

# Urban Primary Healthcare Program (Phase II) in Bangladesh

## *Secondary Case Study*

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# Context

Bangladesh has been undergoing a process of rapid urbanization over the past two decades, with increasing numbers of rural residents moving to urban areas due to poverty and a changing rural environment marked by river erosion and frequent natural disasters. Much of this formerly pastoral population migrated to informal settlements in urban areas, which often lack access to proper hygiene, healthcare, and social services. This caused a balloon in the burden of urban residents without reliable access to primary healthcare services, especially because the government's capacity to provide services did not scale at the same pace as the changing population dynamics within Bangladesh's cities. In order to meet the needs of the growing populace living in urban informal settlements, the government chose to expand primary health care coverage through partnerships with the private sector (Albis et al. 2019)

The Urban Primary Healthcare Project (UPHCP) has been a staple of urban public health in Bangladesh since 1998, expanding to numerous cities in the country over the course of 22 years and 4 project phases. Conceived by the Government of Bangladesh (GoB), with the support of Asian Development Bank (ADB) and a variety of other donors, UPHCP began as an effort to improve health coverage for the country's rapidly growing population of urban poor, who were increasingly facing difficulties accessing affordable health services. The core of the program focused on a partnership between the central Ministry of Local Government, Rural Development and Cooperatives (MOLG), Urban Local Bodies (ULBs), and local urban non-governmental organizations (NGOs) whereby the MOLG and ULBs contracted NGOs to provide primary healthcare services in an effort to expand coverage of government-funded care (Albis et al. 2019).

The first phase of the project (UPHCP-I), lasting from 1998-2005, focused on setting up contractual arrangements for primary health care service provision between ULBs and NGOs in the city corporations of Dhaka, Chittagong, Khulna, and Rajshahi. Impact evaluations indicated positive maternal/child health outcomes resulting from this new model (Heard et al., 2013; Albis et al. 2019). This led to the second phase of the project, UPHCP-II (2005-2012), the focus of this case study, which extended the program's reach to two additional city corporations - Barisal and Sylhet - and five municipalities - Bogra, Comilla, Sirajganj, Madhabdi, and Savar (ADB 2014).

UPHCP-II was a comprehensive program, aiming to tackle the issue of urban health through a variety of activities. Most relevant for the purposes of this case study is the contracting-out of an essential services package (created by the central Ministry of Health and Family Welfare (MoH)) to NGOs, which included: immunization; micronutrient malnutrition support; family planning; prenatal, obstetric, and postnatal care; HIV/AIDS care; and other maternal, child, and reproductive health services. These services and related medications were provided for free to the poor, identified through health entitlement cards allocated via a household poverty survey (Albis et al. 2019).

There are several other components to this work that are important to acknowledge. In addition primary health services, the project also focused on sanitation and hygiene measures, including case management of childhood pneumonia and diarrhea; services dealing with tuberculosis, leprosy, malaria, filarial and visceral leishmaniasis; and health education. The project also had a behavioral change component, aimed at educating the urban population in order to improve health behaviors (Albis et al. 2019). While these additional components likely contributed to program success, our focus for this study is an analysis of the engagement between the public and private sectors.

Contracting between the government and the NGOs was run by a central Project Management Unit (PMU) under the MOLG, which provided technical, administrative and logistical leadership (Islam et al. 2018). NGOs provided bid packages, consisting of separate technical and financial components to the PMU. Bids were initially assessed based on the strength of the technical proposal, and then the contract was awarded to the lowest cost proposal deemed technically sound. NGOs agreed to meet certain service delivery and quality targets, evaluated via regular monitoring checks, if selected for a government contract (ADB 2014; Albis et al. 2019).

This case study explores the implementation and results of UPHCP-II, including whether and how it achieved its intended outcomes and the factors that may have helped or hindered the success of this public-private engagement. The remainder of the case study is organized into the following sections: Methods; Results; Key Success Factors; and Discussion.

# Methods

This case study is one of six developed for the Strengthening Mixed Health Systems (SMHS) project that presents analysis from existing evaluations of public-private engagements for health and new interviews and review of the data. The secondary case data collection and analysis for all six cases uses both existing research and supplemental primary data collection to answer the questions: (1) is there evidence that this public private engagement (PPE) is associated with improved outcomes, and (2) what factors are associated with helping and/or hindering the success of the engagement. After identifying the PPEs for these case studies, we undertook a structured search of the literature to compile existing peer-reviewed and grey literature about the PPE that would help us to answer the above questions. In addition, we attempted to interview researchers of PPE evaluations and PPE implementers/partners, when they could be identified, to collect supplementary data on the two questions. The resulting documents and transcripts were then coded and analyzed using a set of closed codes centering on four themes: PPE context and background, theory of change, process evaluation results (activities, outputs, and outcomes), and helping/hindering factors. The qualitative analysis of the process evaluation results and factors coding is presented in the Results section of the case study. For the factor coding specifically, we utilized a set of codes designed based on the PPE Factor Ecosystem that was developed as part of the SMHS project; a description of the ten factors is included in Box 1.

## **Box 1. PPE Factor Ecosystem**

The factors presented in the Results were developed as part of a systematic evidence review conducted by the research team. This review surfaced common factors in the published literature that were cited as playing a role in either helping or hurting the success of PPEs, resulting in the development of a new ecosystem framework. The factors in the ecosystem include Environmental, Structural, and Engagement factors, specifically:

- Environmental – shaping the environment in which a PPE operates (including political, financial, legal and organizational).
- Structural – defining the architecture of a PPE (including engagement models, formality, and resources for engagement).
- Will to engage - the intention, interest, or commitment of individual PPE actor and their institutions to enter and sustain the engagement.
- Trust - the belief that the opposite sector is acting in good faith and has the goodwill and integrity to effectively participate in an engagement.
- Mutual understanding – the understanding of the opposite sector’s capacities, motivations, resources, and role in the health system.
- Communication – the process and approach used by sector partners to exchange information and participate in dialogue.
- Engagement rationale – the basis of and motivation for the engagement.
- Technical and managerial capacities – the capacities of PPE actors related to the technical area of PPE focus as well as project management and joint leadership.
- Accountability – the process and approach used by sector partners to hold one another accountable for carrying out their roles and responsibilities in the PPE.
- Other – while the above types represent factors that emerged from the literature, we allowed for open coding of factors that arose in evaluations, documentation or interviews of the focus PPE that did not otherwise fit into the above categories.

For this case study on UPHCP-II, a total of three articles were identified, reviewed, and coded. Interviews were conducted with two key informants using structured interview protocols, including one researcher and one implementer from the public sector. Transcripts from these interviews were coded using the same set of closed codes centered around key themes. While these evaluations and interviews provide important insight into the question of helping and hindering factors, it is important to note the limitation that existing studies may not have sought to explicitly measure factors; as such, those identified through the coding of existing evaluations may not provide a fully representative view of the factors that influenced the effectiveness or lack thereof of the engagement.

## Results

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The UPHCP-II project had the following anticipated outputs: (1) provision of primary healthcare (PHC) through partnership agreements and behavioral change communication and marketing; (2) construction of urban PHC infrastructure and environmental health facilities; (3) capacity building and policy support for urban PHC; and (4) support for project implementation and operational research (ADB 2014). This case study focuses primarily on the first, third, and fourth outputs.

UPHCP-II established 24 partnership agreements with 12 NGOs in six city corporations and five municipalities for the provision of PHC services. Each partnership agreement covered 200,000 to 300,000 people. At least one PHC center catering to 30,000 to 50,000 people, and at least one satellite or mini clinic per 10,000 people, was established (ADB 2014). The project established 24 comprehensive reproductive health care centers (CRHCCs), which provided emergency obstetric care, newborn care, and other specialized services, 161 primary health care centers (PHCCs), 24 voluntary counseling and confidential testing centers (VCCTCs), and 24 primary eye care centers (PECCs) (ADB 2014).

The evaluation of the UPHCP-II program reveals a significant improvement in several maternal, newborn and child health indicators, suggesting that the program was effective in achieving many of its ultimate intended outcomes. These improvements included a decrease in neonatal mortality rate from 37.9 to 27.9 per 1000 live births, a decrease of 26.4%. Further improvements included: a decrease in infant mortality rates (51.8 to 39.6 per 1000 live births) and child mortality rates (15.0 to 10.2 per 1000 live births), and under-five mortality rates (66.0 to 49.4 per 1000 live births) (Albis et al. 2019).

One of the key goals of the project was to reduce the equity gap in access to quality health services. The evidence shows that this equity gap reduced significantly: over the course of the project, the differential in under five mortality rates between the lowest and highest wealth quartiles reduced from 77.7 to 1.4 per 1000 births, indicating dramatically improved access to health services for the poorest populations (Albis et al. 2019).

# Key Success Factors

A number of factors were identified in this analysis that may have contributed to the success of UPHCP-II, along with a few that may have hindered its progress. These factors include the environmental context, the structure of the engagement, varying engagement rationales, capacities of partners, and accountability mechanisms.

**Environmental context.** Bangladesh has a complex health system, with a variety of actors involved in the UPHCP-II project. These stakeholders include the MOLG, MoH, ULBs, ADB and other funders, and implementing NGOs. Key informants noted the unique organization of the PPE, in which MOLG and MOH were working towards a model of “co-stewarding urban health” (SMHS Interview, 2020). The MOH was the key technical ministry in the partnership—meaning that it led the creation of the essential services package, clinical standards, and quality assurance, while the MOLG was the executing agency responsible for urban PHC. This left a sort of gap in perceived responsibility for urban primary care; MOLG technically should have been responsible but placed more priority on infrastructure projects. MOH was responsible for rural health and urban health at secondary and tertiary care, and saw it MOLG’s responsibility to take care of urban PHC. Participants noted that this required close coordination between the two ministries, though in practice this coordination could have been stronger to ultimately help enhance service delivery. (SMHS Interview, 2020)

Participants indicated that involvement of the MOLG was a challenge at times due to their broad purview over all aspects of local government – including public works, sanitation, roads, sewers and other infrastructure-based priorities (SMHS Interview, 2020). Because infrastructure improvements are more tangible and visible than improvements in health service delivery, our participant noted that elected officials did not always prioritize the “softer” achievements, explaining that *“trying to get that mindset to change and advocate for more prioritization of urban health is also one of the challenges”* (SMHS Interview, 2020).

Despite challenges in coordination and priority-setting on the public sector side of the project, UPHCP-II benefitted from strong private sector partners. Bangladesh has a vibrant and active NGO ecosystem, with a variety of local organizations dedicating time and money to the improvement of health services (SMHS Interview, 2020). The strength of the pool of NGO applicants helped the project’s success, especially because a low performing NGO could easily be replaced with a different partner during the regular competitive bidding processes. Key informants also noted that the NGO community was empowered to speak up if dissatisfied with aspects of the scheme, introducing a reciprocal aspect to the accountability between partners (SMHS Interview, 2020).

**Structural factors.** The structure of the UPHCP-II engagement played a significant role in its success, though some aspects of the contracting mechanisms could have been improved. As described previously, the scheme was implemented through NGOs selected via a competitive bidding process. NGOs submitted separate technical and financial proposals and were assessed primarily on the strength of their technical expertise (ADB 2014). Once selected, NGOs needed to meet certain service delivery and income targets to remain eligible for participation in the scheme, or risk losing their contracts. NGOs also needed to meet other criteria, such as strong record-keeping practices, comprehensive financial management mechanisms, timely submission of bills, and others related to running a successful business (SMHS Interview, 2020). The competitive bidding process and stringent conditions for participation ensured that the strongest, most capable NGOs were participating in the scheme and ultimately contributed to project sustainability (SMHS Interview, 2020).

According to key informants, the income targets in particular were strong additions to the



structure of UPHCP-II contracts. In order to continue participation, and to be able to generate enough reimbursement revenue to operate, the NGOs needed to build a stable clientele. The inclusion of the income targets in the contract directly led NGOs to focus on community outreach, including education on health and sanitation and weekly satellite clinics, in an effort to expand their beneficiary pool. As one participant explained, “*NGOs needed to ensure that they have sufficient income to supplement, because at least 30% of services are for the poor - so they need to expand their catchment. NGOs had a defined catchment but needed to reach out more to the community, to expand the beneficiary pool so they did this through branding, behavioral communication change, and information/education/communication measures*” (SMHS Interview, 2020). This was also important because, if there were delays in project funding flows, NGOs needed to be able to temporarily cover costs of services on their own while awaiting reimbursement (SMHS Interview, 2020).

While most of the structural factors contributed to UPHCP-II’s success, there were also some challenges associated with the contracts between NGOs and the government. Due to the competitive nature of the bidding process which weighted the financial proposal in the final selection and the inability of the government to cover all costs associated with services delivery, some NGOs would cut staff salaries in order to ensure a winning bid (SMHS Interview, 2020). This led to challenges in retaining skilled providers.

**Engagement rationale.** Both government and NGOs had strong reasoning for wanting to engage with the opposite sector. Both parties benefitted from the arrangement, bringing their strengths to the initiative and relying on the other party to fill in some of their weaknesses (SMHS Interview, 2020).

On the private sector side, NGOs involved in the scheme had valuable opportunities to build their organizational capacity for service delivery and for engagement with donors. This benefitted both the NGOs at the organizational level as well as the personnel level; one informant noted that “*there was a career development aspect – staff were part of an important project and they got to experience this type of multi-sector or multi-party type of project with government involved, NGOs involved, donors and international donors*” (SMHS Interview, 2020). There were also opportunities for private sector workers involved in the scheme to participate in public sector workshops and trainings and to be linked to other private sector partners holding similar sessions (SMHS Interview, 2020). This was an incentive for the NGOs to capacitate their staff members and, in doing so, capacitate their organization.

NGOs also benefitted from access to government resources to take on large-scale service delivery projects. One informant noted that NGOs felt “*honored*” to take part in the government scheme and to be able to further their organizational missions through partnership with the public sector (SMHS Interview, 2020). Interview participants noted that NGOs did not always have adequate funding to carry out service delivery projects, but through partnership with the public sector (and subsequent access to government resources) they could fulfill this part of their mission.

The government also had strong reasons to engage in PPEs in this context. The public sector recognized that they did not have the capacity to meet the growing needs for primary health services in urban areas, leaving gaps in coverage for some of the most vulnerable populations. Through partnership with NGOs, they were able to fill these gaps and fulfill their responsibility for health service provision (SMHS Interview, 2020). The public sector also appreciated the NGOs’ capacity to make flexible decisions without the bureaucracy inherent in large government institutions. One participant noted that this flexibility allowed NGOs to more easily achieve time-bound goals, without being bogged down in the layers of red tape associated with government decision-making (SMHS Interview, 2020).

**Capacities of partners.** The engagements were also structured such that a central PMU, situated within the MOLG, was responsible for day-to-day oversight of the UPHCP-II project.

The evidence suggests that the PMU had strong central managerial capacities and was successfully able to support implementers through the process of the job (SMHS Interview, 2020). The PMU's main strengths included: well-developed supportive supervision which identified problems as they were happening; ability to manage the complex competitive bidding process and work with a variety of partner NGOs; and its approach of organizing formal quarterly meetings which ensured a culture of sharing and accountability (SMHS Interview, 2020). This allowed the PMU to monitor NGO progress, work with partners through a steering committee and a project coordination committee, and troubleshoot if some partner organizations were not meeting their income or service delivery goals.

NGO capacities were also important factors in the success of UPHCP-II. The NGOs with the strongest technical capacity to implement the service delivery targets were selected as partners, which was key in ensuring high-quality care. NGOs also increased their capacities to provide high-quality care through participation in the program. Albis et al. (2019) measured this increased capacity by the improved availability of staff, training, management of equipment and drugs, infection prevention, waste disposal, and use of registers. Through participation in UPHCP-II, NGOs became more efficient in service delivery due to increased capacity of providers and other improvements in technical/managerial capabilities associated with involvement in the scheme (Albis et al. 2019).

**Accountability.** UPHCP-II benefitted from strong accountability measures laid out in the structure of the agreements between NGOs and government counterparts from the beginning. In the contract agreement between the partners, there were clearly defined roles and responsibilities, meaning that there was little room for misunderstandings (SMHS Interview, 2020). There were also a series of organizational mechanisms in place within the PMU, like quarterly progress review meetings, a dedicated project coordination committee, and steering committee, which were tasked with reviewing, planning and making recommendations on accountability mechanisms (SMHS Interview, 2020).

Accountability was addressed at each tier of UPHCP-II—Project Implementation Units (PIUs) within the ULBs, the central PMU, and the NGOs. There were monitoring mechanisms in place for both the service delivery and financial aspects of the performance (ADB 2014). Internal and external clinical and financial audits held partners accountable to good governance, integrity and the expectation of successful project execution. There was also a “culture of zero tolerance” of misconduct within the development partners and government, which influenced NGOs to build their trustworthiness (SMHS Interview, 2020).

In terms of clinical accountability, the project had a built-in quality assurance monitoring mechanism. Every 6 months, the PMU and Quality Assurance team would visit the NGO facilities to review performance against an Integrated Supervisory Instrument (ISI) checklist, whereby the clinics would be reviewed against a set of matrix of indicators to measure quality (SMHS Interview, 2020). After this process had been completed in each clinic, the facilities were ranked from highest performance to lowest, with the goal of the PMU being able to identify weak areas of facilities and play a supportive supervisory role to help facilities make changes if needed (SMHS Interview, 2020).



# Discussion

Overall, the evidence indicates that the UPHCP-II project in Bangladesh was highly successful. While the second phase of the project ran from 2005-2012, the initiative is still running (on its fourth iteration) as of 2021, which is a strong indicator that it is making a difference in the lives of Bangladesh's urban poor populations. The second phase of the program succeeded in improving indicators across the board, with especially stark differences apparent in the equity of quality health services.

There are a number of reasons why UPHCP-II was likely so successful. First, the engagement took place within a hospitable environment, especially prominent in the population of vibrant, passionate NGOs. The NGO private sector partners were the lifeblood of this project, directly responsible for delivering high quality care to patients every day.

From the beginning, the structure of the engagement was thoughtfully constructed, with a number of mechanisms in place to ensure success. The competitive bidding among NGOs ensured participation from the strongest partners and gave the organizations strong incentives to continue performing at high levels or risk being replaced in the next contract cycle. Contracts also stipulated minimum service delivery and financial targets for the NGOs, ensuring sustainability of the program beyond government funding. Contracts included stipulations for monitoring and accountability mechanisms (for both financial and clinical aspects), and the central PMU organized quarterly monitoring and communication checks to ensure that NGOs were performing to plan.

These robust structures led to accountability on both sides of the engagement, which eventually led to trust between parties; evidence suggests that partners from both sectors perceived that they could rely on their counterparts to fulfill their end of the deal. This trust, coupled with clear intrinsic goals on both sides, appears to have led to highly engaged, motivated, and fulfilled partners. NGO workers were also happy to gain experience working on a project with a variety of big donors and technical partners, providing incentive for them to continue working on the engagements despite sometimes low pay.

Though we cannot make conclusions on causal relationships between factors, we can note some trends in temporality. For example, the strong environmental factors associated with the Bangladesh context, including the vibrant NGO culture, were present before the project began. Similarly, robust structural factors in place at the program's inception seemed to set UPHCP-II for success early on, and preceded the successful factors related to partner capacities and accountability. There are key lessons to take away from the success of UPHCP-II, particularly related to the importance of ecosystem factors in shaping an engagement.

# References

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This case study is one of a series of six secondary cases written for the Strengthening Mixed Health Systems program, analyzing the factors helping and hindering the effectiveness of public-private engagements for health in low- and middle-income countries. All case studies, as well as a report presenting cross-cutting findings, can be found on the Strengthening Mixed Health Systems project website.

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