be the second option to ULBs in obtaining lands for construction of new infrastructures for subprojects. In case, the municipalities or city corporations do not have their own lands suitable for the construction or there are no other public lands they can arrange for it, ULBs will seek donations from private landowners in accordance with the following guidelines:

(i) Donations must be voluntary, and the landowners will have the right to refuse donation requests of ULBs without the fear of adverse consequences.
(ii) ULBs will ensure that voluntary donations do not severely affect the living standards of affected people, and are linked directly to benefits for the affected people, with community sanctioned measures to replace any losses that are agreed to through verbal and written records by affected people. Donations will not be sought from small and marginal landowners who might be caused impoverished by the action.
(iii) If donations are required, the concerned landowners will be consulted very early in the subproject selection process.
(iv) Lands without disputes and claims should be donated, and documented with the

details required by land administration.

(v) Where these lands are in use by squatters and other vulnerable groups, ULBs will implement the applicable mitigation measures adopted in this framework having adequate grievance redress mechanisms in place.

(vi) Any voluntary donation will be executed following the applicable law in Bangladesh and all records of execution will be verified by an independent third party such as a designated non-government organization or legal authority. Records of donations will accompany the funding requests made to PMU, LGD, and will remain open to review by ADB and other interested organizations and persons.

F. Selection of Sites and Social Safeguards Screening

31. ULBs are responsible to identify existing HCCs for upgradation and sites for construction of new HCCs based on beneficiary size and availability of health care services for the urban poor. The elected representatives will be instrumental in needs identification and selection of sites. Intensive consultation with the communities and key stakeholders will be conducted before selection of sites. Consultation topics would include, among other issues, the (i) objectives of UPHCSDP as a whole and those of physical works required for the HCCs; (ii) social safeguard implications of using private and public lands; (iii) identification of individuals / families who could be convinced by ULBs and community for land donation; (iv) availability of public lands in the area which could be used for new construction; and (v) any other issues that would help to avoid acquisition and yet would somehow make the land available. The communities will also assist ULBs in consultation process to determine (i) if the communities and/or well-to-do individuals / families can make the required lands available on donation; (ii) whether the lands could be purchased directly on ―willing buyer-seller‖ basis; or (iii) whether the lands will have to be obtained through legal acquisition.

32. To the extent feasible, ULBs will try to (i) avoid subprojects that will require private land acquisition; (ii) carry out the extension/renovation works in the lands already owned by them; (iii) use their own or other public lands for building new structures.

33. Generally, PMU will not accept a site for new infrastructure construction which will:

(i) Require involuntary land donation, or direct purchases that are not offered on ―willing buyer-seller basis;

(ii) Affect private homesteads;

(iii) Render households using public lands homeless;

(iv) Affect mosques, temples, graveyards, cremation grounds, and other places/objects that are of religious and cultural significance;

(v) Significantly restrict access to common property resources and livelihood activities of groups and communities; and

(vi) Affect tribes, minor races, ethnic sects and community peoples with their land/assets and pose a risk to their language and culture.

34. However, if there is no alternate to get the land without affecting private homesteads or rendering any kind of loss of residential/ commercial/ industrial structures by owners or by squatters/unauthorized occupants, appropriate compensation has to be paid to the DPs as per the entitlement matrix.

35. The ULBs will document the consultation proceedings and obtain a no objection from the community and key stakeholders along with photographs of meetings, and signature of key

stakeholders having role in decision making and selection of sites. Construction of infrastructure for HCCs in selected sites will be subjected to an initial social screening and preparation of mitigation plans, if necessary. The social screening will identify any potential safeguards issues and impacts by using a specified instrument given at Annex-I of this SSPF. The social screening will be followed for accepting a site for construction and preparation and implementation of any mitigation plans.

G. Eligibility of Displaced Persons and Entitlements

1. Eligibility Criteria

36. All affected development partners will be entitled to compensation and resettlement assistance based on severity of impacts.[3] Nevertheless, eligibility to receive compensation and other assistance will be limited by the cut-off date. This date will correspond to the census and an inventory of losses (IOL) of assets to be carried out for the subprojects as part of the social impact assessment. In case of legal acquisition, the date of service of notice under section 3 of the ARIP Ordinance II of 1982 will be the legal cut-off date. No new DPs will be included for compensation and entitlements after this date. The disclosure of resettlement plans will include the eligibility cut-off date in the subproject areas. The absence of legal title will not bar for the DPs to get compensation and assistance, as specified in the entitlement matrix (Table A18.2).

37. Owners of movable or transferable/shift able (temporary or simple built with materials like tin, earth, straw or thatch) structures located on ULB land will be entitled for compensation under UPHCSDP for any development they may have made on the land before cut-off date. Vulnerable DPs or DHs will qualify for additional assistance to facilitate them in relocation and restoration of their livelihoods.

38. Non-vulnerable households squatting on ULB land or having businesses thereon will be entitled for compensation for their affected structures and assistance for shifting them. Any structure not directly used by a non-vulnerable household, i.e., rented out for income will not qualify for additional resettlement assistance.

2. Categories of Development Partners and Types of Losses

39. As noted in the Glossary of Terms, DPs include any people, households, firms, or private institutions who, on account of changes that result from the project will have their (i) standard of living adversely affected; (ii) right, title, or interest in any house, land (including residential, commercial, agricultural, forest, and/or grazing land), water resources, or any other moveable or fixed assets acquired, dispossessed, restricted, or otherwise adversely affected, in full or in part, permanently or temporarily; and/or (iii) business, occupation, place of work or residence, or habitat adversely affected, with or without displacement.

40. The following categories of development partners may be affected if land acquisition is required during implementation of the project:

(i) DPs whose land is affected – DPs whose land is being used for agricultural, residential, or commercial purposes and is affected either in part or in total and the effects are either temporary or permanent;

[3] The severity of impacts is based on the difference between temporary and permanent effects and minor and significant impacts as defined in ADB's Policy and the Glossary of Terms of this SSPF.

(ii) DPs whose structures are affected – DPs whose structures (including ancillary and secondary structures) are being used for residential, commercial or worship purposes which are affected in part or in total and the effects are either temporary or permanent;
(iii) DPs with other assets affected – DPs who have other assets, such as crops or trees, affected either temporarily or permanently;
(iv) DPs losing income or livelihoods – DPs whose business, source of income or livelihood (including employees of affected businesses) is affected in part or in total, and affected either temporarily or permanently;
(v) DPs losing access to common property resources – DPs whose access to or use of common property resources is affected on a temporary or permanent basis;
(vi) DPs included in any of the above categories who are defined as vulnerable;
(vii) DPs who have no formal legal rights but who have claims to such lands that ore recognized or recognizable under national laws; and
(viii) DPs who have neither formal legal rights nor recognized or recognizable rights.[4]

3. Compensation and Entitlement Policy

41. Compensation and entitlements for each category of DPs (as described above) are based on type and level of loss or impact. An entitlement matrix (Table A18.2) has been prepared on the basis of expected impacts and entitlements approved by the Government of Bangladesh for similar projects. It identifies the categories of impact and shows the entitlements for each type of loss. If additional or unforeseen impacts are identified during detail design and/or implementation, then such losses will be included in a revised entitlement matrix and the resettlement plans. This entitled matrix is also applicable for tribal people if affected.

Table A18.2: Entitlement Matrix

Type of Loss	Application	Definition of DPs	Entitlement	Additional Issues
1. Loss of land (agricultural, commercial, homestead, pond, orchard common land)	Land	Legal owner(s) of land	Replacement value (RV) of land [Cash Compensation under Law (CCL) and additional grant to cover replacement value] at market price to be determined by property valuation Assessment team (PVAT)	Registration cost for purchase of equivalent quantum of land with same quality is added with current market price determined by PVAT under LGD
2. Loss of Structure residential/ commercial/ industrial structure by owner	Structure	Owners structures identified by DC and/ or in Census	(i) CCL by Deputy Commissioner (DC) comprising market price and 50% premium on market price (ii) Additional grant as required to ensure replacement value. (iii) Transfer grant of Tk2,500 per DH for structure (iv) Land development and reconstruction grant equivalent to 12.5% of the replacement value of structure. (v) Additional assistance of Tk5,000 to each to	Cash compensation under law is determined by DC and replacement value will be determined by PVAT under LGD

[4] Para. 7 and para. 8 of SPS, Safeguard Requirements 2: Involuntary Resettlement, page 45.

Type of Loss	Application	Definition of DPs	Entitlement	Additional Issues
			vulnerable DHs including female headed DHs (as defined in glossary) (vi) Salvaged materials free of deductions.	
3. Loss of residential/ Commercial structure by squatters and unauthorized occupants	Squatters Uthulis	Informal settlers/ squatters/ non-tilted DPs occupying public land without title/ or squatting on Government land	(i) Replacement value of structure at market price determined by PVAT. (ii) Transfer grant @ 12.5% of replacement value of structure assessed by PVAT. (iii) Reconstruction grant @ 12.5% of the replacement value of structure assessed by.	(i) Verification of JVS and PVAT data. (ii) They will be treated as vulnerable DPs, and will be given a grant of an amount of Tk10,000 to each PHA. (iii) For any new construction electricity, gas, water supply etc. to be developed.
4. Loss of fish stock, trees, crops (including banana, betel leaf), perennials	Standing crops, trees, fish stock	(i) Person with legal ownership of the land (ii) Socially recognized occupant of the trees/ fishes	(i) Compensation at the rate estimated by the Dept. of Forest (DOF) for trees, Dept. of Agriculture (DOA) for crops and Dept. of Fisheries for fish stock. (ii) For fruit bearing trees compensation for fruit @ 30% of timber value X 1 year, and for perennials compensation for fruits @ 30% of timber value X 3 years. (iii) Compensation for fish stocks as determined by PVAT. (iv) 5 saplings will be distributed among each affected household. (v) Owners will be allowed to cut and take away their trees, perennial crops/ fishes etc. free of cost without delaying the project works.	DC will be determining compensation under law either assistance from DOF, DAE, DAM and fisheries Department.
5. Loss of access to cultivable land by owner cultivator/ tenant/ share cropper	Farm land and growth centers	Tenants/ share cropper/ Legal owner/ socially recognized occupant of land	(i) Compensation for standing crops to owner cultivator/ sharecroppers or lessees as determined by PVAT. (ii) Cash grant equivalent to 1 year's income from land for titled/ non-titled lease holders or users as determined by PVAT. (iii) Cash grant of Tk1,000 per decimal of land in growth centers to tenants. (iv) Owner to take away the crop.	(i) Census will be conducted by independent agency to identify the tenants. (ii) Grant to be paid after taking possession of land and the legal/ socially recognized owner is paid CCL for land and on certification of receipt by legal/ socially recognized owner. (iii) Additional cash

Type of Loss	Application	Definition of DPs	Entitlement	Additional Issues
				grand to cover current market value of crop compensation as prescribed by PVAT in case of private owner himself cultivating crop
6. Loss of business, income and work days due to displacement	Relocating HDs and affected business/ premises	DHs, owners of business (including renters of commercial structure) employees	(i) Cash grant of Tk5,000 per DH for lost income/ workdays to cover transition period. (ii) Cash grant of Tk6,000 for loss of business income by affected business operators. (iii) Cash grant of Tk3,000 to affected employees or compensation equivalent to 2 months' wages whichever is the higher.	Census will be conducted to identify the relocating DH, affected businesses and employees
7. Loss of business by Community Based Enterprises (CBEs) due to dislocation		Owner/operator of the business as recorded by JVS	Business restoration grant to be determined by JVT/PVAT subject to minimum of Tk50,000 and maximum of Tk100,000 per unit for medium CBEs and Tk25,000 to Tk50,000 per unit for small CBEs. Other parameters will be determined by JVT/PVAT to define medium and small CBEs	(i) All persons recorded by the JVS (ii) Cash grant to be paid while taking possession of land
8. Displaced or damaged community structures or common property resources (CPR)	Community structures	Community group (representative)	(i) Replacement value of structure at market price determined by PVAT. (ii) Transfer grant of Tk2,500 per DH for structure to owners. (iii) Land development and reconstruction grant equivalent to 12.5% of the replacement value of structure. (iv) Utility services loss grant @ 5% of PVAT amount (electricity, gas, water supply etc.). (v) Cash grant @ of 25% of RV per CPR for facilitating establishment of a better one. (vi) Salvaged materials free of deductions.	(i) Cash compensation under law is determined by DC and replacement value will be determined by PVAT under LGD. (ii) Demolition of CPR to be avoided as far as possible. (iii) For any new electricity, gas, water supply etc. to be developed (iv) New CPR will be established with a better quality.
9. Poor and vulnerable households	Vulnerable HH	Poor and vulnerable households including information settler, squatters/	(i) Additional cash grant of Tk15,000 for affected women headed households and Tk10,000 for other vulnerable households.	(i) Identification of vulnerable households as per guide line. (ii) Income restoration schemes as

Type of Loss	Application	Definition of DPs	Entitlement	Additional Issues
		women headed household without elderly son/ non-titled DPs identified by JVT.	(ii) For training, Tk10,000 per DP nominated by project affected household for income generation activity.	outlined separately for vulnerable households. (iii) Arrange training on income generating activities.
10. Temporary impact during construction		Community/ Individual	(i) The contactor shall bear the cost of any impact on structure or land due to movement of machinery and in connection with collection and transportation of materials. (ii) All temporary use of lands outside proposed right of way to be through written approval of the landowner and contractor. (iii) Land will be returned to owner, rehabilitated to original or preferably to better standard.	(i) Community people should be consulted before starting of consultation regarding air pollution, noise pollution and other environmental impact. (ii) The laborers in the camp would be trained about safety measures during construction, aware of health safety, STDs, safe sex etc. (iii) The contractor shall ensure first aid box and other safety measures like condoms at construction site.
11. Unforeseen impact	Any impact recognized at the final design stage	Any and all DPs	Determined as per policy on unique findings at detailed design stage.	Social screening will determine any additional impact and census will be conducted to assess such losses.

CCL = cash compensation under law, CPR = common property resources, DC = Deputy Commissioner, DH = displaced household, DP = displaced person, HH = household, JVS = joint verification survey, JVT = joint verification team, LGD = Local Government Division, PVAT = property valuation assessment team, STD = sexually transmitted disease.
Source: Asian Development Bank

III. SOCIOECONOMIC INFORMATION

42. ULBs with assistance and guidance from PMU will carry out social impact assessment/screening and following the results of the initial social screening, carry out inventory of losses and DP census for identification of involuntary resettlement impacts and preparation of resettlement plans. The displaced persons and their communities will be consulted on the subproject and the likely social safeguards issues.

A. Inventory of Losses (IOL)

43. Following the initial screening, detail inventory of lands and assets to be affected will be carried out. The inventory will include area of land and assets by category to facilitate determination of compensation at replacement cost. The inventory will also include names of the owners and impacted persons. A hand sketch of land parcel to be taken for the construction will be prepared showing current use including location of structures.

B. Development Partner Census and Socioeconomic Survey

44. Full census of all displaced persons listed in the Inventory will be undertaken. The census will identify the ownership, usage and productivity of land under acquisition or being restricted for use by the occupants. It will also include income and other determining factors for categorization of the DPs by poverty and vulnerability.

45. Since number of displaced households will be very less, the DP census will cover socio-economic information, vulnerability, health and gender issues, and health service facilities accessed by them. The social impact assessment will entail interviews with the affected community as well as administer structured surveys of DHs.

C. Stakeholder Consultation

46. The Social Development Officer (SDO) at PMU will facilitate PIUs in conducting focus group discussions (FGDs) and stakeholder consultation in the HCC catchment areas and obtaining views of the affected persons and their communities on the proposed interventions for improved health services and consequent resettlement needs. The assessment will also identify those who might experience indirect and secondary impacts of the project interventions and any vulnerable groups who might require special attention during project implementation.

D. Gender Considerations

47. All survey data will be disaggregated to identify specific social impacts and gender issues. Social preparation and action plan will be prepared based on results of social and safeguards issues and sufficient measures included ensuring social safety and the rights of women and female-headed households. During disbursement of assistance and compensation, priority will be given to female headed households. Additional assistance will be provided for all the female-headed households who will be considered as vulnerable group. A separate Gender Action Plan has been prepared for this project.

E. Determining Compensation and Replacement Costs

1. Principles and Methodology

48. The principles of valuation of acquired land and assets are devised as per ADB Safeguard Requirements 2 of the SPS 2009. The policy states that all losses of the displaced persons must be paid at full replacement cost at the time of dispossession of the property acquired for infrastructure projects. The calculation of replacement costs will be based on (i) current market price at the time of dispossession, (ii) transaction/legalization costs, (iii) transitional and restoration (land preparation and reconstruction) costs, (v) interest accrued, and (vi) other applicable payments. To ensure compensation at replacement cost, good practice examples in compliance with ADB policy will be followed for determining the replacement cost of acquired assets.

49. LGD will form a Property Valuation Advisory Team (PVAT) for each of the project ULBs to design methodology for determining current market price and recommend replacement cost for all assets to be acquired. PVATs will also assist ULBs in negotiating price for direct purchase of land. The calculation of unit value will be done by considering the current market price and the associated transaction and titling cost so as to meet the replacement cost of the land and other assets.

2. Valuation by Deputy Commissioners

50. Deputy Commissioners at respective districts will determine market value of land averaging sale price of land parcels for 12 preceding months from the date of serving notice under section 3. Sale price will be collected for each type of land (*viti, bari, nal, nala, nadi, balu,* fallow and the like) from each of the lowest land administrative units called *mauza*. The prices will be averaged for each type in each *mauza* and a 50% premium will be added to determine the compensation under law. For acquired structures, the DCs will take assistance from the Public Works Department (PWD) for unit rates and again add 50% for compensation under law. For determining compensation for trees, Divisional Forest Office will be approached for assistance. Department of Agriculture Extension (DAE) and Department of Agriculture Marketing (DAM) will assist the DCs in determining compensation for standing crops. Fisheries Department at the district level will assist in determining compensation for fish stock.

3. Establishment of Replacement Value

51. In establishing the unit prices for calculating replacement costs (replacement value or RV) and complying with the Compensation and Entitlement Policy, PIUs with the help of SDO will verify the prevailing market unit prices of property to be affected by the subprojects.

52. **Land.** The PIUs with assistance from SDO will assess affected private lands considering: (i) the present status of development; (ii) demand for land in the area based on its use (agricultural, residential or commercial) and surrounding factors that influence demand such as the proposed development programs of ULBs; and (iii) location of the land in relation to its accessibility and other factors. An independent agency/consultant will gather information on land prices in three locations that are similar in character to each plot of affected land. They will first verify the price of land in the subproject areas by asking at least 10 respondents including landowners, recent buyers or sellers of land, and deed writers at the sub-registers' offices who have recently handled transactions in or near the affected area(s). The consultant will then follow the same process to verify land prices in two other locations with similar characteristics. As prices vary the statistical mode value will be calculated and that will be the basis for comparing DC determined rates and establishing the unit prices for estimating the replacement cost for land. If there is a difference between the price determined by the DC and the one obtained from the market survey then the difference will be paid (as additional grant).

53. **Housing and other structures.** The compensation for immovable properties will be determined on the basis of replacement cost as on date without depreciation, based on the most updated Schedule of Rates by the Public Works Department (PWD), GoB. The replacement costs of structure for RP budget will be arrived based on the schedule of rates for civil works (thirteenth edition) by the PWD (effective from 1st June 2011).

54. **Business or other sources of income.** The PIUs with the help of SDO will conduct a survey of daily incomes and the rent of structures from a sample of businesses in the subproject areas.

55. **Crops and trees.** If significant numbers of crops and trees will be affected by land acquisition (temporary or permanent) the PIUs and SDO will survey unit prices, in consultation with agriculture/horticulture experts. Unit prices for seasonal crops will be based on the highest market price during the season to ensure that compensation is adequate and unit prices for perennial crops will be based on their average price for the past 12 months. Unit prices for compensation of fruit trees will be based on the market value of the fruits; timber trees will be

priced according to their species, age and quality. Values determined will be used to verify DC rates.

4. Ensuring Replacement Value

56. DCs will pay cash compensation under law (CCL) for land and assets in the process of land acquisition. If the CCL is less than the replacement value determined by PIUs for their subprojects, additional payment will be directly made to the DPs equivalent to the difference between RV and CCL.

57. In case of compensating squatters on ULB land, only the compensation as per entitlement matrix (type 3 of table 1) will be offered to the displaced persons for any physical assets developed by them on the land.

IV. CONSULTATION, PARTICIPATION, AND DISCLOSURE

A. Consultation and Participation Strategy

58. Consultation is a continuous process and will also be carried out during detail design, implementation, and implementation monitoring of the project at the city corporation and municipality levels. The beneficiaries and likely displaced persons will be fully informed, closely consulted, and encouraged to participate in the design, implementation, and monitoring of the UPHCSDP subprojects. Consultation and communication with the beneficiaries and other stakeholders during project design will be an integral part of the process of gathering relevant data for impact assessment and facilitate the development of appropriate options for social impact management. Consultation during social surveys will be to obtain views of the beneficiaries, development partners, and other stakeholders on the project implementation process, compensation, and resettlement provisions in following this SSPF in compliance of the government laws and ADB Safeguard Requirement 2.

59. The areas for participation of the primary stakeholders include: (i) identify alternatives to avoid or minimize resettlement; (ii) assist in inventory and assessment of unavoidable losses; (iii) assist developing alternative options for relocation and income restoration; (iv) provide inputs for entitlement provisions; and (vi) identify likely conflict areas with resettlers. At least 30% of the peoples to be consulted would be women of the project area. If tribal communities are affected or benefited by the project, separate consultations have to be conducted with them in order to disclose project objectives, benefits and impacts.

B. Institutional Responsibilities

60. PMU will be responsible to ensure that communities are meaningfully consulted during selection and screening of subproject sites. ULBs will be the primary responsible institution to conduct community consultation under the guidance of the SDO with the PMU. Consultation during implementation will be carried out as participatory monitoring and outcomes will be fed into the periodic project progress reports.

C. Disclosure of Social Safeguards Planning Framework

61. Initial discussions will be held with the primary stakeholders (beneficiaries, landowners, household members, and NGOs) on the PHC concept following approval of this SSPF and during social screening, social impact assessment and preparation of resettlement strategy for

applicable sites. These consultations will include community meetings and FGDs with beneficiaries and affected persons (if any). The screening reports will include an appendix that identifies all participants in meetings and all those consulted in the process.

62. The SSPF will be made available, both in English and Bangla languages, to the beneficiary communities and DPs at the ULB offices, once approved and endorsed. The English versions of the SSPF will be disclosed on ADB website after it is endorsed by LGD, prior to contract signing, and kept at ULB offices as a public document accessible to all the stakeholders especially the beneficiaries and likely DPs. The SSPF will be summarized into a Public Information Brochure, containing information on all necessary items, especially the compensation eligibility and entitlement provisions, translated into Bangla and distributed to the stakeholders especially the DPs and DHs.

(i) the EA will submit the following documents to ADB for disclosure on ADB's website:
(ii) a draft resettlement plan and/or resettlement framework endorsed by the EA before project appraisal;
(iii) the final RP endorsed by the EA after the census of DPs has been completed;
(iv) a new RP or an updated RP, and a corrective action plan prepared during project implementation, if any; and
(v) the resettlement monitoring reports.

V. COMPENSATION, INCOME RESTORATION, AND RELOCATION

A. Income Restoration Measures

63. Displaced persons affected with their lands and productive assets involving considerable impact on their livelihood will be assisted with compensation for their lost assets in the immediate term and additional assistance for loss of workdays and income. Cash compensation will be calculated by multiplying the established unit prices by the size/number/quantities of affected lands, assets, replacement materials and labor, crops/trees, etc., as appropriate, following the guidelines in the Entitlement Matrix. The bases for establishing unit process and total costs will be disclosed to DPs during consultations on compensation.

64. The PIUs with assistance from SDO will use socioeconomic data from the census survey to classify the sources of each DP's affected income. There will be different types of intervention to restore incomes, depending on the type and nature of the affected livelihood. DPs who depend on agriculture will be provided with replacement land, if available or replacement value of the land including titling cost. If they are involved in micro-business, they will receive cash compensation as stipulated in the entitlement matrix of this SSPF. PIUs will require civil works contractors to give preference in employment to members of a DP's households when forming workforces for the construction of infrastructures. These interventions are provided for in the Compensation and Entitlement Policy of this SSPF, which stipulates that ULBs will provide adequate and timely budgetary support.

B. Relocation Strategy

65. Relocation is a contingent measure in the SSPF since work undertaken during project preparation indicated that resettlement effects are unlikely. Furthermore, subprojects will be designed to avoid or minimize land acquisition and resettlement impacts. If relocation (because

of unavoidable acquisition of private land) is necessary the PIUs will allocate land for DPs within their jurisdictions that are conducive to social rehabilitation, accessible to social services and drinking water, with space for sanitary latrines. The timing of relocation will be made convenient for DPs, who will receive a transfer and subsistence allowance in accordance with the entitlement matrix will be subject to review by the SDO, PMU.

66. The vulnerable DPs, including those experiencing indirect or secondary impact, will be eligible for assistance due to loss of employment/wage because of dislocation. The RPs will have provisions to provide assistance to affected businesses to restore and regain their businesses. All businesses irrespective of titled/non-titled owners of business premises, will receive a cash grant for loss of access to business premise, plus shifting or moving allowance, and onetime cash grant for loss of income. This assistance is intended to supplement the income loss during transitional period to re-establish businesses in new locations. Given the small size of subprojects, there would be little scope of developing a relocation site for the DPs.

VI. GRIEVANCE REDRESS MECHANISM

A. Introduction

67. ULBs will establish a procedure to answer to subproject-related queries and address complaints and grievances about any irregularities in application of the guidelines adopted for assessment and mitigation of social and environmental safeguard impacts. As to land acquisition, the complaints may range from disputes over ownership and inheritance of the acquired lands to affected assets missed by the census of the displaced persons and assets. With the restriction on acquisition, the more likely complaints may relate to lack of arrangements for temporary relocation of trading activities; relocation of squatters; traders not being allowed back to their original space after construction; and the like. Based on consensus, the procedure will help to resolve issues/conflicts amicably and quickly without resorting to any expensive, time-consuming legal actions.

68. The affected persons and the community will be fully informed about the provision of grievance redress mechanism (GRM), the process of producing petitions and hearing and the jurisdictions of the GRM during disclosure of SSPF/RPs and consultation.

B. Structure and Composition

69. A Grievance Redress Committee (GRC) will be formed in each City Corporation and Municipality with memberships (below) to ensure proper presentation of complaints and grievances, as well as impartial hearings and transparent decisions.

Table A18.3: Composition of Grievance Redress Committee

ULB Mayor	Convener
CEO/Secretary of the ULB	Member Secretary
Representative of a Local/National NGO (if applicable)	Member
Headmaster of the local High School	Member
Female Teacher of local High School	Member
One representative from tribal community (in case tribal people complain)	Member

Source: Asian Development Bank.

70. The head of PIUs will nominate the convener and the member secretary while the Upazila Nirbahi Officer (UNO) will nominate representative of NGO, and the headmaster and the female teacher of local high school for the GRC in each ULB following the request from the PIUs. If the aggrieved person is a female, the ULB will ask a female Ward Counselor to participate in the hearing. The Convener will include one male and one female representative of displaced persons in the case there is any resettlement issues involved in the infrastructure construction.

C. Procedures of Grievance Resolution

71. All grievances will be received at the ULB level and will be resolved at the local level within 15 days of receiving of the complaint. If resolution attempts at the municipality level fail, the ULBs will refer the complaints to PMU along with the minutes of the hearings. If a decision made at this level is found unacceptable by the aggrieved person, PMU can refer the case to the Secretary, LGD with all proceedings and case records. Resolution will be made at these levels within 15 days of placement of case records. A decision agreed with the aggrieved person at any level of hearing will be binding on the concerned ULBs and the PMU. However, GRM will not restrict any aggrieved persons right to see the resolutions in the court of law.

72. To ensure impartiality and transparency, hearings on complaints will remain open to the public. The GRCs will record the details of the complaints and the reasons that led to acceptance or rejection of the cases. The ULBs will keep records of all resolved and unresolved complaints and grievances and make them available for review as and when asked for by PMU, ADB and any persons/entities interested in urban health development activities.

73. Aggrieved persons will be able to submit their grievance/complaint about any aspects of project implementation and compensation to displaced persons. Grievances can be shared with the PIU verbally or in written form, but in case of the verbal form, the ULB representatives in the GRC will write it down in the first instance during the meeting at no cost to the complainants. The complainants will sign and formally produce to the GRCs at respective office of the ULB.

VII. INSTITUTIONAL ARRANGEMENTS AND IMPLEMENTATION

A. Institutional Capacity

74. The Local Government Division (LGD) of the Ministry Local Government, Rural Development and Cooperatives (MOLGRDC) is responsible for execution of the UPHCSDP. LGD has the experience of implementing similar projects during the last 20 years since March 1998. It is implementing the third UPHC Project since 2012 and using available land for new infrastructure for HCCs or obtaining the same through voluntary donation. The same Project Management Unit (PMU) is developing the second phase UPHCSDP and will be responsible for its implementation. Out of the 11 City Corporations (CC) and 14 Municipalities covered under this additional financing, 10 CCs and 4 Municipalities have previous experience in implementation of the third UPHCP and one CC under the first two project phases. Obtaining land for new infrastructure will be done in a given fashion exercised in these UPHCPs.

75. The PMU is headed by a Project Director (PD) and staffed with two Deputy PDs, and several officers including one Executive Engineer. At the ULB level, there is an elected body headed by a Mayor. The Mayor is assisted by the Chief Executive Officer (CEO) who is the administrative head of the ULB comprising Engineering Division, Administrate Division, and Health, Family Planning and Cleanliness Division. An Executive Engineer heads the engineering division, a Secretary the administration and a Medical Officer heads the health division. However,

the PD, PMU will designate its Executive Engineer at PMU with additional responsibility of Social Development Officer (SDO) to assist the ULBs in implementing the SSPF including preparation and implementation of resettlement plans.

B. Institutional Responsibilities

1. National Urban Primary Health Care Committee

76. The Government of Bangladesh has established a National Urban Primary Health Care Committee (NUPHCC) with the Honorable Minister for Local Government in Chair and the honorable Mayor of Dhaka City Corporation as Vice Chair. NUPHCC is responsible to provide overall policy and program guidance for urban primary health care, annual review and overall guidance to the project, provide opportunity for incorporating feedback of Mayors and other stakeholders in the urban PHC policy and program, resolve inter-ministerial coordination issues and mobilize resources for urban PHC.

2. National Project Steering Committee

77. A National Project Steering Committee (NPSC) has also been formed with the Secretary, Local Government Division in the Chair. The NPSC is responsible to provide policy guidance to the Project, approve annual work plan and annual budgets, review the physical and financial progress of the Project, coordinate between LGD and MoHFW, monitor the performance of PMU, coordinate with Development Partners and coordinate with other ongoing urban PHC projects.

3. Project Management

78. The Project Management Unit (PMU) of the LGD for the second phase UPHCSDP will prepare infrastructure design for HCCs (subproject) those will be implemented by respective ULBs. Each ULB will establish a Project Implementation Unit (PIU). The PIU will be headed by a Project Officer and the Chief Executive Officer or the Executive Engineer or the Medical Officer will act as the Project Officer under additional responsibility. PMU will oversee the entire preparation and implementation process, and provide the necessary technical support as and when required in the project cycle. It will ensure that all subprojects are selected, designed and implemented by fully considering, among other requirements, the provisions of this SSPF. The PIUs will work under the guidance of SDO for implementation of SSPF.

79. The SDO will verify the ULBs' social screening findings and prepare report on safeguard issues and impacts; prepare schematic location maps of all categories of impacts; and finalize estimates of impacts by categories with the applicable mitigation measures and their costs. Where ULBs propose to finance land acquisition on their own or with funds from other sources, the Consultant will determine the acquisition needs, prepare the standard land acquisition proposals (LAPs), and demarcate the acquisitions on the ground; and assess the safeguard impacts. Based on the findings, they will prepare the applicable impact mitigation plans (Resettlement Plans), for ADB review and clearance.

80. Wherever they decide to acquire lands, ULBs will submit the LAPs to the Deputy Commissioners (DCs) and follow through the acquisition process to payment of cash compensation under law (CCL). The Consultant will assist ULBs implement any impact mitigation action plans which, with or without land acquisition, would be prepared by the Consultant for individual subprojects. The ULBs and PMU will ensure full implementation of the action plans before work orders are issued to the civil works contractors.

81. The SDO will oversee implementation of the mitigation plans and preparation of periodic progress reports by ULBs and consultants for review by PMU and ADB.

C. Property Valuation Advisory Team

82. Where acquisition of land will be involved, or land will be obtained through direct purchase, ULBs will form a Property Valuation Advisory Team (PVAT) with approval from the PD, PMU for determining replacement value of land for acquisition or negotiating price of land for direct purchase, and for other resettlement benefits as mentioned in the entitlement matrix.

Table A18.4: Composition of PVAT

ULB Mayor	Convener
CEO/Secretary of the ULB	Member Secretary
Representative of a Local/National NGO (if applicable)	Member
Nominated representative of the DC office/AC Land	Member
Councilor of concerned ward	Member

Source: Asian Development Bank.

83. The PVAT will review and set methodologies for market survey of land and assets to be acquired for the subprojects. An independent agency/consultant will carry out market survey and prepare report on current market price of land and other assets. Reviewing the findings and applicable titling and associated costs, PVAT will recommend replacement value. LGD will approve and concerned ULB accept the replacement value recommended by PVATs. In case of direct purchase, PVATs will sit with the land owner for negotiation and settle down a price acceptable to the land owner.

D. Implementation Schedule

84. Land acquisition needs would be understood when ULBs would select sites before preparation of site specific detail engineering design of the infrastructures. It is expected that the quantum of land would be only in the order of 12 decimal or less per sub project, and the acquisition would be done by the respective DC office within 6 months' time.

85. If any resettlement plan is to be prepared, it would be prepared during detail engineering design and implemented by the respective ULBs before award of civil works contracts. Sample outline of RP is available in the annex to appendix 2 of ADB SPS 2009 (page 51 to 54).

VIII. BUDGET AND FINANCING

86. Implementation of any mitigation plans under this SSPF will be financed by the Project. However, budgets for subproject land and RP implementation will be financed by respective PIUs. The budgets for compensation for land, structures, other assets, crops and trees, and special assistance will be calculated using the market rates reflecting replacement cost. The costs for relocation and special assistance will be consistent with the SSPF policies. Other costs involving project disclosure, public consultations and focus group discussions, surveys, income restoration, and monitoring and evaluation will be incorporated in the RP budget. There will also be a budget allocation for SSPF administration (10% of the total) and a 10% contingency.

87. All resettlement funds will be provided by the PIUs based on the financing plan agreed by

LGD and ADB. Land acquisition, compensation, relocation and rehabilitation of income and livelihood will be considered as an integral component of subproject costs. RP budget is not included in the project cost as those will be provided from the ULBs' own resources.

88. The PMU would ensure that PIUs provide funds to the DCs for land acquisition and implement RP on time. PMU will also ensure that subproject RPs are submitted to ADB for approval, and that funds for compensation and entitlement under the RPs are fully provided to DPs prior to the award of the civil work contract.

89. Compensation under law for land acquisition will be paid to the legal owners of land and property by the concerned Deputy Commissioner's LA section. DCs will prepare individual checks accompanied with receiving copies of payment and undertaking note. However, resettlement and income restoration cash assistance will be provided directly by concerned PIUs with assistance from SDO at PMU.

IX. MONITORING AND EVALUATION

90. LGD will establish a monitoring system for the project implementation stage involving LGD and PMU staff and prepare progress reports on all aspects of social screening, social impact assessment, land acquisition, compensation, and resettlement activities and operations. LGD/PMU will monitor the following issues to review the performance of ULBs on SSPF implementation and compliance with the Safeguard Requirements 2 of the SPS 2009.

91. **Initial social screening.** PMU will review the initial social screening report prepared by ULB for each subproject before issuance of work order for civil works construction under each ULB. It will ensure whether the social safeguard impacts have been avoided or addressed properly following the SSPF.

92. **Legal records in obtaining lands.** Land transfer deeds duly registered under applicable law in Bangladesh for lands obtained through voluntary donation, as well as through direct purchase by ULBs on ―willing buyer-seller‖ basis, with prices and names and addresses of peoples witnessed the act of donation or price negotiations and payment, and evidence of actual payment.

93. **Progress in land acquisition.** If ULBs obtain land through legal acquisition, annual report indicating progress in land acquisition and implementation of impact mitigation plans, including compensation payment by DCs and ULBs including income restoration efforts by ULBs.

94. **Land allocation by ULGP for infrastructure construction.** All infrastructures constructed on ULB lands will be the property of the concerned city corporation or municipalities. Each ULB will authorize the Project Director, PMU, UPHCSDP for construction of infrastructure on lands owned or arranged by ULBs through acquisition, direct purchase or voluntary donation following the SSPF.

95. An independent evaluation will be carried out at project completion to assess how effectively and efficiently the different procedural tasks have been carried out; relative advantage/disadvantages of the suggested land obtaining options; land acquisition and impact mitigation activities, if any, have been carried out; and efficacy of the provisions adopted in this SSPF. Lessons learned will be documented for future similar projects.

96. The Project Director, PMU will direct monthly progress reports to the Secretary, LGD, reflecting the progress in matters related to social screening, social impact assessment, social management in obtaining land through direct purchase or voluntary donation, implementation of any mitigation plans with particular attention to compensation payments, consultation, participation of DPs in resettlement plan implementation, and grievance resolution.

97. LGD will submit annual reports to ADB on progress of resettlement activities and share the same with the National Urban Primary Health Care Committee and the National Project Steering Committee. The LGD will advise PMU on the timely implementation of the RPs, based on this SSPF, and any mitigation plans and submission of the progress reports to ADB and other financing agencies.

98. LGD/PMU will prepare updates on project implementation prior to review missions by ADB which would include summary information on HCCs that have obtained lands using any of the options suggested above for infrastructure construction.

X. SOCIAL SAFEGUARD SCREENING

[To be filled in by ULBs for each of the HCC sites as may be necessary, where private lands are to be acquired, or public lands (including ULBs' own) or donated lands are to be resumed from authorized and unauthorized private uses. The ULBs will include a summary of the impacts and mitigation requirements for each of the sites in the Screening Report. Impacts identification and the mitigation eligibility and requirements should follow the principles adopted in this SSPF.]

A. Identification

1. Name of ULB: …… *Ward No/Union name: ……*
District/Municipality/CC Name: ……

2. Project component: ....

3. Brief description of the physical works: ……
…….....
…….....

4. Screening Date(s): *……..*

B. Participation in Screening

5. Names of <u>consultants' representatives</u>:

6. On Behalf of ULB:

7. <u>Local Government representatives and community members & organizations</u> participated in screening: List them in separate pages with names and addresses, in terms of community selection and any other information to identify them during preparation of impact mitigation plans.

8. <u>Would-be affected/benefited persons</u> participated in screening: List them in separate pages with names, addresses in terms of community selection where they would be affected, and any other information to identify them during preparation of impact mitigation plans.

C. Land Requirements & Ownership

9. Will there be a need for additional lands to carry out the intended works under this contract?*
[ ] Yes [ ] No *(* 'Additional lands' mean lands beyond the existing available land)*

*10. If 'Yes', the required lands presently belong to (*Indicate all that apply*):*
[ ] ULB [ ] Government – *khas* & other GoB agencies
[ ] Others (Mention): *…….....*

D. Current Land Use & Potential Impacts

*11. If the required lands belong to <u>Private Citizens</u>, they are currently used for (*Indicate all that apply*):*
[ ] Agriculture # of households using the lands: …….....
[ ] Residential purposes # of households living on them: …….....
[ ] Commercial purposes # of persons using them: ……..... #of shops: .....
[ ] Other Uses (Mention): ..……..…… # of users: …

*12. If the required lands belong to ULB and/or <u>Government agencies</u>, they are currently used for (*Indicate all that apply*):*
[ ] Agriculture # of persons/households using the lands: …….....
[ ] Residential purposes # of households living on them: …….....
[ ] Commercial purposes # of persons using them: …… # of shops: ……
[ ] Other Uses (Mention): ……..…….. # of users: ……

13. How many of the present users have lease agreements with the concerned government agencies?
…….....

14. Number of <u>private homesteads</u> that would be affected <u>on private lands</u>:
<u>Entirely</u>, requiring relocation: ……. *<u>Partially</u>*, but can still live on present homestead: .....

15. Number of <u>business premises/buildings</u> that would be affected <u>on private lands</u>: ……..
Entirely and will require relocation: ……..... # of businesses housed in them: ……...
Partially, but can still use the premises: ..…… # of businesses housed in them: ……...

16. Residential households will be affected on <u>public lands</u>: ……..
<u>Entirely affected</u> and will require relocation: # of these structures: ……
# of structures built with brick, RCC, & other expensive and durable materials: ……..
# of structures built with inexpensive salvageable materials (bamboo, GI sheets, etc.: ….

<u>Partially affected</u>, but can still live on the present homestead: # of structures: ……
# of structures built with brick, RCC, & other expensive and durable materials: ……..
# of structures built with inexpensive salvageable materials (bamboo, GI sheets, etc.): ….

17. # of <u>business premises</u> that would be affected on <u>public lands</u>:

<u>Entirely affected</u> and will require relocation:
# of these structures: …….
# of businesses housed in these structures: …….
# of persons presently employed in the above businesses: …….
# of these structures built with brick, RCC, & other durable materials: …….
# of structure built with inexpensive salvageable materials (bamboo, GI sheets, etc.): ……

<u>Partially affected</u>, but can still stay in the present premises:
# of these structures: ..……

# of businesses housed in these structures: ……
# of persons presently employed in these businesses: ……
# of these structures built with brick, RCC, & other durable materials: ……
# of structure built with inexpensive salvageable materials (bamboo, GI sheets, etc.): ……

18. # of businesses/trading activities that would be displaced from <u>make-shift structures</u> on the project area: ……..

19. Do the proposed project works affect any community groups' access to any resources that are used for livelihood purposes?

[ ] Yes [ ] No

20. If 'Yes', description of the resources:
……
……
……
……
……

21. Do the proposed works affect community facilities like school, cemetery, mosque, temple, or others that are of religious, cultural and historical significance?

[ ] Yes [ ] No

22. If 'Yes', description of the facilities: ……..
……
……
……
23. Describe any other impacts that have <u>not</u> been covered in this questionnaire?
……
……

24. Describe alternatives, if any, to avoid or minimize use of additional lands:
……
……

E. ADDITIONAL INFORMATION ON TRIBES, MINOR RACES, ETHNIC SECTS AND COMMUNITY PEOPLES

(This section must be filled in if sites are in areas that are also inhabited by tribes, minor races, ethnic sects and community peoples)

25. Is the project site located in an area inhabited by tribes, minor races, ethnic sects and community peoples?

[ ] Yes [ ] No

If the answer is no, skip this section of the form.

26. If the answer is Yes, is there any tribes, minor races, ethnic sects and community peoples impacted by the land acquisition or any other interventions of the project?

[ ] Yes [ ] No

27. If the answer is Yes to question no. 26, is there any tribes, minor races, ethnic sects and community peoples also likely to be benefited from the subproject?

[ ] Yes [ ] No

28. If the answer is Yes to question no. 26, is there any tribes, minor races, ethnic sects and community peoples likely to be affected by the subproject?

[ ] Yes [ ] No

If the answers to questions 26, 27 and/or 28 are no, skip the following sections of the form.

29. Have the tribes, minor races, ethnic sects and community peoples and the potentially affected tribes, minor races, ethnic sects and community peoples been made aware of the potential positive and negative impacts and consulted for their feedback and inputs?

[ ] Yes [ ] No

Has there been a *broad-based community consensus* on the proposed works?

[ ] Yes [ ] No

30. Total number of would-be affected tribes, minor races, ethnic sects and community peoples' households: .....

31. The potentially affected tribes, minor races, ethnic sects and community peoples' households have the following forms of rights to the required lands:

[ ] Legal: # of households: …….

[ ] Customary: # of households: …….

[ ] Lease agreements with any GoB agencies: # of households: ……..…

[ ] Others (Mention): …….. # of households: ..……

32. Does the project affect any objects that are of religious and cultural significance to the tribes, minor races, ethnic sects and community peoples?

[ ] Yes [ ] No

33. If 'Yes', description of the objects:

……

……

34. The following are the three main economic activities of the potential affected tribes, minor races, ethnic sects and community peoples' households:

a. ……

b. ……

c. ……

35. Social concerns expressed by tribes, minor races, ethnic sects and community peoples' communities/organizations about the works proposed under the subproject: ……

……

36. The tribes, minor races, ethnic sects and community peoples' communities/organizations perceive the social outcomes of the subproject:

[ ] Positive [ ] Negative [ ] Neither positive nor negative

37. Names of tribes, minor races, ethnic sects and community peoples' community members and organizations who participated in screening:

……

38. Apart from tribes, minor races, ethnic sects and community peoples, are the project affected person (PAP) otherwise vulnerable?

a. Female headed HH Affected persons F M

b. Other Female PAP	Affected persons F	M
c. Disabled PAP	Affected persons F	M
d. Tribal PAP	Affected persons F	M
e. Hijra PAP		

==========

39. Probable rehabilitation/ development assistance

What	Quantity	Likely Cost

On behalf of the ULB, this Screening Form has been filled in by:

Name: …… Designation: …….
Signature: …… Date: ……...

ANNEX 19
MILESTONE-BASED PAYMENT

A. Background

1. The proposed additional financing for Urban Primary Health Care Services Delivery Project is budgeted with a total of $142 million, to be financed as follows: ADB $110 million loan, Asian Development Bank (ADB) Urban Climate Change Resilience Trust Fund (UCCRTF) $2 million grant, and Government of Bangladesh $30 million. Detailed cost estimates have been prepared that cover $142 million (Table A19.1).

2. ADB's financing applies the project loan modality. Out of ADB's total loan amount, $90 million will be available for disbursement through a combination of direct payment and use of advance accounts. The statement of expenditure (SOE) procedure will be adopted to facilitate reimbursement and liquidation. The advance account and SOE procedure will be established and maintained to utilize this loan amount. The remaining $20 million will use a "milestone-based payment" (MBP) approach where disbursements are subject to conditions[1] to encourage the Ministry of Local Government, Rural Development and Cooperatives (MOLGRDC) and the Local Government Division (LGD) to carry out institutional reform actions.[2] A matrix with specific institutional actions and verification protocol are provided in Tables A19.2 and A19.3 respectively.

3. MBP funding will be available as reimbursement based on two conditions:

(i) That the government reports project-related eligible expenditures incurred according to pre-agreed economic codes; and

(ii) That the government furnishes satisfactory evidence that it has achieved the institutional reform actions targets in accordance with the verification protocol.

4. The two-pronged approach for ADB financing requires that the detailed cost estimates identify five financiers: ADB 'conventional' financing, ADB MBP, ADB UCCRTF, and Government of Bangladesh.

5. For the government, the ADB financing will have two different sources of funding: Reimbursable Project Aid (RPA) (through advance accounts), including Direct Project Aid (DPA), if relevant, from ADB ($90 million) and Reimbursable Project Aid (RPA) (through GOB) ($20 million). The application of two different ADB financing sources means that the GOB will account and report separately for ADB's conventional financing and MBP financing.

B. Estimated Cost for the Proposed Additional Financing and Milestone-Based Payment Budget

[1] Both ADB and the World Bank have experience using this disbursement option in Bangladesh under project investment loan modality. ADB is using it for the Third Primary Education Development Project (PEDP3) and the Secondary Education Sector Investment Program (SESIP). The World Bank refers to the option as Eligible Expenditure Program (EEP) and is using it for the College Education Development Project (CEDP).

[2] The institutional reform actions matrix will cover three assurances made by LGD during the Consultation Mission in August 2016 regarding the sustainability of primary health care (PHC): 1) LGD will strengthen the Urban Development Wing (UDW) with fully dedicated staff, TOR and organogram; 2) LGD's Budget Management Committee will create a revenue budget head for PHC in city corporations and municipalities; and, 3) LGD will develop a strategy for retention and career progressing for medical officers working in urban local bodies (ULBs).

6. The project investment cost is estimated at $142 million (see Table A19.1). ADB will finance $110 million, which will cover civil works, training and partnership agreements, physical and price contingencies as well as interest charges during implementation. ADB will also contribute $2 million as grant to address climate resilience. Government's contribution will be used for the project management unit (PMU)/project implementation units (PIUs) and tax/value-added tax (VAT).

Table A19.1: Detailed Cost Estimates by Financier ($ Million)

Items	Total	ADB			GOB
		OCR loan	MBP	UCCRTF	
A. Investment Costs					
1. Civil Works	23.5	0.6	20.0	0.1	2.8
2. Equipment and Furniture	4.3	3.1		0.8	0.4
3. Vehicles	0.5	0.4			0.1
4. Training					
Local Training, Seminar and Workshop	2.3	1.9		0.4	
Overseas Training	1.3	1.0		0.3	
Subtotal	*3.6*	*2.9*		*0.7*	
5. Consultancy					
International Consultants (Firm)	8.4	5.4			3.0
International Consultants (Individual)	0.5	0.3			0.2
National Consultants (Firm)	0.6	0.4			0.2
National Consultants (Individual)	1.2	0.6		0.4	0.2
Subtotal	*10.7*	*6.7*		*0.4*	*3.6*
6. Partnership Agreements	80.4	64.4			16.0
7. Human Resources for PMU and PIU	4.5				4.5
8. Operating Costs for PMU and PIU	1.5				1.5
9. LGED Service Charge	0.2				0.2
Total Baseline Costs [A]	**129.2**	**78.1**	**20.0**	**2.00**	**29.1**
B. Contingencies	-				
Physical Contingencies	1.8	1.6			0.2
Price Contingencies	5.3	4.6			0.7
Total: Contingencies [B]	*7.1*	*6.2*			*0.9*
C. Unallocated Financing/Interest Charges during Implementation	5.7	5.7			
Total Project Cost [A+B+C]	**142.0**	**90.0**	**20.0**	**2.00**	**30.0**

ADB = Asian Development Bank, GOB = Government of Bangladesh, LGED = Local Government Engineering Department, PIU = Project Implementation Unit, PMU = Project Management Office, UCCRTF = Urban Climate Change Resilience Trust Fund.
Source: Asian Development Bank.

7. The table shows that the most significant costs will relate to civil works (total ADB loan financing of $20.7 million) and partnership agreements (total ADB loan financing of $64.4 million). To streamline procedures and ensure parallel utilization of ADB's ordinary and MBP financing, the MBP financing will be allocated for civil works only.

8. The MBP approach would be based on identifying a set of institutional reform actions for the MOLGRDC to undertake (Section C below) and pre-agreed project-related eligible expenditures amounting to $20.0 million.

C. Budgeting and Disbursement Procedures

9. The following explains the funds flow arrangement and process of disbursement and reimbursement under MBP financing.

10. In the Development Project Proposal (DPP), costing is done against specific inputs (eligible economic codes) and reflects the sources of funds against economic code such as GOB, RPA (through GOB), RPA (through advance account), and Direct Project Aid (DPA).

11. In order to relate the specific eligible expenditures with MBP, the DPP will state that all expenditure from the MBP funding source will be incurred from the source of RPA (through GOB) as MBP, irrespective of any economic code and this will reflect all costs against the specific economic code – Civil Works (7000) – as RPA (through GOB).

12. The government allocates the budget in the specific year of the Annual Development Program (ADP). The project will thereafter, during implementation, spend the funds under each source of funding and against each economic code, maintain the accounts accordingly, and achieve the targets as agreed in the institutional actions matrix. SOEs of incurred expenditure will be submitted by the project to ADB, and ADB will reimburse the eligible expenditure to the GOB Treasury directly.

13. The disbursement arrangements will thus include the following requirements:

(i) **Achievement of institutional reform actions is demonstrated** – Assessing the achievement of institutional reform actions demonstrated will be based on the *verification protocol* that for each target provides a detailed definition of the agreed action and what constitutes the achievement, defines the verification procedure and applicable data sources, the expected timing of verification (consistent with data), and which entity will be responsible for monitoring progress. The verification of achievements will be done jointly by ADB and the GOB during review missions based on the monitoring reports.

(ii) **Incurred (cumulative) eligible expenditures are documented** – ADB will reimburse funds to the government based on pre-identified eligible expenditures incurred by the government for agreed civil works activities. This will be reported through six-monthly interim unaudited expenditure statements prepared by the PMU and submitted by the project director. Any reimbursements will furthermore be subject to the government achieving the agreed institutional reform action targets (as per above).

14. Should the targets agreed in the institutional actions matrix not be met, the incurred expenditures will not be reimbursed to the government, and the incurred expenditures will instead be treated as government expenditure for the project.

Table A19.2: Institutional Reform Actions Matrix

Institutional Reform Actions	Targets / Disbursement Conditions	Indicators and Verification Source	Amounts Allocated to Disbursement Conditions
1) Established LGD non-development revenue budget line for urban PHC and its allocations to ULBs for PHC	By 1 July 2019: a. LGD's Budget Committee prepares proposal to establish LGD non-development budget line for urban PHC and submits it to MoF's Finance Division.	a. Proposal by LGD's Budget Committee and submission memo.	$3 million
	By 1 July 2020: b. Urban PHC budget line established in LGD's non-development revenue budget and financing provided for urban PHC through LGD's non-development revenue budget from FY2020–2021.	b. Budget line included in LGD Budget Book.	$7 million
2) Strengthened UDW with a designated PHC unit, permanent staff, equipment, supplies, etc.	By 1 April 2020: a. Recruiting support staff for the UDW.	a. & b. Report on the recruitment status.	$2 million
	By 1 April 2020: b. Filling positions of officials as per Government Order.		$3 million
3) Strengthened ULB Health Departments to improve organizational capacity.	By 1 December 2019: a. LGD's UDW instructs project ULBs to prepare organogram and Reorganization Plan.	a. Instruction letter.	$2 million
	By 1 December 2020: b. At least 20 project ULBs to submit organograms and Reorganization Plans to LGD for approval.	b. Organograms and Reorganization Plans.	$3 million

FY = fiscal year, GOB = Government of Bangladesh, ICT = information and communication technology, LGD = Local Government Division, MOF = Ministry of Finance, PHC = primary health care, UDW = Urban Development Wing, ULB = urban local body.
Source: Asian Development Bank.

Table A19.3. Verification Protocols

Institutional Reform Actions	Definition and Description of Achievement and Verification	Information Source	Verification and Procedure
1) Established LGD revenue budget line for urban PHC and its allocations for UDW and ULBs for PHC.			
By 1 July 2019: a. LGD's Budget Committee prepares proposal to establish LGD budget line for urban PHC and submits it to MoF's Finance Division. By 1 July 2020: b. Urban PHC budget line established in LGD's non-development revenue budget and financing provided for urban PHC through LGD's non-development revenue budget from FY2020–2021.	a. Proposal by LGD's Budget Committee and submission memorandum. The Proposal should include analysis of financial requirements for urban PHC for project and post-project scenarios covering project ULBs and selected non-project ULBs. b. Budget line included in LGD Budget Book FY2020–2021.	a. LGD Proposal and submission memorandum b. LGD Budget Book FY2020–2021	a. & b. ADB will review to its satisfaction the achievement of the action. ADB will initiate the process of disbursement upon achievement of the action.
2) Strengthened UDW with a designated PHC unit, permanent staff, equipment, supplies, etc.			
By 1 April 2020: a. Recruiting support staff for the UDW. By 1 April 2020: b. Filling positions of officials as per Government Order.	a. & b. LGD Report on the recruitment status where all sanctioned positions (as per Government Order establishing UDW) are filled. No positions can be vacant or on special duty. The report includes details such as name, position, and date the position was filled.	a. & b. LGD Report on the recruitment status	a. & b. ADB will review to its satisfaction the achievement of the action. ADB will initiate the process of disbursement upon achievement of the action.
3) Strengthened ULB Health Departments to improve organizational capacity.			
By 1 December 2019: a. LGD's UDW instructs project ULBs to prepare organogram and Reorganization Plan. By 1 December 2020: b. Project ULBs to submit an organogram and Reorganization Plan to LGD for approval.	**Definitions:** "*Reorganization Plan"* is a plan that responds to recommendations made by an assessment on staffing levels, job descriptions, career progression, and organizational structure of the ULB health department concerned. a. LGD issues instruction letter to all project ULBs to prepare organogram and Reorganization Plan. b. At least 20 project ULBs submit organograms and Reorganization Plans and submission letters to LGD for approval.	a. Instruction letter b. Organograms and Reorganization Plans and submission letters	a. & b. ADB will review to its satisfaction the achievement of the action. ADB will initiate the process of disbursement upon achievement of the action.

ADB = Asian Development Bank, FY = fiscal year, GOB = Government of Bangladesh, ICT = information and communication technology, LGD = Local Government Division, MoF = Ministry of Finance, PHC = primary health care, UDW = Urban Development Wing, ULB = urban local body.
Source: Asian Development Bank.

ANNEX 20
URBAN PRIMARY HEALTH CARE SUSTAINABILITY FUND

1. In designing the Second Urban Primary Health Care Project (UPHCP-II) in 2009, it was decided to plan for the eventual ending of donor funding for urban primary health care (UPHC) services and for urban local bodies (ULBs) to take steps towards greater financial independence with the support of the Local Government Department (LGD). This resulted in setting up the UPHC Sustainability Fund (UPHCSF) as a new project component, which conveyed the intention that ULBs would in time to take over responsibility for funding UPHC.

2. ADB's 2009 Report and Recommendation of the President (RRP) to the Board of Directors for the proposed loan thus stated that UPHCP-II would support the effective implementation of the UPHCSF. The UPHCSF was to be fully operational in each city corporation (CC) by December 2013,[1] which would require that orders for the establishment of funds be issued, bank accounts opened, and revenue income deposited.

A. Structure of the Sustainability Funds

3. LGD in 2009 issued an Operational Procedure (Guidelines) which outlines applicable rules and conditions for the UPHCSF, including for income generation, as well as governance structure and monitoring arrangements. The Guidelines reflected an assumption that ULBs would be motivated to replicate UPHC services as funded under UPHCP-II and be motivated to make contributions to enable this.

4. According to the Guidelines, CCs and municipalities would establish UPHCSFs and deposit a minimum of 1% of their own revenue budgets at the end of each fiscal year. This minimum deposit was to increase annually by a further 1% of the revenues budget each year, and would be supplemented by 80% of excess user income generated by partner service providers that would be deposited in the same accounts at the end of each quarter.[2]

5. The Guidelines created the basis for setting up UPHCSF Executive Committees at the national level (meeting annually) and ULB level (meeting quarterly) to ensure compliance with the rules and conditions.[3] This would include that the use of funds approved by the ULB-level committees would be subject to review of the national-level committee.

B. Sources and Uses of Sustainability Funds

6. Contributions have so far been a small proportion of the proposed minimum 1% of the ULB revenue budgets. The total contributions for 2009/10-2016/17 from the ULBs and partner service providers as well as accumulated interest are shown in **Table A20.1**. It is notable that the amounts transferred by CCs and municipalities to the UPHCSFs are only a fraction of the required deposits. Also, 3 of 14 ULBs have not made any contributions.

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[1] This was the target date stated in the Design and Monitoring Framework (DMF), but in fact the UPHCSF was already established in June 2010 (i.e., FY2009–2010).

[2] The remaining 20% of user income generated was to be used by the partner service providers to improve their own services.

[3] The national committee is chaired by the LGD Secretary and comprises ULB Chief Executive Officers (CEOs)/Secretaries, partner service provider representatives and a UPHCP-II representative. The ULB level committees have seven members and are chaired by the Mayor, and have technical and financial working groups.

7. To date there have been no releases of resources from the UPHCSFs, which may be a result of the elaborate rules for utilization that were established in the Guidelines.[4]

[4] An example of a restrictive rule on utilization included in the Guidelines is one that requires that the CC or municipality "*makes a financial contribution from its own revenue equivalent to the amount of user fees to be applied to such PHC purpose, i.e. equal matching fund for the approved purpose.*"

Table A20.1: UPHCSF Financial Data as of 13 July 2017, Taka Millions

SL	Urban Local Bodies (ULBs)	Total Revenue Budget *	Allocation of 1%**	Transfers by CCs and Municipalities to UPHCSFs			Transfers from partner service providers	Interest Accrued	Total Current Balance
				UPHCP-II	UPHCSCP	Sum			
		2009/10-2013/14 (5 years)		*2009/10-2016/17 (8 years)*					
1	Dhaka South City Corp.	63,307.7	633.1	30.0		30.0	15.5	11.6	**57.1**
2	Dhaka North City Corp.	12,265.1	122.7				11.5	0.1	**11.7**
3	Rajshahi City Corp.	3,648.8	36.5	1.0	2.4	3.4		0.7	**4.1**
4	Khulna City Corp.	4,324.6	43.2	1.3	0.9	2.2		0.3	**2.5**
5	Sylhet City Corp.	1,552.5	15.5	1.6	1.2	2.8	0.6	0.3	**3.7**
6	Barishal City Corp	3,342.2	33.4	1.7		1.7	2.4	0.3	**4.4**
7	Rangpur City Corp.	724.2	7.2		3.0	3.0		0.3	**3.3**
8	Cumilla City Corp.	1,404.0	14.0	2.6		2.6		0.2	**2.8**
9	Narayanganj City Corp.	2,349.8	23.5		11.6	11.6		0.5	**12.1**
10	Gazipur City Corp.	10,714.6	107.1						
11	Kushtia Municipality	484.5	4.8	0.5	0.2	0.7	1.0	0.1	**1.7**
12	Gopalganj Municipality	586.7	5.9		0.2	0.2			**0.2**
13	Siranjganj Municipality	320.1	3.2	1.1	0.7	1.8			**1.8**
14	Kishoreganj Municipality	679.9	6.8						
	TOTAL	**105,704.5**	**1,057.0**	**39.8**	**20.1**	**59.9**	**31.0**	**14.4**	**105.3**

* Latest data available.
**These sums assume that the “minimum” contributions would be only 1% of the revenue budget in every year of the period, instead if increasing by one percentage point per year, as suggested in the Guidelines.
Source: Project Management Unit.

9. The uncertainty of future donor financing of UPHC (upon completion of the project)[5] raises questions about whether the current low balances in the UPHCSFs are adequate to their uses as planned, in the immediate future. Moreover, the lack of utilization to date does not warrant optimism about the ability of the UPHCSFs to contribute positively to future sustainability. At the very least, regardless of the rate of funds flow into the UPHCSFs, it is critical that the existing balances begin to be utilized.

C. Recommended Actions for the Sustainability Funds

10. Given the limited UPHCSFs balances and the lack of utilization, it is necessary to consider two broad alternatives to the current arrangement. These are:

(i) Close the Sustainability Funds and draw down the balances by spending them according to the provisions in the Guidelines; or
(ii) Continue and expand the Funds within the framework of an improved structure and set of processes and policies as expressed in revised Guidelines.

11. It is recommended to continue the UPHCSFs within an improved set-up, which could involve the following steps:

(i) The Guidelines should be revised to make them more user-friendly and facilitate funds utilization,[6] e.g. by (i) dropping the requirement that matching funds be contributed by ULBs from their own revenue budgets, and (ii) relaxing restrictions on the use of funds to support day-to-day recurrent costs that cannot be met by current funding arrangements.
(ii) Technical assistance should be made available to ULBs to help them develop applications that are likely to be approved.
(iii) A meeting of Mayors/Chief Executive Officer (CEOs)/Chief Health Officers (CHOs) should be convened to assess existing challenges and develop practical ways to improve continuation and use of the UPHCSFs.
(iv) LGD should encourage the ULBs to set up Urban Health Departments with favorable personnel and administrative structures, processes and policies to support long-term sustainability of UPHC services after the end of outside aid.[7]

12. Furthermore, specific considerations and actions are needed to ensure adequate financing for UPHC in future. This is briefly outlined in the next section.

E. Complementary Financing from LGD

13. The ultimate priority should be for LGD and the ULBs to establish UPHC-specific own revenue budget lines, which will provide by far the best long-term prospects of achieving financial sustainability for UPHC activities once external support ends. At the same time, it would preclude the need for UPHCSF in future. It is hence recommended that LGD creates an own non-

[5] It appears that the UPHCSDP that followed UPHCP-II merely continued the use of Sustainability Funds as designed originally, without revision or modification in the contribution requirements or in the Guidelines.
[6] Revising the Guidelines, including for LGD to provide funding to the UPHCSF, will require approval by the Ministry of Finance's Finance Division.
[7] Two critical pre-requisites in this regard are: (i) development of supportive administrative features to make recruitment of PHC staff more successful than is currently the case and (ii) creation of a budget line for Urban Health Departments to cover both investments and operational costs.

development revenue budget line specifically for UPHC and instructs the ULBs to do similarly (to enable transfers from LGD).

14. Furthermore, LGD should match ULB contributions to the Funds to (i) convey its commitment to sustaining the UPHC activities after project-end, and (ii) create concrete incentives to the ULBs to make (and to steadily increase) their contributions. Complementary financing for UPHC services can apply alternative mixes of contributory financing, e.g.:

(i) **50-50 split between ULBs and LGD.** Financing shared equally by the ULB account in the Sustainability Fund and the appropriate budget line item of LGD dedicated for supporting the Sustainability Fund. In other words, LGD will contribute, for any approved intervention, an amount equal to the amount committed to it by the ULB.

(ii) **Higher LGD financing share.** Financing by LGD based on the proportion of the population of the ULB catchment area that have household incomes below the poverty line subject to fixed minimum and maximum portions.[8] The minimum and maximum portions to be paid by LGD would thus be dictated by the poverty level of the specific ULB (and hence be indirectly related to the revenue-raising capacity of the ULB and in the needs of the population).

(iii) **Formula-based funding.** Financing shared by LGD and ULB according to a formula that sets the matching portion contributed by LGD higher depending upon the proportion of the beneficiaries that have household incomes below the poverty line (i.e. a higher proportion of poor beneficiaries will result in a higher cost contribution by LGD).

15. Cost sharing arrangements between LGD and the ULBs should consider that CCs have more financial resources than municipalities. Also, the Guidelines would need to be specifically amended to enable LGD to make provisions for the UPHCSF.

16. In principle, it could also be considered to continue LGD block grants for the ULBs for UPHC services. However, experience shows LGD block grants for health, and for UPHC services, not to be effective due to (i) lack of prioritization, and (ii) weak monitoring and accountability. Hence, it is not at present recommended to continue LGD block grants to ULBs for health without significantly improving the functionality of existing arrangements.[9]

[8] For example, if the minimum portion to be contributed by LGD were to be, say, 67%, every Tk 1 commitment by a ULB would be matched by a Tk 2 matching contribution by LGD. If the maximum portion to be contributed by the LGD were to be 95%, every Tk 1 commitment by a ULB would be matched by a Tk 19 contribution by LGD.

[9] Appropriate rules/guidelines regarding block grant allocations to the ULB's can be formulated (as per recommendations in para. 14), so that ULB mayors and officials will not consider such funds allocations as intending to curtail their planned infrastructure developments in the ULBs. In it, specific percentage for UPHC should be mentioned. For example, a similar guideline exists for *upazilas*.