PROJECT EVALUATION, LESSONS LEARNED, AND PROJECT DESIGN FEATURES

A. Evaluation of the Second Urban Primary Health Care Project

1. The project completion report of the Second Urban Primary Health Care Project was completed in September 2014.[1] Overall, the project was assessed as highly successful. The project design was highly relevant. The project was highly effective and efficient in achieving the outcomes and outputs. It had a significant impact on poverty through improvement of health, reduction of mortality and morbidity rates, and improvement in the nutritional status of the urban poor, particularly women and children. The project design and implementation arrangements were sound, replicable, and strongly supported by stakeholders, as demonstrated by the implementation of the ongoing project. Together with the gains from behavior change communication and marketing (BCCM) interventions and client satisfaction with primary health care (PHC) services provided by public–private partnership (PPP) service providers, the project is thus deemed likely sustainable. The project's efforts merit continuation given (i) Bangladesh's rapid urbanization; (ii) the need for support to fully realize the legal mandate of urban local bodies (ULBs) to provide PHC in urban areas; (iii) the need to expand PHC service coverage among the poor to achieve Millennium Development Goals 4 and 5; and (iv) the need to further strengthen the sustainability of the PPP modality for providing PHC services. The project completion report identified several lessons learned as follows:

(i) To minimize large variations in PPP service providers' performance, it is necessary to (a) evaluate, contract, and mobilize service providers within a specific time frame to avoid delays; (b) critically evaluate budget proposals to ensure they are sufficient to deliver PHC services; and (c) set realistic selection criteria for evaluating the experience of service providers and their capacity to deliver services.

(ii) BCCM is important for expanding coverage of PHC services delivery and raising awareness among partnership agreement area residents, especially women and children.

(iii) Identification and targeting of the poor must be based on a simple set of criteria and supported by existing poverty maps or urban poverty mapping undertaken during project preparation. Eligibility requirements for obtaining red cards must be clear to households, and their application must be consistent across the service providers and adhered to by providers in determining eligibility and distributing cards. To accurately measure health indicators and gather reliable data for evaluating project performance, it is necessary to regularly update the list of poor beneficiaries to effectively identify and track those who have left their respective partnership agreement areas and to collect data on unique individuals obtaining services at PHC centers.

(iv) The project management unit (PMU) and project implementation unit (PIU) staff must (a) have adequate capacity for procuring goods and services to avoid delays in contracting and awarding processes; (b) ensure that tender documents contain bid criteria that are pertinent to the required works or consultancy services; and (c) keep records of evaluation reports to enhance transparency and rigor, in line with undertakings under Asian Development Bank (ADB) loan and grant agreements. For this purpose, the design of future projects should incorporate a dedicated procurement specialist to support the PMU as well as training on ADB procurement and financial management guidelines and procedures for PMU/PIU staff.

[1] ADB. 2014. *Completion Report: Second Urban Primary Health Care Project in Bangladesh*. Manila.

(v) PMU and PIU staff must be trained to (a) proactively monitor funds flow, regularly update project accounts, and track loan and grant drawdowns to manage project funds effectively; and (b) regularly reconcile loan and grant accounts with ADB's records. To facilitate financial management, projects as complex as the Second Urban Primary Health Care Project should have an operational computerized financial management information system.

2. Though the design of the subsequent phase identified and addressed the abovementioned issues, some areas, for example—selection criteria of PPP service providers that have implication on service quality, BCCM approach, avoidance of procurement and fund flow delays—needed further strengthening.

B. Evaluation of the Urban Primary Health Care Services Delivery Project

1. Independent Midterm Review

3. An independent review team carried out a midterm review of the Urban Primary Health Care Services Delivery Project in November 2015.[2] The review provided an in-depth analysis and independent review of the project progress against its agreed purpose and outputs and provided recommendations to improve the impact of the project. The key messages of the review were:

(i) The project has increased access to the Essential Services Delivery Plus services to the poor households.
(ii) At the end of earlier project (Second Urban Primary Health Care Project), 26.5 million service contacts were recorded of which 79% were women and 21% men. In comparison, as of the midterm review, the Urban Primary Health Care Services Delivery Project had recorded 23.5 million contacts of which 74% were women and 26% men.
(iii) Free PHC services to urban poor are being delivered as entitlement through allotment of red cards (distributed to 90% of identified poor until September 2015) and service providers in the project are attracting target beneficiaries, especially from low-income households.
(iv) The vacuum created by lack of urban public primary health infrastructure and limited primary health services by the government is being partially balanced by fragmented services provided by different nongovernment organizations, including those working on implementing the Urban Primary Health Care Services Delivery Project.
(v) Urban Primary Health Care Services Delivery Project has strengthened the mandate of the Local Government Division (LGD) to provide urban PHC services in the country through (i) establishing PHC infrastructure and services network; (ii) involving ULBs in project areas to monitor the performance of service providers; (iii) supporting creation of institutions at national, local, and donor levels to deliver urban PHC services; and (iv) supporting the LGD to operationalize the National Urban Health Strategy.
(vi) The model of urban PHC service delivery established by Urban Primary Health Care Services Delivery Project merits continuation and expansion to meet the growing demands in the short term and contribute significantly to Bangladesh's effort in moving towards universal health coverage in the longer term.

[2] Raichowdhury, S. et al. 2016. *Final Report of Independent Review Team at Midterm Review of the Urban Primary Health Care Services Delivery Project, February 2016*.

(vii) Several challenges remain, and lessons learned need time to be internalized in the institutional structures of the national and local levels. However, the Urban Primary Health Care Services Delivery Project merits extension and a follow-on to continue providing leadership to support the country's plans to deliver urban PHC services in a programmatic mode.

2. Assessment on Sustainability and Health Service Delivery

4. To assist in the design of the additional financing, an assessment on the current implementation, sustainability-related measures, and an analysis of the routine data collected under the Urban Primary Health Care Services Delivery Project (2012–present) was conducted.

5. **Sustainability.** ADB has been involved for almost 20 years in project modality. There is a need to strengthen the central and local government urban health system in terms of financial, management/administrative and technical capacity of LGD and ULBs. The current phase has incorporated some of the activities but has not been able to gain much traction. The intended purpose of the Sustainability Fund in contributing to the sustainability of urban PHC was undermined by uneven contributions from city corporations/municipalities and lack of practical guidelines on utilization of the fund. Because of the limited budget at city corporations/municipality level, sustainability can only be assured through establishment of budget line at the LGD level which has been strongly communicated to LGD and was acknowledged as critical.

6. **Human resource capacity and development**. The capacity and retention of human resources at ULB level need to be strengthened by (i) increasing position levels, (ii) implementing career development plan, and (iii) utilizing project technical assistance and material support for capacity development.

7. **Quality of services.** Using data from Integrated Supervisory Instruments, the achievement of service quality indicators—such as use of partograph, antenatal care visits, availability and completeness of postpartum hemorrhage kit, emergency kit and eclamptic kit, infection prevention protocol, clinical waste management, medical staff knowledge of newborn danger signs and maternal danger signs and community satisfaction—has been high, with 96% of the PPP service providers scoring above 80 (out of 100).

8. **Service coverage and equity.** At least 30% of each major category of health services is accessed by the poor. The access to child health by the poor fluctuated in which most quarters reported below 30%, possibly due to seasonal difference. Less than 30% of menstrual regulation was accessed by the poor.

9. **Utilization of services.** Analysis of service data shows that the antenatal and postnatal service contacts per facility delivery reported were higher than the findings of the project and national surveys. The exceptionally high service contact-delivery ratio, especially antenatal care, suggest many maternity clients deliver elsewhere and there might be data quality issue. The proportion of caesareans to total facility deliveries was approximately 37% from 2013 to 2016, warrants further examination in the increasing trend.

10. **Health management information system.** Delay in implementation of the health management information system has affected the effectiveness in the steering and management functions of urban PHC at the ULB level. Consequently, the service data are not included in the national health statistics. Most importantly, data analysis and use are not evidenced; and quality of data is affected.

C. Lessons Learned and Incorporated into the Project Design

11. Key recommendations from the project reviews and project surveys as well as assessments and consultations held during project preparation were incorporated into the design of the proposed additional financing of the Urban Primary Health Care Services Delivery Project (please see table below).

Lessons Learned and Incorporation into the Project Design

Issue	Lessons Learned from UPHCSDP	Project Design Features
Sustainability of urban PHC	High level actions targeting long-term sustainability of urban PHC have been identified; the implementation however has been slow.	Sustainability to be ensured through a two-prong approach: **(i) At central level:** • establish a revenue budget line specifically for PHC services; • strengthen UDW of LGD to (a) strengthen operations and capacity and (b) take on PMU role (e.g., current PMU staff may be regularized into UDW); and • address medical officers' retention issue by developing a career planning scheme (like LGED's city and municipal engineer career progression model). **(ii) At ULB level.** Strengthen ULBs to manage urban PHC service through: • develop capacity in steering and monitoring, and financial management of PHC service delivery; • ensure sufficient budgeting for PHC services; • develop human resources: (a) support recruitment and capacity development of human resources, and (b) address medical officers' retention issue through career planning scheme; • establish urban HMIS; and • redefine Urban Primary Health Care Sustainability Fund mechanism.
ULBs' capacity development	UPHCSDP demonstrated commitment in capacity building of ULBs through collaborating with PIUs in monitoring of PPP service providers. The effort could be further expanded to include other activities.	The project will integrate the PIU staff into the ULB health department, and build capacity related to quality management and urban HMIS. The project will introduce a pilot initiative in at least four urban local bodies which will be given expanded scope in direct management of urban PHC services.

Issue	Lessons Learned from UPHCSDP	Project Design Features
Infrastructure	Investment in infrastructure remains important in terms of service delivery and anchoring community participation. The current design could be further enhanced to improve space efficiency, work flow, infection prevention and control, as well as engineering and environmental aspects.	Some adjustments will be addressed to improve the operations, engineering, and environmental aspects, such as: • increase area for consultation and treatment; • provide hand washing facilities; • improve drainage; and • use solar energy to supplement power supply.
Climate change and health	The project included climate change resilience features (solar power panels) in selected new construction called green clinics. However, the design and operations could be further improved.	Major outputs of the project in climate resilience will include: • climate risk and vulnerability assessment completed; • climate resilient health care infrastructure and services introduced; and • urban PHC awareness on climate change and resilience enhanced.
PANGO tender	QCBS in the past gave higher priority on financial offer, i.e. selection of lowest financial offer among qualified bids. These have affected quality of service delivery.	The QCBS tender will give higher priority on quality relative to cost (80:20), and the evaluation criteria will provide fixed amounts for provisional sums for medicine, medical supplies, minor equipment and instruments, and furniture.
Target setting	Existing target setting has not fully captured the dynamics of urban growth.	Target setting will incorporate annual projection of catchment population. Based on population size, the project can estimate annual number of pregnancy and births for setting targets for selected services.
M&E	The project generates enormous routine service data but lacks a quality assurance mechanism for ensuring data quality. There is space for improvement in terms of data analysis and use. Outputs of the PPME firm will need to be closely monitored.	Implementation of an electronic patient registration system which is part of a computerized HMIS will be prioritized to improve reporting (data quality) and monitoring (data use). An M&E officer will be recruited by PMU to monitor the achievements of service providers against the targets, and supervise the outputs of PPME firm.
Service delivery	Given the rising prevalence of NCD, detection/screening of NCD needs to be enhanced. Child malnutrition/stunting remains a challenge. Improvement in neonatal mortality among the poor lags.	Within the framework of the ESD+, NCD screening, nutritional care, and newborn care will be strengthened.
BCCM	There is little evidence that the BCCM strategy has been applied, and BCCM activities have predominantly relied on printed materials and less on interpersonal communication.	Delivery channels of BCCM will consider the needs and lifestyle of the target population to enhance health seeking behavior and use of health information. BCCM will advocate for greater ownership of urban PHC at LGD and ULB levels.

Issue	Lessons Learned from UPHCSDP	Project Design Features
	Baseline and end line surveys for BCCM were administered by the BCCM firm.	
Project management	Implementation arrangements need to consider both routine operations and quality implementation guidance.	External support may be engaged to assist and guide PMU in selected technical areas, e.g., HMIS, nutrition, technical guidance to adjust project activities based on findings of operations research.

ADB = Asian Development Bank, BCCM = behavior change communication and marketing, ESD+ = Essential Service Delivery Plus, HMIS = health management information system, LGD = Local Government Division, LGED = Local Government Engineering Department, M&E = monitoring and evaluation, NCD = noncommunicable disease, PANGO = partnership area nongovernment organization, PHC = primary health care, PIU = project implementation unit, PMU = project management unit, PPME = project performance monitoring and evaluation, PPP = public–private partnership, QCBS = quality- and cost-based selection, UDW = Urban Development Wing, ULB = urban local body, UPHCSDP = Urban Primary Health Care Services Delivery Project.
Source: Asian Development Bank.