



Report and Recommendation of the President to the Board of Directors

Project Number: 42177-013
June 2012

Proposed Loan, Technical Assistance Grant, and Administration of Grant People's Republic of Bangladesh: Urban Primary Health Care Services Delivery Project

This document is being disclosed to the public prior to Board consideration in accordance with ADB's Public Communications Policy (2011). Subject to any revisions required following Board consideration, this document is deemed final.

Asian Development Bank

CURRENCY EQUIVALENTS

(as of 1 June 2012)

Currency unit	–	taka (Tk)
Tk1.00	=	\$0.0122
\$1.00	=	Tk81.88

ABBREVIATIONS

ADB	–	Asian Development Bank
BCC	–	behavior change communication
IT	–	information technology
LGD	–	Local Government Division
M&E	–	monitoring and evaluation
MOHFW	–	Ministry of Health and Family Welfare
MOLGRDC	–	Ministry of Local Government and Rural Development Cooperatives
NGO	–	nongovernment organization
PAM	–	project administration manual
PHC	–	primary health care
PIU	–	project implementation unit
PMU	–	project management unit
PPP	–	public–private partnership
TA	–	technical assistance
ULB	–	urban local body
UPHCP I	–	Urban Primary Health Care Project
UPHCP II	–	Second Urban Primary Health Care Project

NOTE

In this report, “\$” refers to US dollars.

Vice-President	X. Zhao, Operations 1
Director General	J. Miranda, South Asia Department (SARD)
Director	S. Ra, Human and Social Development Division, SARD
Team leaders	B. Chin, Young Professional (Social Sector Specialist), SARD H. Win, Social Sector Specialist, SARD
Team members	M. S. Alam, Project Analyst, Bangladesh Resident Mission (BRM), SARD E. Bagtas, Operations Assistant, SARD O. G. Domagas, Financial Control Specialist, Controller’s Department A. M. Faisal, Project Officer (Environment), BRM, SARD A. Fox, Senior Procurement Specialist, Central Operations Services Office H. Hong, Senior Financing Partnerships Specialist, Office of Cofinancing Operations J. Mahmood, Senior Project Officer, BRM, SARD L. Nazarbekova, Senior Counsel, Office of the General Counsel G.S. Song, Senior Social Development Specialist, SARD F. Sultana, Senior Social Development Officer (Gender), BRM, SARD
Peer reviewer	S. Tanaka, Social Development Specialist, Pacific Department

In preparing any country program or strategy, financing any project, or by making any designation of or reference to a particular territory or geographic area in this document, the Asian Development Bank does not intend to make any judgments as to the legal or other status of any territory or area.

CONTENTS

	Page
PROJECT AT A GLANCE	
I. THE PROPOSAL	1
II. THE PROJECT	1
A. Rationale	1
B. Impact and Outcome	3
C. Outputs	3
D. Investment and Financing Plans	5
E. Implementation Arrangements	6
III. TECHNICAL ASSISTANCE	7
IV. DUE DILIGENCE	8
A. Economic and Financial	8
B. Governance	8
C. Poverty and Social	9
D. Safeguards	9
E. Risks and Mitigating Measures	9
V. ASSURANCES AND CONDITIONS	10
VI. RECOMMENDATION	10
APPENDIXES	
1. Design and Monitoring Framework	11
2. List of Linked Documents	14

PROJECT AT A GLANCE

1. Project Name: Urban Primary Health Care Services Delivery Project		2. Project Number: 42177-013													
3. Country: Bangladesh		4. Department/Division: South Asia Department/Human and Social Development Division													
5. Sector Classification:															
		Sectors	Primary												
		Multisector													
			√												
			Urban sector development												
6. Thematic Classification:															
		Themes	Primary												
		Social development	√												
		Private sector development													
		Gender equity													
		Governance													
			Human development												
			Public-private partnerships												
			Gender equity in human capabilities												
			Economic and financial governance												
6a. Climate Change Impact		6b. Gender Mainstreaming													
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Mitigation</td> <td style="text-align: center;">Low</td> </tr> <tr> <td>Adaptation</td> <td style="text-align: center;">Low</td> </tr> </table>		Mitigation	Low	Adaptation	Low	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Gender equity theme (GEN)</td> <td style="text-align: center;">√</td> </tr> <tr> <td>Effective gender mainstreaming (EGM)</td> <td></td> </tr> <tr> <td>Some gender benefits (SGB)</td> <td></td> </tr> <tr> <td>No gender elements (NGE)</td> <td></td> </tr> </table>		Gender equity theme (GEN)	√	Effective gender mainstreaming (EGM)		Some gender benefits (SGB)		No gender elements (NGE)	
Mitigation	Low														
Adaptation	Low														
Gender equity theme (GEN)	√														
Effective gender mainstreaming (EGM)															
Some gender benefits (SGB)															
No gender elements (NGE)															
7. Targeting Classification:		8. Location Impact:													
General Intervention	Targeted Intervention														
	Geographic dimensions of inclusive growth	Millennium development goals	Income poverty at household level												
		√ MDG4, MDG5, MDG6													
		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Urban</td> <td style="text-align: center;">High</td> </tr> </table>		Urban	High										
Urban	High														
9. Project Risk Categorization: Low															
10. Safeguards Categorization:															
		Environment	B												
		Involuntary resettlement	C												
		Indigenous peoples	C												
11. ADB Financing:															
	Sovereign/Non-sovereign	Modality	Source												
	Sovereign	Project loan	Asian Development Fund												
	Sovereign	Capacity development technical assistance	Technical Assistance Special Fund												
	Total		50.4												
12. Cofinancing:															
	Financier	Category	Amount (\$ Million)												
	Government of Sweden	Official-Grant	20.0												
	Total		20.0												
13. Counterpart Financing:															
	Source	Amount (\$ Million)													
	Government	11.0													
	Total	11.0													
14. Aid Effectiveness:															
	Parallel project implementation unit	No													
	Program-based approach	No													

I. THE PROPOSAL

1. I submit for your approval the following report and recommendation on (i) a proposed loan, and (ii) proposed administration of a grant to be provided by the Government of Sweden through Swedish International Development Cooperation Agency, both to the People's Republic of Bangladesh, for the Urban Primary Health Care Services Delivery Project.¹ This report also describes proposed technical assistance (TA) for Supporting the Urban Primary Health Care Services Delivery Project, and if the Board approves the proposed loan and administration of the grant, I, acting under the authority delegated to me by the Board, will approve the TA.

2. The project builds upon two previous urban primary health care (PHC) projects supported by the Asian Development Bank (ADB) in Bangladesh to develop and strengthen institutional capacity for sustainable delivery of pro-poor primary health services in urban areas through public-private partnerships (PPPs).²

II. THE PROJECT

A. Rationale

3. Bangladesh is undergoing rapid urbanization. This is largely fuelled by the migration from rural areas of people in search of employment and trying to escape poverty and frequent natural disasters. A result has been a growing number of impoverished city dwellers. Poor living conditions leave the urban poor, especially women and children, more exposed to health problems than the general population, a vulnerability that is compounded by their lack of public health awareness and access to basic health services. The mortality rate for children under 5 in urban slums is 91 per 1,000 live births,³ compared with 77 per 1,000 live births in rural areas.⁴ Children from the poorest urban wealth quintile are four times more likely to be chronically malnourished than children from the wealthiest urban quintile.⁵ Among the urban poor, 70% of women give birth at home with the help only of untrained traditional birth attendants.⁶ This exposes them to a higher risk of complications. The 2.46 fertility rate among urban slum dwellers is much higher than the 1.85 in non-slum areas (footnote 3). Many slum women also face domestic and workplace violence, which raises the need overall for women to have access to urgent medical attention.

4. Because the poor have a small asset base, sound health is essential for generating their daily income and subsistence. Poor health not only limits their productivity and their opportunities to earn and escape poverty but illness also often deprives them of previous income gains by forcing them to spend on emergency catastrophic health care. These factors make investment in pro-poor basic health services and public health promotion critical to reducing urban poverty and protecting the well-being of the overall population in urban areas, which account for over 60% of the country's gross domestic product.

¹ The design and monitoring framework is in Appendix 1.

² ADB provided project preparatory technical assistance. ADB. 2010. *Technical Assistance to the People's Republic of Bangladesh for Preparing the Urban Primary Health Care Sector Development Project*. Manila.

³ National Institute of Population Research and Training (NIPORT), Measure Evaluation, International Centre for Diarrheal Disease Research, Bangladesh, and Associates for Community and Population Research. 2008. *2006 Bangladesh Urban Health Survey*. Dhaka.

⁴ NIPORT, Mitra and Associates, and Macro International. 2009. *Bangladesh Demographic and Health Survey 2007*. Dhaka.

⁵ World Health Organization, Centre for Health Development. 2011. *Bangladesh: Urban Health Profile*. Kobe.

⁶ N. Fronczak, S. E. Arifeen, A. C. Moran, L. E. Caulfield, and A. H. Baqui. 2007. Delivery practices of traditional birth attendants in Dhaka slums, Bangladesh. *Journal of Health, Population and Nutrition*. 25 (4). pp. 479–487.

5. The statutory responsibility for the delivery of PHC in urban areas rests with the urban local bodies (ULBs), under the oversight of the Local Government Division (LGD) of the Ministry of Local Government and Rural Development Cooperatives (MOLGRDC). However, rapid unplanned urbanization has overwhelmed the capacity of the ULBs to meet the vast need for urban PHC. The private sector is the dominant provider of basic health care in urban areas but these services vary in quality and the poor often cannot afford them. Private health enterprises generally also do not provide disease preventive and health promotion services, which have low profit margins. These barriers, along with physical, social and other factors result in limited access to and low use of essential health services by the urban poor.

6. As a strategy for addressing the large unmet need for urban PHC, the Government of Bangladesh has long recognized the need to tap nongovernment resources and expertise to quickly expand coverage of services and reach vulnerable communities. In 1998, the government initiated a PPP pilot PHC program with support from ADB under the Urban Primary Health Care Project (UPHCP I).⁷ UPHCP I contracted out government-financed PHC services to nonprofit private service providers. Under the contracting arrangement, the private sector assumes a share of financial risks tied to their performance and cost recovery targets, as well as certain operational risks in delivering agreed services. ADB's project completion report on the UPHCP I in 2007⁸ found the PPP approach successful, innovative, and replicable, a conclusion that was validated in 2008 by ADB's Independent Evaluation Department.⁹ This resulted in a subsequent investment during 2005–2012 under the Second Urban Primary Health Care Project (UPHCP II), which expanded the area covered.¹⁰ Based on the experiences of UPHCP I and UPHCP II, the government's five-year plan for 2011–2015 called for continuing the approach established by ADB's previous urban PHC projects for delivering basic health services to the urban population.¹¹

7. The project builds on the key lessons learned from UPHCP I and UPHCP II and seek to further enhance related governance structures and health service delivery.¹² To improve governance, the project will strengthen the government's strategic framework for addressing urban health; support relevant institutional arrangements, policies, and guidelines; advocate mechanisms to mobilize regular local revenue for urban PHC; and support more direct involvement and ownership by ULBs in managing delivery of urban health services. To improve health service delivery, the project will include measures to strengthen quality, accessibility, and use of services so that they have a larger beneficial impact on urban health. These steps will include the development of a robust quality assurance system, systemized monitoring and evaluation (M&E), better identification and targeting of the poor, better physical access for the poor, and increased outreach activities.

8. The project has the following key features: (i) scaling up a pro-poor model of urban PHC services delivery through PPP to cover a wider geographic area; (ii) making substantial use of health information technology (IT) to improve service delivery, training, and management;

⁷ ADB. 1997. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Asian Development Fund Grant to the People's Republic of Bangladesh for the Urban Primary Health Care Project*. Manila.

⁸ ADB. 2007. *Completion Report: Urban Primary Health Care Project in Bangladesh*. Manila.

⁹ ADB. 2008. *Validation Report: Urban Primary Health Care Project in Bangladesh*. Manila.

¹⁰ ADB. 2005. *Report and Recommendation of the President to the Board of Directors: Proposed Loan and Asian Development Fund Grant to the People's Republic of Bangladesh for the Second Urban Primary Health Care Project*. Manila.

¹¹ Government of Bangladesh. 2011. *Sixth Five-Year Plan, 2011–2015*. Dhaka (Part 1, Chapter 5: p. 132).

¹² For a summary of key evaluation findings and lessons of UPHCP I and UPHCP II and their incorporation into project design, see Urban Primary Health Care Project Evaluation, Lessons Learned, and Design Features (accessible from the list of linked documents in Appendix 2).

(iii) integrating climate change mitigation measures (solar energy efficiency and rain water harvesting) to improve operational efficiency in selected health facilities; and (iv) supporting a subsector program framework to improve intergovernment and development partner coordination on urban health.¹³

9. ADB has addressed rapid urbanization in the country by placing a high priority on empowering local governments, improving urban planning, and making the economic growth process more inclusive.¹⁴ The proposed project conforms with ADB's holistic, multidisciplinary approach to urban sector development as a core operation in Bangladesh and will help transform the country's institutions so that they can better deal with rapid urbanization. It will reduce urban poverty and inequality, address a critical gap in urban basic services, and enhance the basic human capital and productivity of the urban poor. It aligns with ADB's Strategy 2020¹⁵ and ADB's health operational plan¹⁶ by building on areas where ADB has a comparative advantage and promoting gender equity and PPP. The project also supports the government's five-year plan commitment to developing strategic partnerships with private sector and nongovernment organizations that can provide support in areas that have traditionally been in the public sector domain and to promote PPPs as a key element of good governance.¹⁷

B. Impact and Outcome

10. The impact of the project will be the improved health of the urban population in Bangladesh, particularly the poor, women, and children. The outcome will be sustainable good quality urban PHC services provided in project areas that target the poor and the needs of women and children.

C. Outputs

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

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

12. **Support for the Local Government Division.** To assist sustained delivery of urban PHC, the project will support strengthening strategic framework for urban health and relevant institutional set-ups. The project will help the LGD implement the country's draft national urban health strategy, in coordination with the Ministry of Health and Family Welfare (MOHFW).¹⁸ The strategy will cover (i) institutional arrangements for urban health in the LGD, (ii) a relevant permanent interministerial coordination structure, (iii) clarification of the mandate of the LGD in relation to the MOHFW for supporting the ULBs in carrying out their urban health responsibilities, and (iv) sustainable financing for urban PHC. The project will also support capacity building of the urban health unit that is being established in the LGD,¹⁹ reviewing and updating LGD policies and guidelines to better address crosscutting urban health issues, and

¹³ Development Coordination (accessible from the list of linked documents in Appendix 2).

¹⁴ ADB. 2011. *Country Partnership Strategy: Bangladesh, 2011–2015*. Manila.

¹⁵ ADB. 2008. *Strategy 2020: The Long-Term Strategic Framework of the Asian Development Bank, 2008–2020*. Manila.

¹⁶ ADB. 2008. *An Operational Plan for Improving Health Access and Outcomes under Strategy 2020*. Manila.

¹⁷ Government of Bangladesh. 2011. *Sixth Five Year Plan, 2011–2015*. Dhaka (Part 1, Chapter 9: p. 231).

¹⁸ Development of the draft national urban health strategy was supported under ADB. 2010. *Technical Assistance to the People's Republic of Bangladesh for Preparing the Second Urban Primary Health Care Project*. Manila.

¹⁹ The envisaged mandate of the urban health unit will cover public health, environmental health, and PHC.

guidelines for ULBs in PPP contract management for urban PHC and in utilization of central government development block grants to encourage increased local government planning and allocations for pro-poor basic social services.²⁰

13. **Support for local governments.** The LGD places a very high priority on strengthening local government institutions and providing them with the assistance necessary for efficient provision of locally relevant public services, including PHC for the poor. The project's support for strengthening local government institutions will target the ULB health departments, which are mainly responsible for delivering urban PHC. Through capacity building, the project will enable ULB health departments to continue managing the urban PHC systems in their localities after the project ends. This will include developing reorganization and staffing plans and strengthening their skills in core project management and in PPP contract management using the UPHCP model. The project outcome will be made more sustainable by enhancing the ULBs' ownership of project services and their increased allocation of resources to urban health. Over the project period, participating ULBs will be required to (i) contribute at least 1% of their local revenue to the urban PHC sustainability fund established by the Ministry of Finance,²¹ and (ii) to gradually increase allocations for urban PHC to at least 20% of the development block grants. To support this greater allocation of resources to urban health, the project will finance an advocacy program to sensitize local governments and the local public to urban health issues. The project will help make the use of limited local public expenditures more efficient by coordinating with the LGD to train ULBs on integrated planning and budgeting for basic social services, including PHC and public and environmental health.

14. **Management systems and innovations.** To support management systems, learning, and innovation in urban PHC, the project will help the government and the implementing partners to effectively adapt IT to manage and deliver services efficiently. This will include support for a computerized health management information system that will ultimately link with the M&E functions of the LGD and the MOHFW; geographic information system mapping of existing health facilities in the partnership agreement areas to improve referral links; and incorporation of e-learning and e-assessment in the project training program. The project will also support an operations research program by reputable research institutions that will become knowledge hubs on urban health.

2. **Output 2: Improved Accessibility, Quality, and Utilization of Urban Primary Health Care Services Delivery System, with a Focus on the Poor, Women, and Children, through Public-Private Partnership**

15. Under this output, the project will (i) support provision of PHC services, including behavior change communication (BCC), through partnership agreements with the nonprofit private sector in 30 partnership areas covering all cities and selected municipalities; and (ii) strengthen the urban PHC infrastructure network to improve physical accessibility.

16. **Urban primary health care services.** The project will deliver a package of essential PHC services aligned with operations of the MOHFW and include comprehensive emergency obstetrics care. The package will focus on maternal and child health, nutrition, family planning, and BCC. Better access to PHC services and health information will bolster the population's resilience to the health related effects of climate change, given the country's great vulnerability

²⁰ Central government support for city corporations and municipalities is through block grants and grants-in-aid from the LGD. The grants-in-aid are for specific activities under the development budget; block grants are for general budgetary support. These mechanisms are outside of project financing.

²¹ The urban PHC sustainability fund was established 22 September 2008 under UPHCP II with objective to sustain PHC services in respective city corporations and municipalities following project completion.

to natural calamities and the diseases and injuries that result, particularly among the poor.²² The project will improve the accessibility, quality, and utilization of PHC services. At least 30% of all services, including drugs, will be given free to the poor, with specific emphasis on women. The project will also allocate additional resources to identifying and targeting the urban poor and will include weekly mobile outreach services to reach the extremely poor and the homeless population. The project will establish collaboration agreements with local partners to reach more of the impoverished in urban areas and to set up effective referral networks.²³ It will work to improve the quality of PHC through strong quality assurance mechanisms; support for the training and qualification of health workers and health managers; a better supply of drugs and medical equipment; and introduction of a small-scale performance incentive scheme and innovation fund in partnership contracts to enhance the accountability of partners for their results and to encourage innovations to improve service delivery.

17. **Infrastructure network.** The project will improve access to and coverage of PHC services by supporting expansion of the urban PHC infrastructure network, including the construction of 12 comprehensive reproductive health centers and 26 PHC centers near slums and other densely populated areas. This new infrastructure will be better designed and more functional than centers provided under UPHCP I and II. The upgrades will include solar power and rainwater harvesting in selected facilities to improve operational efficiency and mitigate climate change impacts.

3. Output 3: Effective Support for Decentralized Project Management

18. The project will support the government's sixth five-year plan's priorities of capacity development in public administration and devolution of responsibilities to local governments by progressively devolving the management and implementation responsibilities of its project management unit (PMU) in the LGD to project implementation units (PIUs) in the health departments of each project city corporation or municipal government. This will strengthen the oversight and supervisory capabilities of the PMU and the management and implementation capacities of the PIUs and ultimately strengthen the project's sustainability. The project will give the PMU and PIUs management and technical support in such key areas as PPP contracting, urban PHC, human resources development, quality assurance, procurement, and financial management. The financial management system employed under UPHCP II will be improved and computerized under the project to minimize fiduciary risks and streamline project accounting processes. The responsibilities of a training coordination cell to be established in the PMU will include detailed review and planning of project capacity development requirements, strategic collaboration with other agencies and training institutes, development of guidelines, and implementation of the training program. The project will also have a strong performance and benefits M&E program that will include support for the health management information system, routine monitoring, and rigorous evaluations of project impacts and effectiveness through household, facility-based, and qualitative surveys.

D. Investment and Financing Plans

19. The project is estimated to cost \$81 million (Table 1).

²² Several studies have shown that Bangladesh is highly vulnerable to the impacts of climate change and that diseases and a wide range of health concerns arise from the damage caused by climate change.

²³ The agreements would be at either project or partnership agreement level with Bangladesh Garment Manufacturing Export Association, Bangladesh Rural Advancement Committee, and the United States Agency for International Development Smiling Sun Franchise Program.

Table 1: Project Investment Plan

Item	Amount (\$ million)
A. Base Cost^a	
1. Output 1: Strengthened institutional governance and local government capacity to sustainably deliver urban PHC services	3.82
2. Output 2: Improved accessibility, quality, and utilization of urban PHC services delivery system, with a focus on the poor, women and children through PPP	62.43
3. Output 3: Effective support for decentralized project management	8.00
Subtotal (A)	74.25
B. Contingencies	5.45
C. Financing Charges during Implementation^b	1.30
Total (A+B+C)	81.00

PHC = primary health care, PPP = public-private partnership.

^a Includes taxes and duties of \$6.85 million to be financed from government resources.

^b Includes interest during construction computed at 1% per annum on the disbursed and outstanding amount.

Source: Asian Development Bank.

20. The government has requested a loan in various currencies equivalent to SDR32,798,000 from ADB's Special Funds resources to help finance the project. The loan will have a 32-year term, including a grace period of 8 years, an interest rate of 1.0% per annum during the grace period and 1.5% per annum thereafter, and such other terms and conditions as set forth in the loan and project agreements.²⁴ Interest during construction will be capitalized. The government has requested cofinancing from the Government of Sweden in the form of a cofinancing grant to be administered by ADB. The United Nations Population Fund will provide parallel financing to support complementary activities.²⁵ Discussion with United Kingdom's Department for International Development and ORBIS International is underway for possible additional cofinancing.

21. The financing plan is in Table 2. ADB will finance \$50 million (61.72% of the financing), the Government of Sweden will provide the equivalent of \$20 million (24.70%), and the Government of Bangladesh will provide the equivalent of \$11 million (13.58%).

Table 2: Financing Plan^a

Source	Amount (\$ million)	Share of Total (%)
Asian Development Bank	50.00	61.72
Government of Sweden ^b	20.00	24.70
Government of Bangladesh	11.00	13.58
Total	81.00	100.00

^a Parallel financing for complementary services will be provided through a \$3.0 million grant by the United Nations Population Fund.

^b Administered by the Asian Development Bank (ADB). This amount also includes ADB's administration fee, audit costs, bank charges, and a provision for foreign exchange fluctuations (if any), to the extent that these items are not covered by the interest and investment income earned on this grant, or any additional grant from the Government of Sweden.

Source: Asian Development Bank estimates.

E. Implementation Arrangements

22. The LGD of the MOLGRDC will be the executing agency and city corporations and municipal governments will be the implementing agencies in their project areas. A PMU established under UPHCP II headed by a full-time project director will be continued in the LGD to provide the technical, administrative, and logistical support required for implementation. An interministerial national project steering committee, chaired by the secretary of LGD and established under UPHCP II will oversee overall project implementation. The project will create

²⁴ The ADB loan will also finance transportation and insurance costs.

²⁵ The United Nations Population Fund will provide support in comprehensive emergency obstetrics care (including equipment and ambulances); family planning (including outreach, materials, and BCC); and adolescent sexual reproductive health (Project Administration Manual [accessible from the list of linked documents in Appendix 2]).

PIUs in ULB health departments to oversee implementation in project cities and municipalities. Urban health coordination committees (UHCCs) will be set up in each project city or municipality to coordinate field activities and stakeholder participation. They will be chaired by ULB chief executive officers. Because cities and municipalities are divided into wards for administrative purposes, ward UHCCs cochaired by ward commissioners and zonal health officers will be created and include representation from local stakeholders. Where standing committees with similar responsibilities already exist—dealing with health and water and sanitation, for example—the role envisaged for the UHCCs may be assigned to these committees so that parallel structures are not set up.

23. Procurement of civil works, goods, and related services will be in accordance with ADB's Procurement Guidelines (2010, as amended from time to time). Packages using national competitive bidding may follow the government's Public Procurement Act, 2006 and Public Procurement Rules, 2008, with modifications agreed between the government and ADB, as set out in the procurement plan. Consulting services will be engaged in accordance with ADB's Guidelines on the Use of Consultants (2010, as amended from time to time). The implementation arrangements are summarized in Table 3 and described in detail in the project administration manual (PAM), which includes an indicative procurement plan.

Table 3: Implementation Arrangements

Aspects		Arrangements	
Implementation period		July 2012–June 2017	
Estimated completion date		30 June 2017	
Management			
(i) Oversight body		National Project Steering Committee; Secretary, LGD (chair); representatives of Ministry of Health and Family Welfare, project urban local bodies, Ministry of Finance, and Planning Commission (members)	
(ii) Executing agency		LGD, Ministry of Local Government and Rural Development Cooperatives	
(iii) Key implementing agencies		City Corporations, municipal governments	
(iv) Implementation unit		A PMU set up under UPHCP II will be continued within the LGD with 18 proposed staff.	
Procurement		ICB NCB Shopping	30 partnership contracts Civil works, vehicles Office equipment, furniture \$36.70 million \$16.64 million \$0.32 million
Consulting services		Firm (QCBS, 90:10) Firm (QCBS, 80:20) Firm (QCBS, 80:20) Firm (CQS) Individual Consultants	Monitoring and evaluation Behavior change communication program Health management information system Operations research (2 packages) 11 person-months, international (2 persons); 208 person-months, national (9 persons) \$1.20 million \$1.50 million \$1.15 million \$0.50 million \$1.17 million
Retroactive financing and/or advance contracting		ADB may, subject to its policies and procedures, allow on request advance contracting of procurement and consulting services, and may finance up to 20% of the loan and the grant amount for eligible expenditures for operational costs incurred in the 12-month period before signing of the loan agreement. Any approval of advance contracting or retroactive financing will not constitute a commitment by ADB to finance the project.	
Disbursement		The loan and grant proceeds will be disbursed in accordance with ADB's <i>Loan Disbursement Handbook</i> (2007, as amended from time to time) and detailed arrangements agreed upon between the Government of Bangladesh and ADB.	

ADB = Asian Development Bank, CQS = consultant qualification selection, ICB = international competitive bidding, LGD = Local Government Division, NCB = national competitive bidding, PMU = project management unit, QCBS = quality- and cost-based selection, UPHCP II = Second Urban Primary Health Care Project.

Source: Asian Development Bank.

III. TECHNICAL ASSISTANCE

24. A TA of \$400,000 is proposed to be attached to the project on a grant basis from ADB's Technical Assistance Special Fund (TASF-IV). The TA will be implemented over 18 months and

provide capacity building and implementation support to minimize delays in project start-up.²⁶ The LGD will be the executing agency for the TA and it will implement the TA through the PMU. ADB will engage the consultants on an individual basis in accordance with its Guidelines on the Use of Consultants (2010, as amended from time to time).

IV. DUE DILIGENCE

A. Economic and Financial

25. **Economic viability.** The project's economic viability has been assessed based on the associated benefits and costs. The economic benefits include (i) the direct benefit for project beneficiaries in health care cost savings; and (ii) productivity gains in terms of disability adjusted life years saved, and such other expected benefits as fewer work days lost due to illness, positive externalities of immunization, and health improvements that will lead to better learning outcomes in school. Three major streams of economic costs are (i) the investment costs, which include the costs of constructing and upgrading PHC facilities, of purchasing equipment, of installing IT-based systems, and of providing training; (ii) indirect project-related costs, including those of maintaining, replacing, and upgrading capital investment, such as the costs of maintaining PHC facilities; and (iii) the operating costs of administration, wages, transport, and utilities. The project's estimated net present value is \$17.5 million. The estimated economic internal rate of return is 27.8%, assuming a discount rate of 12%. A sensitivity analysis shows that the project will yield economic internal rates of return of over 12% even with significant adverse changes to key assumptions. This suggests that the project is a sound investment.

26. **Financial sustainability.** Financial affordability and sustainability of the project has been analyzed based on the country's medium-term budgetary framework and current five-year plan. The government's annual commitment to the project as a percentage of total government expenditure averages 0.08% over the five-year period. The long-term sustainability of the project will depend on several key factors: (i) cost recovery; (ii) the ability of the LGD to cover estimated investments and associated recurrent expenditures for urban health; (iii) gradual increases by ULBs in their allocation for urban PHC and other pro-poor basic services to at least 20% of the development block grants (footnote 20); and (iv) delivery of at least 1% contribution by each participating ULB of their annual revenue budget to the urban PHC sustainability fund (footnote 21). Given a positive outlook for growth in gross domestic product and government investment, allocations for local government development are expected to increase and urban health programming will likely receive more resources than it does now. The cost of continuing the program for one year after the project ends in 2017 have been projected at Tk0.92 billion, or 0.05% of total government expenditure. The government is projected to be fiscally able to provide this level of funding.

B. Governance

27. Project-related governance risks have been assessed, as required by ADB's *Guidelines for Implementing the Governance and Anticorruption Action Plan II*.²⁷ The assessment found that adequate management system and staff capacity were established in the PMU under UPHCP II and will be retained. Because this project will have greater geographic coverage and aims to develop sustainable capacity in ULBs for delivering basic health services, the risk assessment and management plan makes several recommendations to strengthen capacity both in the executing and implementing agencies and to improve procedures for efficient

²⁶ Details of the TA are in Technical Assistance for Supporting the Urban Primary Health Care Services Delivery Project (accessible from the list of linked documents in Appendix 2).

²⁷ ADB. 2008. *Guidelines for Implementing the Governance and Anticorruption Action Plan II*. Manila.

management and effective control in financial management and procurement.²⁸ ADB's Anticorruption Policy (1998, as amended to date) was explained to and discussed with the government and the LGD. The specific policy requirements and supplementary measures are described in the PAM and key ones are reflected in the loan covenants.

C. Poverty and Social

28. The project will improve the lives and productivity of the urban poor by providing them with affordable access to basic health services. It will expand the reach of basic health services through pro-poor project interventions. These will include strong outreach activities to ensure community participation in all stages of project implementation and evaluation, social and BCC activities targeting the most vulnerable populations, strengthened poverty identification and targeting, and the management of a fee-exemption system. By focusing on women's health, the project will enhance gender equity. A gender action plan has been prepared to promote gender equity in the project areas by such measures as (i) reducing inequalities in sex-disaggregated health indicators, and (ii) gender training and institutional support while developing personnel capacity in gender mainstreaming and monitoring project outputs.

D. Safeguards

29. **Environment.** This is a category B project. The project will support construction of new healthcare centers and the improvement of existing facilities. It is not expected to have significant or irreversible negative environmental impacts during either construction or operation. Any environmental risks will be effectively addressed through proper mitigation measures at the design, planning, construction, and operation phases. An environment assessment and review framework has been prepared and disclosed because land and sites for project civil works will be identified only after implementation begins. The executing agency has ample institutional capacity to carry out environmental safeguards and compliance measures, along with capacity to manage related risks and implementation of the environmental assessment and review framework.

30. **Social safeguards.** This is a category C project for involuntary resettlement and indigenous peoples. No land acquisition will be involved because existing unoccupied land already owned by the ULBs will be used for project's civil works. The project will use institutional arrangements and assurance mechanisms to ensure compliance with safeguard requirements in new construction. A resettlement framework for conducting social screening, assessment, and stakeholder consultations is included in the PAM. Since this project covers only urban areas, no impact on indigenous peoples is expected.

E. Risks and Mitigating Measures

31. Major risks and mitigating measures are summarized in Table 4.

Table 4: Summary of Risks and Mitigating Measures

Risks	Mitigating Measures
Fiduciary and fund flow. Compliance with public financial management procedures, particularly on record-keeping, accounting, and internal controls is inadequate due to lack of staff capacity and understanding of rules. Delayed payment to contractors and frequent cash flow problems affect timely project implementation.	A financial management specialist will be hired to improve the staff capacity and financial management system of PMU and PIUs. A computerized financial management system will be developed to address cumbersome manual reconciliation of books. The PMU will closely monitor cash flow status and address payment bottlenecks to avoid cash flow issues and payment delays. Authority to make quarterly payments for contracts of partner NGOs will be delegated to well performing implementing agencies, with post-audit done by PMU.

²⁸ The recommendations are summarized in the Risk Assessment and Management Plan (accessible from the list of linked documents in Appendix 2).

Risks	Mitigating Measures
Partnership. Difficult relations between local governments and the NGO partners disrupt smooth implementation of partnership agreements. The NGO partners are not supervised effectively.	The project will establish a partnership committee with wide representation from local governments and the private sector to mediate and ensure smooth relations between contracting parties and for fair and transparent performance monitoring. The project will have a robust monitoring and evaluation and quality assurance system with objective indicators of performance to monitor service delivery. International consulting services supported under the associated technical assistance and a bid evaluation committee with wide representation from government agencies and development partners will help the LGD prepare and evaluate bid documents and contracts.
Financial sustainability. Recurrent expenditures are inadequate to sustain contracts with and services of partnership agreement NGOs after the project ends.	These risks will be mitigated by (i) enhancing ownership of the project outcome by urban local bodies and their commitments to increase their allocations of local government resources to urban health; (ii) providing guidelines and capacity building support for local governments to improve efficient use of their finances; and (iii) supporting the implementation of an urban health strategy and related subsector framework under the government's next five-year plan to create fiscal space and program planning, as well as for mobilizing longer-term commitments of other development partners' resources.
Governance and anticorruption. Governance risks are not improved. Citizen demands for participation and greater transparency and accountability from government are not met.	In addition to ensuring awareness of ADB's zero tolerance policy for fraud and corruption, the project will make information on implementation progress, procurement, and recruitment activities public via a project website for enhanced transparency, and accountability, in line with ADB's Public Communications Policy (2011).

ADB = Asian Development Bank, LGD = Local Government Division, NGO = nongovernment organization, PIU = project implementation unit, PMU = project management unit.

Source: Asian Development Bank.

V. ASSURANCES AND CONDITIONS

32. The government, the MOLGRDC, and the LGD have assured ADB that implementation of the project shall conform to all applicable ADB policies, including those concerning anticorruption measures, safeguards, gender, procurement, consulting services, and disbursement as described in detail in the PAM and loan documents. The government, the MOLGRDC, and the LGD have agreed with ADB on certain covenants for the project, which are set forth in the loan agreement, the grant agreement, and the project agreement.

VI. RECOMMENDATION

33. I am satisfied that the proposed loan would comply with the Articles of Agreement of the Asian Development Bank (ADB) and recommend that the Board approve

- (i) the loan in various currencies equivalent to SDR32,798,000 to the People's Republic of Bangladesh for the Urban Primary Health Care Services Delivery Project, from ADB's Special Funds resources, with an interest charge at the rate of 1.0% per annum during the grace period and 1.5% per annum thereafter; for a term of 32 years, including a grace period of 8 years; and such other terms and conditions as are substantially in accordance with those set forth in the draft loan and project agreements presented to the Board; and
- (ii) the administration by ADB of the grant not exceeding the equivalent of \$20,000,000 to the People's Republic of Bangladesh for the Urban Primary Health Care Services Delivery Project, to be provided by the Government of Sweden.

Haruhiko Kuroda
President

26 June 2012

DESIGN AND MONITORING FRAMEWORK^a

Design Summary	Performance Targets and Indicators with Baselines	Data Sources and Reporting Mechanisms	Assumptions and Risks
Impact Improved health of the urban population, particularly the poor, women, and children	By 2020, for urban population: MMR is reduced from 194 to 143 per 100,000 live births U5MR is reduced from 63 to 48 per 1,000 live births and gender disparities eliminated (<5% difference) Proportion of underweight is reduced from 28% to 21% and stunted children reduced from 36% to 27% and gender disparities reduced (<5% difference between sexes) TFR is maintained at 2.0 Differentials in MMR, U5MR, TFR, and child malnutrition between the lowest wealth quintile and the highest wealth quintile in urban areas is reduced by 15%	BMMS 2010, MDG and future BMMS reports BDHS 2007, MDG and future BDHS reports BDHS 2011, MDG and future BDHS reports BDHS 2011, MDG and future BDHS reports	Assumption The government and partner institutions remain committed to health as a priority for inclusive growth and reducing poverty. Risk The priorities and programs of the Government of Bangladesh change.
Outcome Sustainable good quality urban PHC services are provided in the project areas and target the poor and the needs of women and children	By 2017, in project areas: 60% of births are attended by skilled health personnel (baseline: 26.5% BMMS 2010) At least 80% of growth monitoring and promotion performed on under-5 children (baseline: 43.3% UPHCP II 2008) At least 60% of eligible couples use modern contraceptives (baseline: 53% UHS 2006) At least 80% of poor households are properly identified as eligible for free healthcare (baseline: 67% UPHCP II 2008) At least 80% of the poor access project health services when needed (baseline: 64.7% UPHCP II 2008) At least 90% of project clients express satisfaction with project services (baseline: 76% UPHCP II 2009)	For all indicators: Project baseline and end-line surveys (household, facility-based, and qualitative) ISI UHS ULB annual development plans	Assumption The government implements investment programs and strategies for strengthening the delivery of pro-poor urban PHC services effectively. Risks Governance and corruption risks are not minimized. Citizen demands for greater participation, transparency, and accountability are not met. ULBs lack sufficient funds to implement programs and strategies for strengthening pro-poor urban PHC services.
Outputs 1. Strengthened institutional governance and local government capacity to sustainably deliver urban PHC services	Governance and capacity Permanent and functional inter-agency coordination structure for urban health is established by December 2013 All project ULBs have a functioning health department with at least 1 staff in each health department trained in PPP contract management and core project management skills by 31 December 2013 Gender-responsive data collection and analysis are computerized through HMIS in 80% of partnership areas by 31 December 2014	For all indicators: Project baseline and end-line surveys (household, facility-based, and qualitative) Project joint review missions Project training program evaluation Project quarterly progress reports	Assumption All participating ULBs are adequately funded and are committed to delivering urban PHC services. Risks Political pressures at the ULB level divert resources and efforts away from the delivery of PHC services.

Design Summary	Performance Targets and Indicators with Baselines	Data Sources and Reporting Mechanisms	Assumptions and Risks
	<p>Sustainability and commitment</p> <p>At least 50% increase in overall allocation to the urban primary health care sustainability fund compared to UPHCP II (2011 baseline: Tk38.5M)</p> <p>At least 5% per annum increase of ULB annual development plans and block grants allocated for PHC and public health related services (2011 baseline: No)</p>	<p>Status report of Urban Health Sustainability Fund</p> <p>ULB annual development plans</p>	<p>Recurrent expenditures are inadequate to sustain services of partnership agreement NGOs after the project ends.</p>
<p>2. Improved accessibility, quality, and utilization of urban PHC services, with a focus on the poor, women, and children, through PPP</p>	<p>By midterm review and sustained until project completion:</p> <p>Accessibility and utilization</p> <p>At least 30% of each of the major project healthcare services (including caesarian section) is provided free-of-charge to holders of government-issued red cards that identify them as poor.</p> <p>At least 80% of facilities planned for construction and upgrading are functioning normally within 3 years of loan effectiveness (12 CRHCCs and 26 PHCCs)</p> <p>Quality</p> <p>At least 80% of children consulting project PHC services for acute respiratory infection receive correct treatment.</p> <p>At least 80% of children consulting for diarrhea receive correct treatment.</p> <p>PPP performance and accountability</p> <p>100% of partnership area NGOs achieves internal quality compliance (financial management, updated clinical registers, clinical waste management, inventory management).</p>	<p>For all indicators:</p> <p>Project baseline and end-line surveys (household, facility-based, qualitative)</p> <p>ISI</p> <p>Patient satisfaction survey (as part of project baseline and end-line survey)</p> <p>Project HMIS</p>	<p>Assumptions</p> <p>Social and cultural factors do not bar the poor and women from accessing facility-based PHC services.</p> <p>NGOs and the government are committed to accountability and performance in PPP contract management.</p> <p>Risk</p> <p>Procedural problems arise in contracting process, because relations between ULBs and contracted NGOs do not remain smooth or NGO partners are not supervised effectively.</p>
<p>3. Effective support for decentralized project management</p>	<p>A fully functional PMU with at least 20% of the staff female is established by loan effectiveness and PIUs are established in ULBs within 3 months of loan effectiveness.</p> <p>Computerized FMIS is functioning fully in partnership areas by 31 December 2014, streamlining accounting procedures and processes at all levels of project implementation (PMU, PIUs, and partner NGOs).</p> <p>Project monitoring and evaluation surveys, follow-up on findings, data collection, and quarterly progress reporting are implemented on schedule.</p>	<p>Project HMIS</p> <p>Project joint review, ADB missions</p> <p>Project quarterly progress reports</p>	<p>Assumptions</p> <p>Qualified counterpart staff and government counterpart funding are available on time.</p> <p>Adequate staffing is available to enforce internal controls and sound financial management.</p> <p>Risk</p> <p>Turnover of counterpart technical staff is high due to resignations, promotions, or assignments to other government or private offices.</p>

Activities with Milestones		Inputs	
1. Strengthened institutional governance and local government capacity to sustainably deliver urban PHC services		ADB:	\$50 million equivalent
		Item	Amount (\$ million equivalent)
1.1.	Draft operational plan of national urban health strategy to implement in collaboration with MOHFW and in consultation with development partners, within 6 months of loan effectiveness	Civil works	15.72
		Utility vehicles	0.93
		ICT, furniture, and office equipment	1.53
1.2.	Develop draft implementation guidelines for ULBs (PPP contract management; use of central government block grants and Urban Health Sustainability Fund), and fully implement training program on urban PHC services for LGD and ULB staff, within 1 year of loan effectiveness	Consulting services (not operations research)	5.02
		Partnership agreements	21.09
		Training and workshops	0.54
		Geographic information system health facilities mapping	0.15
1.3.	Complete ULB perception survey by December 2013 for all project ULBs and develop and implement a marketing/advocacy program by March 2014	Interest charge	1.30
1.4.	Make HMIS fully-operational in all partnership areas by January 2015; initiate all operations research studies by June 2013 for completion by June 2015	Unallocated	3.72
2. Improved accessibility, quality, and utilization of urban PHC services delivery system, with a focus on the poor, women, and children, through PPP		Government of Sweden:	\$20 million equivalent
		Item	Amount (\$ million equivalent)
2.1.	Sign partnership agreements with NGOs in 30 partnership areas—within 6 months of loan effectiveness for the 24 existing partnership areas, and within 1 year of loan effectiveness for 6 new partnership areas	Consulting services (operations research)	0.50
		Partnership agreements	15.91
		Training and workshops	1.56
2.2.	Draw up a list of the poor in every partnership area, within 3 months of loan effectiveness and distribute red cards to those identified as poor within 5 months of the signing of the partnership agreement, with proper annual updating	Review and special audit	0.23
		Urban strategy implementation	0.20
2.3.	Conduct ISI surveys every 6 months from loan effectiveness and regular follow-up and feedback of ISI findings by quality assurance team	Unallocated	1.60
3. Effective support for decentralized project management		Government:	\$11 million equivalent
		Item	Amount (\$ million equivalent)
3.1.	Establish a fully functional PMU with at least 20% of the staff female and PIUs in ULBs within 3 months of loan effectiveness	Land registration	0.15
3.2.	Recruit consultants to provide technical support to PMU	Duties and taxes	6.85
3.3.	Have fully functional FMIS in place by January 2015	Project management staff and operating cost	3.56
3.4.	Finalize training plan by 31 March 2013. Ensure that training activities are timely and at least 80% of scheduled participants attend the training sessions	Construction services (LGED)	0.31
		Unallocated	0.13
		ADB Attached TA	\$0.40 million
		Item	Amount (\$ million)
		Consultant services	0.382
		Training and seminars	0.005
		Miscellaneous support costs	0.008
		Contingencies	0.005

ADB = Asian Development Bank, BDHS = Bangladesh demographic and health survey, BMMS = Bangladesh maternal mortality survey, CRHCC = comprehensive reproductive health care center, FMIS = financial management information system, HMIS = health management information system, ICT = information and communications technology, ISI = integrated supervisory instrument, IT = information technology, LGD = Local Government Division, MDG = Millennium Development Goal, MMR = maternal mortality ratio, MOHFW = Ministry of Health and Family Welfare, NGO = nongovernment organization, PHC = primary health care, PHCC = primary health care center, PIU = project implementation unit, PMU = project management unit, PPP = public–private partnership, TFR = total fertility rate, U5MR = under-5 mortality rate, UHS = urban health survey, ULB = urban local body, UPHCP II = Second Urban Primary Health Care Project.

^a Baseline and target indicators at impact and outcome levels will be updated following availability of 2011 BDHS, BMMS, and UPHCP II end-line survey data.

Source: Asian Development Bank.

LIST OF LINKED DOCUMENTS

(<http://adb.org/Documents/RRPs/?id=42177-013-3>)

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

Supplementary Documents

15. Financial Management Assessment
16. Procurement Capacity Assessment
17. Local Government Institutional Assessment
18. Urban Primary Health Care Project Evaluation, Lessons Learned, and Design Features
19. Technical Assistance for Supporting the Urban Primary Health Care Services Delivery Project