A. Evaluation of UPHCP (first phase)

1. The project completion report (PCR) of Urban Primary Health Care Project (UPHCP) was completed in March 2007. The overall assessment was rated as successful. The Project design was (i) highly relevant, effective and efficacious in achieving the outcomes; (ii) efficient in achieving outcome and outputs; and (iii) likely sustainable. It significantly impacted on poverty through improvement of the health condition, reduction of mortality and morbidity, and improvement of the nutrition status of the urban poor, and particularly women and children. The Project design and implementation were sound, replicable, and in high demand by the urban population, as demonstrated by the implementation of the on-going follow-up project. Most target outputs and outcomes have been met. The PCR identified a number of lessons learned as follows:

   a. Public-private partnerships for primary health service delivery among the urban poor, and particularly women and children, proved to be a replicable, effective, and innovative approach.
   b. Pro-poor targeting is difficult without necessary and adequate provisions and safeguards in the bidding process for selection of partner agencies.
   c. Site selection is often constrained when striking a balance between the availability of land and the suitability of the site, in terms the ease of access by poor women and children, which varies with proximity to slums and squatter settlements and other health service facilities. The design of existing urban primary health care centers, particularly the CRHCCs, should be improved with respect to layout and internal arrangements, so as to make them more patient-friendly.
   d. There is a need for increased awareness among catchment area residents regarding the availability of primary health care facilities and services, so as to maximize utilization of infrastructure.
   e. Efficient cash and fund flows are essential for smooth operation of the partner agencies.
   f. Depreciation of local currency can generate huge funding surpluses.
   g. Coordination among local government agencies, the Ministry of Health and Family Welfare (MOHFW), and other concerned stakeholders needs to be further improved.

2. While the above lessons were incorporated and improved upon in the design of UPHCP II, some areas, such as poverty identification and targeting, balancing land availability with enhanced functionality of civil works design, fund flow issues, and coordination with MOHFW, need further strengthening in the new project design.

B. Evaluation of UPHCP II (second phase)

1. Independent Mid-term Review

3. An Independent Review Team carried out a Mid-Term Review of the Second Urban Primary Health Care Project (UPHCP II) from 15-31 March 2009. The Review provided an in-
depth analysis and independent review of the project progress against its agreed purpose and outputs and provides recommendations to improve the impact of the project. The key messages of the Review Team were as follows:

a. The UPHCP II has increased access to the Essential Service Package by the urban poor in Bangladesh
b. Service outreach and the Red Card system implement entitlement by the poor
c. Improved access by the poor to Emergency Obstetric Care and MR will contribute to achievement of MDG 5 (reduction of maternal mortality) and MDG 4 (reduction of neonatal and infant mortality)
d. The project responds to the urban dynamic in Bangladesh in terms of the projected growth in urban population, the legal framework which mandates local government to provide primary care in urban areas and the service needs of poor, disproportionately youthful and reproductively active populations
e. UPHCP II uses an innovative model of service delivery, Public Private Partnership or PPP which offers valuable lessons for MOHFW in contracting out. The Bangladesh PPP experience in contracting NGOs for primary care is also relevant across South Asia.
f. The UPHCP II model merits continuation in the context of rapid urbanization; delivering on the legal mandate for local government to provide primary care in urban areas; achieving the MDGs, especially MDG 5, through significantly extending service coverage to the poor and the PPP modality of contracting NGOs providing an important exemplar for MOHFW in the context of the HNPSP Sector Investment Program (SIP).
g. Sustaining increased provision of urban health services to the poor through the UPHCP II is complex and has many dimensions (continued relevance, contribution to implementation of national policy, institutional, financial, managerial, etc) for which strengthened technical support for the project is required
h. Despite its achievements, the UPHCP II program could do better.

2. Quantitative Assessment of Data Collected under UPHCP II

To help inform design of the third phase of UPHCP, ADB commissioned an objective assessment of evidence around outcomes and achievements of UPHCP II, and the extent to which the project has fulfilled objectives of efficiency, quality, equity, and financial sustainability. The analysis was undertaken during December 2011 to February 2012, and done primarily through statistical analysis of financial and monitoring and evaluation survey data of UPHCP II. The main findings of the assessment are as follows:

Quality of PHC services
a. Using data from ISIs, service quality indicators, such as functioning of equipment, availability of drugs, infection prevention, waste disposal, use of registers, and overall and waiting time satisfaction of non-poor patients, have significantly improved from 2008 – 2011.

---

4 Data from several sources were obtained and used in the analysis, including: 1) baseline and midline health facility surveys; 2) six waves of Integrated Supervisory Instruments (ISIs); 3) baseline household women’s questionnaire of ever-married women aged 15-49; 4) baseline and midline qualitative studies using participatory rapid appraisal (PRA) techniques, such as focus group discussions and in-depth interviews; and 5) Quarter Performance Reports (QPR). This study draws on the health facility surveys, ISIs, baseline household survey, qualitative surveys, and information from the QPRs. Two clinic visits were also conducted at: 1) Nari Maitree PA 06 in Dhaka City Corporation and 2) Population Services & Training Center of Smiling Sun Franchise Program in Aftab Nagar, Dhaka City Corporation.
b. Using data from health facilities, there are also improvements in the availability of maternal and child health services and knowledge of service providers from 2008 – 2009, but not in the quality of infrastructure.

**PHC service coverage and equity**

a. At least 30% of each major category of health services is accessed by the poor from 2008 - 2011, with the exception of child health and communicable disease control services that dipped below 30% in 2010. Each major category of service covers a specific set of services. Less than 30% of some specific services, such as Caesarian section delivery, menstrual regulation, post abortion care, child immunizations, and diagnostic services, are accessed by the poor.

b. For the maternal and child health services coverage rates that increased over time, larger gains are found mostly in the poor households, which suggests that there is a narrowing of the gap between coverage of the poor and all households.

c. The performance indicators for 90% full immunization coverage and 60% use of modern family planning methods are nearly achieved at 89.9% and 59.8%, respectively, in 2008. However, the proportion of trained birth attendance has yet to increase by 10%.

**Efficiency of health care delivery**

a. The majority of PAs have more than doubled or for a few even tripled their total number of services. While most PAs have increased their expenditures over time, the increase in the total number of services suggests that PAs are becoming more efficient based on the decreasing cost per service for most of them. Even though several quality of health services indicators increase, costs by PA slightly increase over time.

b. Direct provision of primary health services in Chittagong lead to some of the highest expenditures across PAs and increased cost per service over time.

C. **Lessons learned and their incorporation into project design**

5. Key recommendations from the above reviews, along with assessment of lessons during project preparatory stage, have been incorporated into the design of the proposed UPHCSDP as follows:

**Table 1: Lessons Learned and their Incorporation into the Project Design**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Lessons Learned from UPHCP II</th>
<th>Project Design Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pro-poor targeting</td>
<td>Partner NGOs should regularly update their poor mapping of households and have a consistent definition implemented across all partner NGOs.</td>
<td>More resources will be made under UPHCSDP to strengthen poverty identification and targeting. The PA NGOs will be provided with technical support for better and more uniform identification of the ‘poor’ eligible for fee exemption (‘red-cards’) and for regular updating and effective management of the red-card system.</td>
</tr>
<tr>
<td>Monitoring and Evaluation</td>
<td>There is current emphasis on reporting and scoring with regard to M&amp;E. The mindset of using M&amp;E as tool for managing and actually improving performance need to be strengthened.</td>
<td>Additional staff and an automated and streamlined HMIS system will be supported to enable real-time reporting and monitoring. As part of HMIS, community-based “last mile” data acquisition and feedback mechanism to users will be strengthened, adapting an innovative pilot in India by Intel Corporation. Project</td>
</tr>
<tr>
<td>Issue</td>
<td>Lessons Learned from UPHCP II</td>
<td>Project Design Features</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td></td>
<td>that the final questionnaire of ISI for each subsequent survey is consistent with previous surveys and captures the necessary modules to make comparisons in trends across time.</td>
<td>guidelines will be introduced on conduct of ISI survey to ensure consistency of modules in each ISI wave to allow comparability of composite scores over time. Project’s Quality Assurance Team will be strengthened, including with a quality assurance consultant based in PMU, to regularly follow up on ISI findings to improve performance of partner NGOs.</td>
</tr>
<tr>
<td>Review of NGO contracting</td>
<td>MIS and record keeping should be streamlined and strengthened to reduce errors and reporting burden on health staff.</td>
<td>To ensure accountability to results and recognize performance, a set of performance-linked indicators, linked to payment disbursements, will be included in contract management of NGOs. The scheme of performance indicators will be a core performance-based aspect of the NGO partnership agreement to enhance accountability of NGOs to achieving results and quality health services delivery. Performance incentives will be calculated based on a composite index of the cumulative performance of 11 health service delivery indicators, considered as clear priorities for UPHCSDP. The scheme is expected to promote key results in these areas. The indicators will be assessed annually based on results of the ISI.</td>
</tr>
<tr>
<td></td>
<td>UPHCP II should be clearer about what its priorities are and focus on those. The PA NGOs should be held more accountable for achieving priorities.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bonuses can be used to emphasize key indicators, but timely distribution of bonuses had been difficult under UPHCP II due to delays in carrying out mid-line and end-line survey.</td>
<td></td>
</tr>
<tr>
<td>Service delivery</td>
<td>Given the youthful nature of Bangladesh’s population the project should provide a greater focus on the needs of adolescents and extend service coverage for this group. Child nutrition services should be strengthened, particularly given the results of the BDHS 2007 that over half of all children in Bangladesh are malnourished</td>
<td>Building on previous phases of UPHCP, the project will further support strengthening the urban PHC delivery system to provide the essential services delivery (ESD+) package through public-private partnership. In line with needs of the urban poor and the demography of Bangladesh, project services will increase focus on family planning, nutrition, adolescent health, and neonatal care.</td>
</tr>
<tr>
<td>Drugs</td>
<td>UPHCP II frequently experienced shortages in drugs and consumables, which have sometimes adversely affected the quality of PHC delivery to the urban poor.</td>
<td>Adequate provisions have been made for procurement of drugs, including free drugs for the poor. Drugs procurement and management guidelines for PA NGOs will be available, and facility managers will be better trained in drugs inventory management.</td>
</tr>
<tr>
<td>Health Promotion</td>
<td>Align BCC efforts to key indicators and poverty focus.</td>
<td>Development and implementation of an effective communication program for health education and social and behavior change in key priority areas of UPHCSDP (MNCH related health care seeking behaviors, nutrition, family planning, hygiene and sanitation) will be supported. The program will be implemented in close coordination with MOHFW, and more efforts will be made to reach most vulnerable</td>
</tr>
</tbody>
</table>
Issue | Lessons Learned from UPHCP II | Project Design Features
--- | --- | ---
Infrastructure | Provision of new PHC facilities is important for quality of care, community ownership and to anchor community participation. Further infrastructure investments should be purpose-based. Health managers should have inputs into infrastructure designs. | The project will improve access to urban PHC through improved infrastructure network. The prototype designs of new infrastructure have been based on extensive consultations with health workers and designed to be more functional and efficient. To help improve operational efficiency of UPHCP clinics, including addressing electricity and water shortages, and high operating costs of diesel generators, the project will introduce (i) rooftop solar energy system (SES), (ii) use of solar water heater (SWH), and (iii) rain water harvesting on pilot basis in selected facilities. 

Training and capacity building | Capacity building within the project has faced a number of challenges with a slow contracting process for the consulting companies envisaged to provide essential technical and management support. | Rather than a training firm, and to institutionalize the capacity, a ‘training coordination cell’ will be established under the PMU, consisting core PMU staff under a DPD, and supported by one international consultant and one national consultant. The unit will review in detail training requirements, collaboration with other agencies/ training institutes, and update and implement the project training plan. 

Project management | Implementation arrangements should ensure adequate support for both day-to-day project management and overall program guidance. | Specialist consultants will be recruited to assist PMU and project implementation in selected technical and management areas. 

Project sustainability | In terms of long term sustainability of urban primary health provision there are a number of high level actions required. | Progressive decentralization of management responsibilities from PMU to PIUs will be supported. More budgetary, procurement and human resources management accountabilities will be delegated to PIUs and PA NGOs. 

Sustainable delivery of urban PHC services will hinge on improvements in related institutional governance and local government capacity, which will be the focus of UPHCSDP assistance. 

To institute strategy and coordination framework for urban health, the project will support the LGD to implement the draft national urban health strategy, supported under UPHCP II. 

Conditions for creating an enabling framework, and supporting a gradual shift from a project to a program approach where there would be predictable budgetary allocations for urban PHC, will be included among Government
D. Preliminary findings from independent review of UPHCP II commissioned by DFID

6. In addition to the aforementioned, DFID, a co-finance of UPHCP II, is in process of carrying out an independent assessment of UPHCP II. The review process is being undertaken during January-March 2012. A final report is expected to be available in April 2012. The purpose of the independent external evaluation is to assess UPHCP II outcomes and identify the lessons learned. The findings aims to complement the review and design work of ADB and the end of the project evaluation focusing on service performance by partner NGOs.

7. Preliminary findings and key lessons from this evaluation of UPHCP II, shared on 22 March 2012, and their incorporation in the design of the new project, are as follows:

Table 2: Preliminary Findings and Key Lessons from Evaluation of UPHCP II

<table>
<thead>
<tr>
<th>Key preliminary findings of DFID assessment</th>
<th>Comments and Project Design Features</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPP through the contacting of NGOs is achieving increased access to Primary Health Care, including Emergency Obstetric Care to increasing numbers of urban dwellers, including the poor, females and girls, but the quality of care needs addressing and there is need for greater focus on achieving MDGs 4 and 5.</td>
<td>Quantitative assessment of qualitative survey and ISIs (quality assurance) data collected under UPHCP II suggests that many of the quality indicators improved over time. However, follow-up of ISI findings for further quality improvements was generally weak under UPHCP II. The design of the new project has provisions to strengthen quality assurance, monitoring, and regular follow up.</td>
</tr>
<tr>
<td>Higher utilization of services by the poor that hold entitlement to free services through a Red Card is demonstrating that fees are a barrier for access by the urban poor, there is need to review and revise how this entitlement is assessed and provided, as current system still excludes segments of the extreme poor.</td>
<td>The proposed project, similar to UPHCP II, will continue to focus on safe motherhood as its core (MDG 5). The focus on MDG 4 (child mortality) is strengthened under the new project, by increasing attention to neonatal care.</td>
</tr>
<tr>
<td>There is some evidence that the UPHCP is helping to strengthen the role and responsibilities of the City and Municipal Health Departments within ULBs towards delivering</td>
<td>While the ‘moral hazard’ of free services and higher utilization should be considered, the proposed project has provisions to improve poverty identification and targeting, specifically for better management and reach of the ‘red card’ system. It also has provisions for reaching the ‘ultra poor’ or homeless (‘floating’) population (who are often by-passed by the red-card system) with mobile services delivery.</td>
</tr>
<tr>
<td>Supporting the need for capacity building and restructuring of ULB health departments, and progressive delegation of management responsibilities from PMU to PIUs are addressed under outputs 1 and 2</td>
<td></td>
</tr>
</tbody>
</table>
The current system of ‘procuring’ partnerships with NGOs through contracts is not helping to build strategic partnerships for the long-term delivery of urban PHC. The finite terms of contract and lack of other longer-term partnership commitments between GOB and NGOs does not provide incentive for NGOs to invest in building their own institutional capacity to work in urban health.

The policy and strategic framework for urban health still needs to be strengthened through full adoption of the urban health strategy, the current focus on urban health is mainly restricted to PHC and activities of NGOs, it should encompass all elements of urban health and needs to address the diverse range of actors, e.g. tertiary hospitals, private-for-profit health providers, pharmaceutical outlets, etc.

The current governance arrangements to provide oversight and coordination for urban health amongst major stakeholders continue to be weak and need strengthening.

The financing of urban PHC services needs to be regularized into the LGD and ULB budgetary system and allocation and release of funds needs to be monitored for growth.

Current coordination at the operational level of urban health services is weak and fragmented around donor funded projects, resulting in areas of overlap and gaps in the provision of services.
Key preliminary findings of DFID assessment

Division of roles and responsibilities between MOH&FW and MOLGRDC needs further clarification and elaboration, especially in the area of regulation and stewardship.

The dynamics of urbanization and health in Bangladesh is not well studied and there is need for more operational research to inform policy makers and planners.

Comments and Project Design Features

relevant players.

Support for this is addressed under output 1, governance aspects of the proposed project.

Operations research is included under output 2 of the proposed project, to be carried out by renowned research institutions also acting as knowledge hubs.
