



Technical Assistance Report

Project Number: 39305
November 2007

People's Republic of Bangladesh: Preparing the Urban Primary Health Care Sector Development Program (Financed by the Japan Special Fund)

CURRENCY EQUIVALENTS

(as of 26 October 2007)

Currency Unit	–	taka (Tk)
Tk1.00	=	\$0.0146
\$1.00	=	Tk68.690

ABBREVIATIONS

ADB	–	Asian Development Bank
LGD	–	Local Government Division
MDG	–	Millennium Development Goal
NGO	–	nongovernment organization
TA	–	technical assistance
UPHCP	–	Urban Primary Health Care Project
UPHCP-II	–	Second Urban Primary Health Care Project

TECHNICAL ASSISTANCE CLASSIFICATION

Targeting Classification	–	Targeted intervention
Sector	–	Health, nutrition, and social protection
Subsectors	–	Health programs, health systems, nutrition
Themes	–	Inclusive social development, gender and development, capacity development
Subthemes	–	Human development, gender equity in opportunities, public-private partnerships

NOTES

- (i) The fiscal year (FY) of the Government and its agencies ends on 30 June. FY before a calendar year denotes the year in which the fiscal year ends, e.g., FY2007 ends on 30 June 2007.
- (ii) In this report, "\$" refers to US dollars.

Vice President	L. Jin, Operations Group 1
Director General	K. Senga, South Asia Department (SARD)
Director	H. Kim, Urban Development Division, SARD
Team leader	S. Bonu, Senior Urban Development Specialist, SARD
Team member	J. Mahmood, Head, Social Sector, Bangladesh Resident Mission, SARD

I. INTRODUCTION

1. The Asian Development Bank (ADB) country strategy and program for Bangladesh (2006–2010)¹ includes support for the urban primary healthcare sector development program. The Government of Bangladesh is supportive of ADB's technical assistance (TA) to assess the achievements of the ongoing Urban Primary Health Care Project (UPHCP) and to explore further support for urban health sector issues.² This TA is part of ADB's support to prepare the urban primary health care sector development program loan.³ A fact-finding mission visited Bangladesh in July 2007 and reached an understanding with the Government on the purpose, output, methodology, key activities, cost estimates and financing plan, implementation arrangements, design and monitoring framework (see Appendix 1) and terms of reference of the TA.

II. ISSUES

2. The Government's national poverty reduction strategy⁴ reaffirms that reducing poverty and accelerating the pace of social development are the most important long-term strategic goals. In the health sector, the strategy accords priority to improving maternal and child health care; strengthening nutrition programs; controlling communicable diseases; and reorienting health care assistance, finance and governance to serve the poorest groups better. Parallel to the Government's Health and Population Sector Development Program, which is concentrated on improving rural health care service delivery and supported by other development partners, ADB's primary focus has been on the delivery of health care services in urban areas through public-private partnerships. ADB's strategy for improving health care conditions for the urban poor are to (i) support the Government's policy for decentralization of health services, communicable disease control, and reproductive health; (ii) develop public-private partnerships for primary health care services; (iii) enhance the private sector's role in health service provision; and (iv) develop alternative health care financing schemes.

3. Public health encompasses multi-sector interventions. To maximize the development impact of health outcomes in urban areas, comprehensive and concerted effort is required to (i) expand access to urban primary health care services; (ii) strengthen municipal public health governance (including institutions, policy, legal and regulatory frameworks, and financial capacity); and (iii) strengthen food and water safety, and improve management of solid waste, including hospital waste. Key issues are the multi-sector nature of public health in an increasingly complex urban physical space; prioritization of investments that balance preventive, promotive and health care needs of the urban poor; and ensuring a strong institutional, policy, legal and regulatory environment for enforcing good public health practices and building on the strengths of the private sector. There are two main dimensions to sustaining the urban primary health care initiative, covering institutional and financing issues. The institutional structure of the project modality is ad hoc. Bangladesh's second Urban Primary Health Care Project (UPHCP-II) has a project management unit for the project's duration (July 2005–December 2011).⁵ The unit needs to be internalized within the governmental budget system so that the institutional arrangement becomes sustainable and core staff are retained within the Government to

¹ ADB. 2005. *Bangladesh Country Strategy and Program, 2006–2010*. Manila.

² During the country program meeting in October 2006, the loan, which was initially for 2008, was shifted to 2009. (ADB. 2006. *Bangladesh: Country Operations Business Plan*. Manila).

³ The TA first appeared in *ADB Business Opportunities* on 29 June 2007.

⁴ Government of Bangladesh. 2005. *Unlocking the potential: National strategy for accelerated poverty reduction*. Dhaka.

⁵ ADB. 2005. *Second Urban Primary Health Care Project*. Manila.

manage urban primary health care for the next couple of decades. The risk of an ad hoc approach is that the Government's urban primary health care initiative is less likely to draw budget support from the Government on a sustained basis if there is no sustainable institutional arrangement in place.

4. Only six city corporations and five municipal towns are covered under UPHCP-II, which leaves most municipal towns uncovered. However, in the absence of a strong institutional structure, the scope for the project to expand geographically will be an issue. Hence, the capacity of the project management structures to expand without compromising on quality and effectiveness needs to be reviewed, as do measures to enhance the capacity of the project management unit to undertake an expanded program. Urban primary health care needs to be institutionalized as a program rather than a project, and the capacity of smaller municipal towns to implement such a program needs to be assessed. Institutional arrangements to strengthen urban public health through training and capacity development programs will be important and also need to be assessed.

5. The mandates of urban local bodies relating to essential public health functions should be examined carefully in close coordination with the Ministry of Health and Family Welfare, the Ministry of Environment and Forestry, and the health donor community. The review should identify areas that are not addressed and those that need improvement. The assessment should then identify effective legal, regulatory, policy and other interventions to be undertaken by the Local Government Division (LGD) of the Ministry of Local Government, Rural Development and Cooperatives so that urban local bodies may effectively implement essential public health functions that fall under their mandate. Due to competing demands among urban local bodies for scarce resources, and growing urban infrastructure needs, primary health care and public health often have low priority within municipal budget systems. Wealthy people in urban areas can afford private health care, which is growing rapidly in urban areas. However, the poor and marginalized living in slums, as well as squatters, need support for primary health care financed through public resources. The very low level of allocations for primary health care and public health within urban local bodies needs to be ramped up slowly and steadily by increasing allocations for urban health within the local government system. Municipal financing with respect to budget support for urban primary health care and public health needs to be assessed, as do various options for sustainable financing of urban primary health care.

6. The first and the second urban primary health care projects have set new modes for delivering social services through innovative public-private partnerships, which are proving to be more effective than the traditional mode of public service delivery.⁶ Within urban infrastructure, public-private partnerships have done much to address solid waste management in South Asia. Likewise, other aspects of essential public health functions are amenable to public-private partnerships, including food safety laboratories, slaughter houses and so on. Gaps in essential public health functions need to be identified, with an assessment made about which functions could be dealt with through public-private partnerships, especially solid waste and hospital waste management.

7. Prevention and promotion are more cost-effective in ensuring desired health outcomes. Prevention and promotion require a multi-sector approach that includes provision of sanitation services and drinking water, environmental health, food safety and hygiene (including safe disposal of solid and hospital waste), and health education. However, the mandates for these essential health functions are fragmented between various government departments and

⁶ Evaluation reports are available at <http://www.adb.org/Health/contracting-BAN.asp>

between the public and private sectors. A more coherent approach is required to ensure that all the players involved in ensuring public health coordinate and cooperate. To some extent, the Ministry of Health and Family Welfare undertakes this responsibility in rural areas. At the city and municipal level, the mandate is mainly with urban local bodies. However, in the absence of strong institutional mechanisms within the LGD in this regard, city and municipal corporations are playing, at best, a weak role in supporting essential public health functions within their jurisdictions. Local governments have various instruments to enforce “public health good”: taxation, regulation, investments and information. Essential public health functions need to be looked at comprehensively from an urban local government perspective to identify gaps in regulation (legal) and enforcement, and taxation and other incentives (policy), in order then to promote better public health. Such an assessment needs also to assess the effectiveness of information dissemination mechanisms to promote public health in urban areas.

8. Communicable disease prevalence continues to be significant in Bangladesh. The reason for this can be traced largely to poor food safety, poor sanitation and sewage infrastructure, weak solid waste and hospital waste management, and almost negligible waste water treatment. Contamination of drinking water by waste water during transmission reduces the health impact of significant investments in water supply and sanitation infrastructure. There is a need to explore, from the urban local body perspective, gaps in the policy, legal, regulatory, institutional and investment aspects of food safety, hospital waste management and solid waste management. An assessment should also be made of the effectiveness and appropriateness of public-private partnerships and sustainable financing models for food safety, hospital waste and solid waste management, as well as new models for effective implementation of such services.

III. THE TECHNICAL ASSISTANCE

A. Impact and Outcome

9. The objective of the TA is to prepare technical, financial, economic, social and environmental assessment reports for the proposed Bangladesh Urban Primary Health Care Sector Development Program. The proposed program will include (i) a policy agenda; (ii) priority investments; and (iii) a component for institutional strengthening within the LGD, city corporations, municipalities and partner agencies. The TA will lay the groundwork and necessary preparation for the ensuing program, whose outcomes would be to improve the health status of the poor in urban areas and to assist Bangladesh in making progress on the Millennium Development Goals (MDGs) in relation to child and maternal health and communicable diseases. To achieve this impact, the TA will (i) assist in designing a program that will increase access to urban primary health care; (ii) improve municipal public health governance, including improved coordination between local governments and the health ministry and developing the institutional and financial capacities of local government bodies to sustain efficient and effective primary health care services; and (iii) strengthen the capacity of urban local bodies to implement their mandates relating to food safety and hospital and solid waste management in partnership with the private sector.

B. Methodology and Key Activities

10. The TA will conduct a rapid evaluation of the UPHCP-II and assess the capacities of the municipalities and the project management unit to implement an expanded program through contracting out to nongovernment organizations (NGOs). The TA also will examine the current UPHCP-II model and examine whether it should be modified to suit the needs of large district municipal headquarters to ensure cost-effectiveness and maximum value for the money spent.

The need for large (50 bed) maternal and children's hospitals in existing and new areas also will be examined. Alternative and innovative health financing modalities to increase the reach of the program to the urban poor, including food and cash vouchers for pregnant women, and very poor clients will be explored under the TA.

11. The TA will review institutional, policy, legal, regulatory and financial issues with regard to the ability of urban local bodies to execute their mandates on essential public health issues. The TA also will compare the legal and regulatory frameworks relating to essential public health functions of urban local bodies with systems in middle-income countries, and recommend program and policy reforms to strengthen the capacity of Bangladesh's urban local bodies to execute essential public health functions. The TA will assess municipal public financing of essential public functions, and recommend mechanisms for the sustainable and increasing contribution of municipal finances for essential public health functions. The TA will explore the role that the private sector can play to strengthen the abilities of urban local bodies to execute their mandates on essential public health.

12. The TA will (i) examine the current status of food safety and hospital and solid waste management with regard to urban local bodies; (ii) recommend a set of policy, legal and regulatory measures to strengthen urban local bodies to discharge their mandates effectively with regard to food safety and solid waste and hospital waste management; (iii) identify investment needs to strengthen food safety and hospital and solid waste management; (iv) examine the application of public-private partnership models, and assist in preparing required documentation to undertake solid waste management through such partnerships in selected city corporations and large municipal towns; and (v) assess the social and poverty impact of proposed interventions, and recommend measures to maximize the impact in reducing poverty, mitigate impacts that might increase vulnerability of the marginalized population, and ensure that the interventions are gender-sensitive and support women's empowerment. The TA also will examine the impact of the proposed interventions on indigenous people, potential resettlement issues and environmental impacts (Appendix 2). It will prepare necessary reports with comprehensive safeguard measures to comply with ADB's safeguard policies. The need for an environmental assessment of the policy matrix will be identified once the scope of the policy reform loan is clear.

C. Cost and Financing

13. The total cost of the TA is estimated at \$815,000 equivalent. Of this, \$650,000 will be financed on a grant basis by the Japan Special Fund, funded by the Government of Japan. The Government will provide \$165,000 equivalent to finance counterpart staff, office accommodation, transport and administration support. The detailed cost estimates and financing plan are shown in Appendix 3. The Government has been informed that approval of the TA does not commit ADB to finance any ensuing project.

D. Implementation Arrangements

14. The Executing Agency for the TA will be the LGD. A steering committee will be established, to be chaired by the LGD secretary and including representatives of the Ministry of Health and Family Welfare, the Economic Relations Department, the Planning Commission, the Establishment Department, the Environment and Forest Department, city corporations, municipalities, NGOs, development partners and civil society. The steering committee will guide and coordinate the TA through monthly meetings. A program coordination unit will be established in the LGD to coordinate the TA, including liaison with stakeholders, data collection

and analysis, support of consultants, provision of logistic support, and organization of workshops. The UPHCP-II project director will be the TA program coordinator, assisted by a full-time planning officer of the LGD, two counterparts (part-time) and two assistants (part-time).

15. The TA will be executed in two phases. The first phase of implementation will require 58 person-months (10 international and 48 national) of consulting services. The indicative terms of reference are in Appendix 4. The two international consultants will be (i) a municipal public health governance and institutional development specialist and team leader (7 person-months) and (ii) a specialist on solid waste management and public-private partnerships (3 person-months). The 48 months of national consultants will include (i) an urban public health and management specialist and deputy team leader (7 person-months), (ii) a municipal public finance specialist (5 person-months), (iii) a health economist (5 person-months), (iv) a food safety specialist (4 person-months), (v) a hospital waste management specialist (4 person-months), (vi) an infrastructure specialist (5 person-months), (vii) an evaluation specialist (5 person-months), (viii) a poverty and social assessment specialist (4 person-months), (ix) a resettlement specialist (3 person-months), (x) an environmental specialist (4 person-months), and (xi) a legal counsel (2 person-months). The remaining consulting services for the second phase (17 person-months) of implementation will be identified at the time of the fact-finding mission, and will be used to bridge technical support and undertake advance actions to accelerate implementation of the proposed program. ADB will engage a combination of a consulting firm for the first phase and individual consultants for the second phase in accordance with ADB's *Guidelines on the Use of Consultants* (2007, as amended from time to time). Quality and cost-based selection and a full technical proposal will be used to select the consultant firm. Minor equipment and office supplies will be procured under the TA in accordance with ADB's *Guidelines for Procurement* (2007, as amended from time to time). All equipment purchased under the TA will be handed to the Government when the TA is completed. To facilitate implementation, the TA will use an advance-payment facility for training, seminars, conferences and surveys. The amount of the advance and its liquidation will be arranged in line with ADB's *Guidelines for Disbursement of Technical Assistance Grant*.

16. The TA will be implemented over 10 months from March 2008 to December 2008, including the bridging technical assistance for advance actions. The consultant team will submit an inception report within a month of the TA starting, a preliminary report of the situation analysis and initial policy matrix within three months, the draft final report within six months, and the final report within seven months. The Government and ADB will comment on the draft final report. The TA will include workshops, stakeholder mapping and institutional mapping. It will employ participatory methods to ensure consultation with a wide range of stakeholders, including civil society, NGOs, and political and administrative leaders at various levels. The consultants will organize at least four workshops to solicit views, discuss recommendations and options, and conduct activities with stakeholders.

IV. THE PRESIDENT'S DECISION

17. The President, acting under the authority delegated by the Board, has approved the provision of technical assistance not exceeding the equivalent of \$650,000 on grant basis to the Government of Bangladesh to be financed by the Japan Special Fund for preparing the Urban Primary Health Care Sector Development Program, and hereby reports this action to the Board.

DESIGN AND MONITORING FRAMEWORK

Design Summary	Performance Indicators / Targets	Data Sources / Monitoring Mechanisms	Assumptions and Risks
<p>Impact (potential program) Improve health, nutrition, and population status of the urban poor</p>	<p>By 2015, ^a reduce infant mortality rates in the project area from 62 to 18 per 1000 live births</p> <p>By 2015, reduce maternal mortality ratio from 320 to 179 per 100,000 births</p>	<p>Household surveys</p>	<p>Assumptions Macroeconomic stability</p> <p>Strong political commitment to human development</p>
<p>Outcome (potential program) Establish sustainable urban primary healthcare system that expands its reach to the urban poor and executes essential public health functions effectively in partnership with the private sector</p> <p>Outcome (project preparatory technical assistance) Design of a program that takes into consideration (i) institutional strengthening aspects; (ii) policy, legal, regulatory and enforcement aspects of essential public health functions; (iii) an investment component to expand urban primary healthcare, food safety, and solid</p>	<p>Unit for urban health established in the Local Government Division (LGD) with a mandate for public health, urban primary health care and waste management</p> <p>City corporations and municipalities strengthened with adequate technical staff and financial resources to implement their public health mandate</p> <p>Improvement in hospital waste management by 20% from the base line</p> <p>Improvement in solid waste management by 10% from baseline, through public-private partnerships</p>	<p>Independent surveys</p> <p>Review missions</p> <p>Tripartite meeting</p> <p>Consultant's report</p>	<p>Assumption LGD is committed to urban public health care</p> <p>Risk City corporations and municipalities have other competing interests and do not allocate resources to urban public health care</p>

Design Summary	Performance Indicators / Targets	Data Sources / Monitoring Mechanisms	Assumptions and Risks
waste and hospital waste management; and (iv) aspects relating to coordination with other ministries, donors and the private sector	Leads to an effective program that is launched in 2009		
<p>Outputs</p> <p>Formulate policy, legal, regulatory and enforcement interventions to strengthen urban local bodies to implement essential public health functions within their mandate</p> <p>Formulate institution and capacity interventions to mainstream urban primary health care provision in local governments, including appropriate coordination mechanisms with the Ministry of Health and Family Welfare and health sector donors</p> <p>Formulation of investment proposals to expand urban primary health care provision through public-private partnerships</p> <p>Formulate investment proposals to strengthen food safety and management of solid waste and hospital waste, among other things, through public-private partnerships</p> <p>Formulate strategies for urban local governments to work with private sector health providers in urban areas to achieve public health good, including innovative public-private partnerships to achieve environmental health and hygiene</p> <p>Explore other innovative financing mechanisms to cater to the extremely poor, including vouchers, and community insurance</p> <p>Formulate fiscal measures for sustainable financing of urban primary healthcare</p>	<p>Inception report</p> <p>Mid-term situation analysis</p> <p>Draft final report</p> <p>Final report</p>	<p>Government steering committee for the technical assistance (TA)</p> <p>Review missions</p> <p>Discussions with government counterparts</p> <p>Effective program design unit</p>	<p>Assumptions</p> <p>Continued LGD commitment to urban primary healthcare</p> <p>Program manager is effective in guiding the consultants during the design phase</p>
<p>Activities with Milestones</p> <p>1. TA preparation</p> <p>1.1. Finalize TA paper and obtain approval by 15 November 2007</p> <p>1.2. Recruit consultant firm by February 2008</p> <p>1.3. Begin consultant activities and feasibility studies including technical, environmental, financial, economic and social assessment from March 2008</p>			<p>Inputs</p> <p>ADB: \$650,000</p> <p>Staff time: 3 person-months</p> <p>Government: \$165,000</p>

<p>2. TA implementation</p> <ul style="list-style-type: none">1.1. Completion of inception report, April 20081.2. Completion of mid-term review, May 20081.3. Completion of draft final report, August 20081.4. Tripartite meeting, August 20081.5. Completion of final report, September 20081.6. Final workshop, August 20081.7. Advance actions and other bridging support, August to December 2008	
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LGD = Local Government Division, TA = technical assistance.

^a As set out in the sector plan within the Country Strategy and Program 2006–2010, which is in line with achieving maternal and child health-related Millennium Development Goals.

INITIAL POVERTY AND SOCIAL ANALYSIS

A. Links to the Country Poverty Analysis

Is the sector identified as a national priority in country poverty analysis? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Is the sector identified as a national priority in country poverty partnership agreement? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<p>Contribution of the sector or subsector to reduce poverty in Bangladesh</p> <p>Catastrophic health shocks leading to hospitalization are an important dimension of vulnerability and impoverishment. The poor pay a significant share of their income for health services. However, their health status is substantially lower than the national average, and their access to health services remains less than desired. The extremely marginalized and poor from rural areas are migrating into urban areas in search of employment. This has led to an increase in the absolute number of poor in urban areas. The urban poor living in slums and squatters also have to deal with environmental hazards resulting from poor living conditions, which is in addition to weak social networks. Bangladesh's health policy (2000) stressed the need to expand health services in urban areas, especially for the poor. However, only 5.3% of government expenditure relates to health, with most of it targeted at the rural poor. The health needs of the urban poor are largely unmet by public interventions. The ensuing program will address many of the concerns relating to primary health care for the urban poor by strengthening and expanding public health services in urban areas. By targeting the urban poor, and by improving their health, the program will help to reduce poverty in Bangladesh.</p>	

B. Poverty Analysis

Targeting Classification: Targeted intervention

<p>What type of poverty analysis is needed?</p> <p>Measures to improve pro-poor targeting were incorporated in the ongoing Urban Primary Health care Project (UPHCP). They include (i) a baseline survey and identification of the urban poor in project areas, mapping of the potential target population, and the introduction of entitlement cards; (ii) identification of constraints faced by the urban poor in accessing health services; (iii) promotion of basic daily health services in slums; (iv) community social mobilization activities to develop health awareness in slums; (v) social marketing to increase demand for health services among the poor living in slums; (vi) increasing the number of trained community organizers and health volunteers; (vii) facility-level health committees in slums and low-income urban areas for monitoring health services to the poor, and representation of the poor on the committees; (viii) involvement of ward commissioners and representatives of nongovernment organizations (NGOs), civil society, and poor communities in monitoring health services to the poor; (ix) setting up targets for NGO outreach workers to mobilize the poor to access health services; (x) independent monitoring to review access and quality of services to the poor; and (xi) an orientation program for all primary health care providers to increase poor people's understanding of health issues and planning of health services for the poor. An analysis of the effectiveness of these measures to reach the poor would be supported by the technical assistance (TA).</p>
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C. Participation Process

Is there a stakeholder analysis? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
The TA will undertake stakeholder analysis and institutional mapping as part of the situation analysis.
Is there a participation strategy? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Stakeholder participation will be ensured at all stages of program design. Workshops and seminars will be

held with a wide range of stakeholders to discuss and obtain feedback on the situation analysis, draft program design and other aspects of the proposed program.

D. Gender Development

Strategy to maximize impacts on women

Women and children are significant beneficiaries of the program. In addition, at least 50% of health workers engaged in the proposed project are likely to be women. The TA will engage a poverty and social assessment specialist to ensure maximum positive impact on women.

Has an output been prepared? Yes No

E. Social Safeguards and Other Social Risks

Item	Significant/ Not Significant/ None	Strategy to Address Issues	Plan Required
Resettlement	<input type="checkbox"/> Significant <input checked="" type="checkbox"/> Not significant <input type="checkbox"/> None	Most of the land will be government or donated land. Resettlement in the city corporations and municipalities will be marginal. A resettlement framework will be proposed for all subprojects initiated after project approval. Provision has been made in the TA for resettlement-related work.	<input type="checkbox"/> Full <input checked="" type="checkbox"/> Short <input type="checkbox"/> None
Affordability	<input type="checkbox"/> Significant <input checked="" type="checkbox"/> Not significant <input type="checkbox"/> None	The TA will help to design a program that will support affordable health care for the poor, better urban public health, and solid waste disposal.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Labor	<input type="checkbox"/> Significant <input checked="" type="checkbox"/> Not significant <input type="checkbox"/> None	The ensuing program will ensure fair wages for laborers constructing health facilities as well as equal wages for men and women for the same type of work.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Indigenous Peoples	<input type="checkbox"/> Significant <input type="checkbox"/> Not significant <input checked="" type="checkbox"/> None	The city corporations and municipalities covered by the project do not overlap any areas inhabited by indigenous peoples.	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Other Risks and/or Vulnerabilities	<input type="checkbox"/> Significant <input checked="" type="checkbox"/> Not significant <input type="checkbox"/> None	The ensuing project will improve hospital and solid waste management practices. It is expected to have no adverse effect on the environment. A summary initial environmental examination and an environmental assessment framework for sector development projects will be designed. Adequate provision is made in the TA for an environmental safeguard specialist.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

COST ESTIMATES AND FINANCING PLAN

(\$'000)

Item	Total Cost
A. Asian Development Bank Financing^a	
1. Consultants	
a. Remuneration and Per Diem	
i. International Consultants	200.0
ii. National Consultants	250.0
b. International and Local Travel	40.0
c. Reports and Communications	10.0
2. Equipment ^b	15.0
3. Workshops, Training, Seminars and Conferences ^c	
a. Facilitators	5.0
b. Workshops and Training Program	40.0
4. Surveys and Studies	30.0
5. Miscellaneous Administration and Support Costs	5.0
6. Representative for Contract Negotiations	5.0
7. Contingencies	50.0
Subtotal (A)	650.0
 B. Government Financing	
1. Office Accommodation and Transport ^d	80.0
2. Remuneration and Per Diem of Counterpart Staff	60.0
3. Others	25.0
Subtotal (B)	165.0
Total	815.0

^a Financed by the Japan Special Fund, funded by the Government of Japan.

^b Computers, printers, audiovisual and office equipment.

^c Covering municipal public health governance, solid and hospital waste management, urban municipal functions, and dissemination of TA findings.

^d Transport costs include only those for government counterpart staff; office accommodation is for consultants and counterpart staff.

Source: Asian Development Bank estimates.

OUTLINE TERMS OF REFERENCE FOR CONSULTANTS

A. Municipal Public Health Governance and Institutional Development Specialist and Team Leader (international, 7 person-months)

1. The team leader will be a specialist in municipal public health governance and institutional development, or the equivalent, with at least 10 years' experience in municipal public health governance reforms, decentralization and institutional development. As team leader, the specialist will (i) lead the technical assistance (TA) with the program coordinator and deputy team leader, and (ii) prepare a task matrix for consultants and counterparts. The specialist will be familiar with cross-cutting issues of poverty reduction, gender, resettlement and environmental concerns. The specialist will be primarily responsible for designing the sector development program loan, which will include an urban primary health care sector investment plan and an urban public health sector reform program. The specialist will (i) determine the roles and capacity requirements of municipal administrations and communities for urban public health management; (ii) develop a program framework and policy matrix for the program, with the help of other specialists; (iii) prepare an action plan associated with the policy matrix that includes responsible stakeholders, resources required and a schedule; and (iv) plan capacity building to strengthen urban public health governance. The specialist will prepare a situation analysis of municipal public health governance and the implementation of public health laws and regulations. The report will include a problem tree analysis, capacity constraint analysis, institutional mapping and stakeholder analysis. This analysis will (i) assess donor activities in the area of municipal public health governance; (ii) identify key issues to improve municipal public health performance and requirements for reform; (iii) identify, with input from other specialists, key sector policy reforms relating to public health and primary health care service delivery at the city corporation and municipal level; (iv) review current and alternative approaches to strengthening municipal public health functions; and (v) identify governance support required for municipal health development. The specialist will prepare a technical feasibility study according to the format and guidelines of the Asian Development Bank (ADB), including the sector analyses and the draft program implementation manual. The team leader, with the assistance of a municipal public finance expert, will assess the financial management capacity of the executing agency and prepare a strategy for strengthening the financial management capacity of the executing agency and other entities participating in the program.

B. Urban Public Health and Management Specialist and Deputy Team Leader (national, 7 person-months)

2. The deputy team leader will be a senior public health specialist with experience in urban primary health care, health sector reform, health services contracting and preparation of project proposals. Along with the team leader, the deputy team leader will be the primary liaison with the Government of Bangladesh, including the Local Government Division (LGD), the Ministry of Health and Family Welfare, city corporations, municipalities, nongovernment organizations (NGOs) and partner agencies. The deputy team leader will assist the team leader to organize and oversee the work and reports of the other consultants, with a focus on project planning. He or she will be responsible to (i) review, with the team and stakeholders, the context of the second Urban Primary Health Care Project (UPHCP-II) in general, including needs, governance, capacity, policies and programs, ensuring that key issues are adequately addressed in the design; (ii) evaluate the UPHCP-II with other team members, including an assessment of the performance, cost and financing, affordability, quality and public perception of services; (iii) prepare a detailed proposal for expansion of the UPHCP-II with a clearly defined project framework, components, implementation arrangements, implementation schedule and performance management system; (iv) propose

policy actions required for successful implementation of the expanded UPHCP-II and sustainability of urban primary health care; (v) work with a health economist in preparing the project cost estimates; (vi) formulate the terms of reference and qualifications for consultants, counterparts and long-term advisers for the expanded UPHCP-II; and (vii) prepare a written report in response to the terms of reference, including a final report resembling a report and recommendation of the President to the Board of Directors that incorporates the reports of other consultants.

C. Municipal Public Finance Specialist (national, 5 person-months)

3. The specialist will be a public finance and economics specialist with at least 5 years' experience with reforms in Bangladesh municipal finance. The specialist will coordinate the team with the program director and the team leader, and help the team leader prepare the technical feasibility study according to ADB's format, including municipal public health finance. For the situation analysis, the specialist will (i) review municipal financing in Bangladesh in general and municipal public health financing in particular; (ii) determine the major sources and uses of municipal finances, drawing on existing information from budgets and projects; (iii) review the overall budget and financing of municipal public health; (iv) review the Government's grant mechanism to urban local bodies; and (v) estimate availability of funds for public health and primary health in urban local bodies, propose financing arrangements for sustainability of urban primary health care, and prepare a detailed report. During the design of the loan, the specialist will (i) assess general recurrent cost implications of both public health and primary health care and propose ways to sustain their impact; (ii) prepare a model municipal medium-term expenditure plan to improve urban health outcomes, including the potential for private sector financing for a medium-sized town; (iii) propose approaches to improve the allocation and use of funds; (iv) review the potential for cost recovery; (v) ensure that the issues of resource availability, resource transfers and an incentive structure for service providers are addressed; and (vi) prepare cost estimates for the policy reform agenda. The specialist will undertake and prepare reports on economic and financial analyses according to ADB guidelines, including the program rationale, justification and information on cost-effectiveness, rate of returns and financial sustainability. The consultant will assist the team leader to assess the financial management capacity of the executing agency.

D. Health Economist (national, 5 person-months)

4. The consultant will focus on project economic and financial analysis, and cost estimates. He or she will be responsible to (i) examine whether user charges are appropriate for various groups of beneficiaries, and the level of such charges; (ii) assess the financial capacities of beneficiaries and NGOs in city corporations and large and small municipalities; (iii) examine how beneficiaries manage catastrophic medical expenses, and suggest what could be done to assist the poor in meeting these costs; (iv) suggest practical mechanisms for determining and monitoring user charges on an ongoing basis; (v) assess the sources and level of financing of the UPHCP and propose a strategy for city corporations to cover the costs of NGO-provided primary health care services as external funding support is phased out; (vi) develop a detailed budget for the investment component of the program; and (vii) prepare an economic analysis and financial sustainability assessment according to ADB's *Handbook for the Economic Analysis of Health Projects*.

E. Food Safety Specialist (national, 4 person-months)

5. The specialist will assess how well urban local bodies are equipped to respond to existing and emerging food safety problems, and whether they have the technical and financial resources, effective institutional frameworks, trained personnel, and sufficient information about the hazards

and risks involved. To improve food safety, the specialist will propose recommendations relating to (i) food legislation and regulations; (ii) inspection and food surveillance programs to inform and enforce legislation and regulations; (iii) health surveillance to ensure the availability of reliable data on which to base risk-management decisions; (iv) regulatory oversight that extends from farm to table; (v) efforts to educate the food industry, food-handlers and consumers; and (vi) adequate surveillance or reporting mechanisms to identify and track food-borne illness. The specialist will prepare an investment plan to strengthen, among other things, laboratories with the capacity to detect common food-borne hazards. The plan will also strengthen the enforcement of food safety regulations in urban local bodies.

F. Hospital Waste Management Specialist (national, 4 person-months)

6. The specialist's outputs will assist to improve people's health and reduce environmental impacts from handling of hospital waste by its proper disposal. The specialist will identify the level of hospital waste management that will be relevant to help implement and enforce proper health and environmentally sound, technically feasible, economically viable and socially acceptable systems for managing hospital waste by urban local bodies. The specialist will conduct a detailed study of one large municipal town and prepare a report based on that study. The specialist will design a feasibility study and environmental assessment of various treatment technologies and locations for a treatment facility, and prepare a report that includes recommendations on institutional development for urban local bodies and the preferred treatment technology and location of a treatment facility. The draft feasibility report will also include (i) an action plan for managing hospital waste, with an accompanying implementation plan to include all necessary schedules, cost estimates and terms of reference; (ii) an optimal long-term concept to separate, store, collect and treat and dispose of hospital waste; (iii) preliminary engineering designs showing the layout plans, typical sections and elevations of the treatment facilities, with performance specifications of all equipment; (iv) recommendations for private sector participation in building and managing hospital waste, with scenarios for pragmatic implementation; (v) a financial and institutional framework that would assume responsibility for oversight and supervision of the hospital waste management system, as well as the proposed method for recovering the cost of debt service and operation and maintenance; and (vi) an implementation plan covering all project sub-components, including scheduling, cost estimates and terms of reference for training, institutional strengthening, additional studies, detailed engineering, and for all other work required to implement the hospital waste management system. The specialist will work in a team with an infrastructure specialist and an environment specialist to prepare an initial environmental assessment and participate in all public consultation events.

G. Infrastructure Specialist (national, 5 person-months)

7. The specialist will be an architect or engineer with experience in health service delivery, and will focus on preparing an infrastructure development and environmental improvement plan for the expanded urban primary health care under the program. The consultant will be responsible specifically to assess (i) a sample of the 163 health facilities and satellite clinics under the UPHCP to identify ways of improving their site location, design and use; and (ii) environmental health problems, proposing ways in which drinking water supply, sanitation and garbage collection can be improved. The consultant will (i) prepare an environmental assessment and plan; (ii) conduct health zoning in identified city corporations and municipalities to identify locations for new services; (iii) review the process whereby land is obtained for constructing health facilities and recommend how to improve the process; (iv) identify any resettlement issues with the help of a sociologist; (v) determine options for the expanded UPHCP, including buying existing buildings, renovating them, or purchasing land for new construction; (vi) develop architectural sketch plans, specifications and

cost estimates for a revised health facility design, maximizing input from current users; (vii) describe the annual maintenance needs of the recommended facilities and propose a maintenance plan; (viii) develop terms of reference for the professional services needed to construct the civil works and improve slum conditions under the expanded UPHCP; and (ix) prepare a written report in response to these terms of reference. The specialist will work in a team with a hospital waste management specialist and an environment specialist to prepare the initial environmental assessment and participate in all public consultation events.

H. Evaluation Specialist (national, 5 person-months)

8. The specialist will evaluate the performance of the model for contracting out model of UPHCP and the likely future demand for its services. He or she will examine how effectively and efficiently the program delivers services compared with other modes of delivery, including services provided through government rural health services. The specialist will help to answer, among others, the following questions (i) whether the project's contracting-out model is cost-effective in delivering essential services in urban areas of Bangladesh; (ii) how the model compares with other models, including in terms of cost-effectiveness; (iii) the strengths, weaknesses, opportunities and threats of the model; (iv) the extent to which the model has achieved its expected outcomes; and (v) whether the contracting-out model should be expanded. Based on the evaluation, the specialist will develop recommendations to inform future program objectives, directions and alignment, with a view to achieving greater development impact. The specialist will assess the capacity of the project management unit to provide services to new municipalities that are dispersed across the country and relatively smaller than city corporations. He or she will investigate and comment on whether the current locational and organizational arrangements are appropriate and develop recommendations on strategies for strengthening coordination and collaboration among various service providers at the level of urban local bodies, with a view to achieving a more integrated and client-focused service for the urban poor. The consultant also will identify best practice models and possible alternative service delivery models for consideration and develop recommendations to improve reporting and accountability. The consultant will distill information about lessons and help the team to build the project applying positive lessons and mitigating negative lessons.

I. Solid Waste and Public-Private Partnership Specialist (international, 3 person-months)

9. The specialist will study one large municipal town to assess the financial and institutional dimensions of solid waste management in built-up areas, and evaluate the feasibility and advisability of involving the private sector. The consultant will recommend appropriate cost-recovery mechanisms and targets, as well as tariff structures. He or she will recommend an optimal strategy for private sector participation and prepare bidding documents for soliciting such participation in solid waste activities. The specialist will determine an appropriate institutional, commercialization or corporatization strategy to improve solid waste management in the project area, including the definition of (i) appropriate roles and responsibilities for participating entities, (ii) the organizational structure, and (iii) staffing. The specialist will conduct a financial analysis of the systems for sweeping, collection, transport and disposal of waste, taking into account operating and maintenance costs in the target areas. He or she will survey different types of generators of solid waste regarding their preferences on collection methods and their ability and willingness to pay for solid waste management service options. The specialist will analyze the feasibility of alternatives for full or partial cost-recovery and propose (i) financial plans, (ii) pricing or rate structures, and (iii) mechanisms for collecting charges. These financial recommendations should (i) accompany the proposed institutional arrangements; (ii) determine appropriate methods of involving the private sector in order to improve efficiency and reduce costs and capital investment in collection, transfer, composting, recycling and general waste disposal; and (iii) examine the legal framework governing relationships among local,

provincial and central levels of government, and between government and potential private sector partners. The consultant will examine a range of private sector participation options available for collection, recycling, transfer, composting and disposal of wastes, including hazardous health care waste, and construction and demolition debris. Options to be included will cover service contracting, management contracting, franchised services, licensed private subscription and concessions. The study should take into account the capacity in each area for delivering the required services and examine the comparative advantages of using public and private sector operators in collection, recycling, transfer and disposal, with careful consideration given to supervision and enforcement. The economies of scale for appropriate sizing of facilities and collection zones will be considered so that privatization strategies outlined by the consultant are cost-effective.

J. Poverty and Social Assessment Specialist (national, 4 person-months)

10. The consultant should have experience in preparing poverty and social assessments for ADB-financed projects. The consultant should be an expert in analyzing household surveys and census data. The consultant will conduct a household survey and poverty and socioeconomic analyses in accordance with ADB requirements. This includes assessing the impact, if any, on ethnic minority groups and the measures needed to address the impact. Based on the findings and recommendations of the survey and analyses, the consultant will provide recommendations to strengthen the project's development impact. The consultant will conduct due diligence to screen for the presence of tribal people in the project coverage areas and to ensure that the TA outputs and information are segregated according to ethnicity to the extent this is possible.

K. Resettlement Specialist (national, 3 person-months)

11. The resettlement specialist should have experience in assessing resettlement needs and preparing a resettlement framework for an ADB-financed project. The consultant will conduct a survey and stakeholder consultation and prepare a resettlement plan in accordance with ADB's *Involuntary Resettlement Policy (1995)*, and its requirements for identified subprojects of the sector development program. The resettlement framework will ensure implementation of the sector development program complies with ADB's resettlement safeguard requirements. The specialist will conduct due diligence of donated land in identified subproject areas to ensure compliance with ADB's policy requirements, and prepare resettlement plans and a framework for any subproject that entails land acquisition or donation. The presentation and substance of the assessment prepared under the TA will meet the quality standards set by ADB for such documents.

L. Environment Specialist (national, 4 person-months)

12. The specialist will have a minimum of 5 years' proven experience in working with international organizations delivering environmental assessments. In accordance with ADB's *Environment Policy (2002)* and *Environmental Guidelines*, as well as Bangladesh's environmental regulations, the specialist will (i) review and compile all environmental baseline data pertinent to Bangladesh, including physical and ecological resources and socioeconomic and cultural components; (ii) review possible environmental aspects of the project's interventions and, if necessary, propose risk-mitigation measures; and (iii) identify and assess the environmental implications of the proposed policy interventions based on an initial review of the links to potential economic and social outcomes. If necessary, the consultant will develop an environmental assessment of policy interventions. If this is not necessary, the length of the specialist's contract will be reduced by one month and reallocated at the time of the midterm review. Any environmental assessment of policy interventions will include preparation of an environmental management plan. The plan will describe the conditions or safeguards required to ensure that the policy interventions

will promote environmentally sound development and efficient use of resources, factors which are to be incorporated as an integral part of the program loan. The plan will fulfill ADB's environmental requirements, including proposed activities, institutional arrangements and responsibilities for reporting, review and related cost estimates. A comprehensive review of environmental implications for the investment component will be produced. If significant environmental impacts are identified, an initial environment examination and summary examination will be developed for the investment component in accordance with ADB's *Environment Policy*. The specialist will conduct public consultations in accordance with ADB's *Public Consultation Policy, 2005*. The specialist will coordinate with team members on all public consultation events and liaise with them to discuss impacts during the TA.

M. Legal Counsel (national, 2 person-months)

13. The legal counsel will be an expert on legal issues and laws in Bangladesh relating to all aspects of public health including food safety, environmental health and sanitation, and municipal laws. The counsel also will have a good understanding of comparative international public health law. He or she will work closely with the team leader and team members, and provide legal inputs to achieve the TA's objectives. The counsel will prepare a situation report on existing policy and the legal framework relating to public and environmental health in Bangladesh. Based on an understanding of the best legal framework practices in middle income countries, the counsel will identify critical gaps in Bangladesh's urban public health legal framework, and suggest policy and legal reforms to improve public health, food safety and environmental health. The counsel will assist the team leader to review the proposed policy matrix from a legal perspective.