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## Provision of Primary Healthcare Services in Urban areas of Bangladesh – the Case of Urban Primary Health Care Project

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# Provision of Primary Healthcare Services in Urban areas of Bangladesh – the Case of Urban Primary Health Care Project<sup>1</sup>

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## Abstract

Primary healthcare in Bangladesh is supposed to be a public responsibility, and until recently the government has tried to provide basic services directly through its own bureaucracy. However, the public sector faces acute problems in meeting the growing needs of urban population, especially the poor. In recent years, new institutions such as partnerships with not-for-profit private organizations are sought to improve the access and quality of primary care. This paper focuses on one urban partnership project, UPHCP in Bangladesh. It analyzes the accountability relationships among different stakeholders involved in the project and cost effectiveness of contracting out. The paper finds that the accountability relationships in UPHCP are not transparent, and the programme is costly in terms of human resources because of multiple principals and agents involved compared to direct government provision. The beneficial impact of UPHCP on urban primary care is well-documented, but such institutional arrangement will have difficulties in expansion on a large scale without external assistance. Another weakness of the programme is the lack of a sense of ownership and trust in its continuity among the population that works against social accountability and client power.

JEL classification: I12, I18

Key words: contracting out, NGOs, primary healthcare

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# **Provision of Primary Healthcare Services in Urban areas of Bangladesh – the Case of Urban Primary Health Care Project**

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## Abbreviations

ADB	Asian Development Bank
BAPSA	Bangladesh Association for Prevention of Septic Abortion
BCC	Behaviour change communication
BPHC	Bangladesh population and health consortium
BWHC	Bangladesh Women's Health coalition
CC	City Corporation
CAPE	Country assistance project evaluation
CRHCC	Comprehensive reproductive health care
DGFW	Directorate of Family Welfare
DGHS	Directorate of Health Service
EPI	Expanded Programme of Immunization
ESP	Essential services package
ISI	Integrated supervisory system
LGD	Local government division
MMR	Maternal mortality ratio
MOHFW	Ministry of Health and Family Welfare
NGO	Non governmental organization
NNP	National Nutrition Project
NSDP	NGO service delivery programme
NUPHCC	National Urban Primary Healthcare Committee
PD	Project Director
PHC	Primary healthcare
PKSF	Palli Karma-shahayak foundation
PIU	Project implementation unit
PMU	Project management unit
PPMES	Project performance monitoring and evaluation system
PSTC	Population services and training center
SDF	Social development foundation
Sida	Swedish International Development Cooperation Agency
UPHCP	Urban Primary Health Care Project
USAID	United States Agency for International Development
UTPS	Unity through population services
WDR	World Development Report

## **Provision of Primary Healthcare Services in Urban areas of Bangladesh – the Case of Urban Primary Health Care Project**

### **I. Introduction**

Primary health care – preventive and curative, is one of the major priority areas for achieving Millennium Development Goals and addressing poverty in nations. Bangladesh has achieved substantial progress in some health indicators (infant mortality, fertility) mainly due to an efficient service provision related to preventive care. Considerable problems, however, remain in curative care and in some areas of reproductive care. The urban poor, especially women lack access and quality of care because government health infrastructure in urban areas is not as developed as in rural areas.

To address the problems involved in direct provision through the public sector new institutions are emerging such as partnership with the private sector (mainly non-profit) related to service provision, while the state retains the financier role. The main idea is to diversify service provision through developing stewardship capacity of the government. One of the important attempts undertaken in Bangladesh is the *Urban Primary health Care Project* (UPHCP) operated by the local government but financed both by donors and the government of Bangladesh. The program was started in 1999, and went into the second phase in 2005.

The overall purpose of this paper is to consider the advantages of UPHCP as an institutional alternative to public sector provision of primary healthcare (PHC) in urban areas of Bangladesh. Specifically, the study will (1) focus on the impact of the program on service delivery to the poor, (2) analyze the institutional strengths/weaknesses of the program as reflected in the organizational design (3) highlight the problems related to cost-effectiveness and financial viability of contracting out.

The evaluation of UPHCP is based on a comparison of stated objectives of the project with the outcomes and achievements, and more importantly, on the study of accountability relationships among different stakeholders. This is done from the perspective of current development and institutional research on public sector governance in health service delivery. Secondary data available in external evaluation report, government documents and self reporting by service provider organizations are used complemented by primary data from own

observation and in-depth interviews carried out by the author during October 2005. It should be noted that conclusions regarding the viability of contracting out is based on only one project and limited to Dhaka City. Moreover, a comparison of actual costs of service delivery involved in contracting out versus direct government provision could not be done because of the lack of data. This can lead to overestimating the positive impact of contracting out.

## **II. Institutional issues related to primary health care (PHC)**

Primary health care is distinguished from their secondary and tertiary counterparts in different ways. It is the basic level of care provided equally to everyone and is largely supply-driven; it is the first point of contact with the health system; it provides preventive, curative, *promotional* and rehabilitative services; and it integrates care and deals with the context. (World Bank website on health system development).

PHC is often considered as a public sector responsibility because of various market failures – externalities, imperfect information and insurance failure, and equity reasons. Following the recommendations of the World Health Organization (The Alma Ata Conference), many poor countries have accepted the financing or funding role of the state with respect to the essential services package (ESP; World Bank 1993) consisting of public health and clinical services.

Table 1. Packages of Essential Public and Clinical health Services

### **Package of Essential Public Health Services**

- Expanded program on immunization and micro-nutrient supplementation
- School health programs to treat worm infections and micronutrient deficiencies
- Programs to increase public knowledge about family planning and nutrition, self-cure, and vector control/disease surveillance activities
- AIDS prevention program with strong STD components

### **Package of Essential Clinical health Services**

- Prenatal and delivery services
- Family planning
- Integrated management of the sick child (including diarrhoeal diseases, acute respiratory infections (ARIs), and malaria)
- Treatment of tuberculosis
- Case management of sexually-transmitted diseases (STDs)

### **Additional Components in the Bangladesh Package**

- behaviour change communication
- violence against women

*Source: World Development Report, 1993*

*Institutions for Service provision:* While the provision of ESP is considered as a public responsibility, government has the option to discharge the responsibility through different institutional arrangements – direct production through its own agencies (may be decentralized local level bureaucracy), and/or nongovernmental or private sector agents. According to the current literature on institutions of service delivery, the choice of alternative institutions is largely dependent on the characteristics of goods and services involved in ESP.

Three economic variables attached to *goods characteristics* are measurability, information asymmetry and contestability (Girishankar, 1999; Preker and Harding 2000; Ahmad 2003). *Measurability* indicates the precision with which policymakers specify the services to be provided and the output/outcome of the provision. This facilitates easy monitoring of performance by the hierarchs, and also reporting and auditing by relevant agencies. *Information asymmetry* can occur at different levels (within or between public and private sectors) and with respect to certain services such as family planning services which have low measurability. In this case, information regarding service delivery performance is available to users or beneficiaries and can be more effectively monitored by beneficiaries rather than public sector hierarchs. For clinical services, information asymmetry between clients and health workers (physician) is a common phenomenon because they are transaction-intensive and more discretionary than activities such as immunization that are less transaction-intensive and non-discretionary. *Contestability* is a measure of potential and actual competition from other suppliers for the business of the purchaser, and is influenced by barriers to entry (Girishankar, op. cit.) due to scale of operation and investment costs.

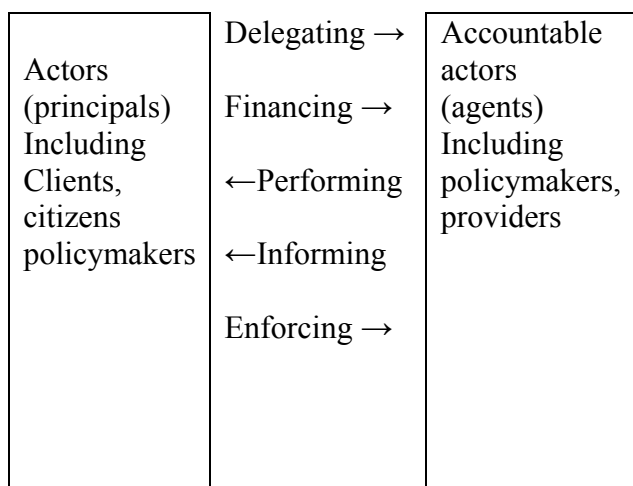
Most of the components of primary health care entail problems of measurability, information asymmetry and externalities, and may be entrusted to local-level providers (Ahmad, 2003) that are close to the beneficiaries of services. Since they are also contestable, opportunities for competition should be open. On the other hand, Government has comparative advantages in certain areas such as referral, regulation and information related to health and family planning.

Entrusting the responsibility of primary healthcare to local-level providers is not the end of the story. To ensure that frontline professionals do their job, a system of accountability between the principal/s and the agent/s must be in place. The following section deals with a

framework of accountability according to the literature on public sector governance (WDR 2004).

### A framework of accountability relationships

Broadly, accountability may involve the following functions among the principals and agents.



Source: WDR 2004, p. 47

The chain of service delivery involves four actors, their roles and relationships with each other. The four actors are citizens/clients, politicians and policymakers, organizational providers, and frontline providers. The four relationships are:

1. of politicians to citizens: voice and politics
2. **of the organizational provider to the state**
3. **of frontline professionals to the organizational provider: management**
4. of the provider to the citizen-client: client power

This paper focuses mainly on the relationships number 2 and 3 with minor comments on 1 and 4.

#### *Policymakers and provider organizations*

Compact, management and the long route of accountability

In a market transaction, there is a direct link between payment by clients and performance of providers. This link breaks down when the state assumes the role of financier and leaves the task of provision to others. In such a case, a long route of accountability has to work through a compact between the policymaker/financier and the provider. The provider agrees to deliver a service in return for being rewarded or penalized depending on the performance. The compact may be an explicit contract with the private sector including for-profit or non-profit organizations, or between different tiers of government (we focus on NGOs in this paper).



### **Contracting out to non-profit organizations**

In recent years, there is a trend towards a growing utilization of private sector providers through contracting out where the government assumes the role of financier and regulator.

Contracting out has several advantages:

- Consumer have access to different alternatives that make voice and exit mechanism work better;
- Reduced burden on the public sector
- Targeting the poorest
- Financial sustainability as a long-run objective through a system of user fee and health insurance
- Similar mission orientation - service delivery with non-profit motive

However, contracting out involves complex problems of accountability and governance, and government has to assume a proper regulatory role. Increasing accountability by separating the policymaker from the provider often requires that the policymaker is mentally, sometimes physically, separated from the provider (WDR 2004). A clear-cut accountability links may be difficult due to multiple principals, multiple tasks, and problems in measuring and attributing outcomes. Contracting out itself may also entail huge costs that may outweigh the benefits gained in service delivery. The five functions - delegating, financing, performing, informing and enforcing, involved in provision of public healthcare services through contracting out are discussed below.

### **Delegation**

In a long route of accountability, the chain of delegation works from citizens to state to health ministry to health management to frontline providers. While the health ministry is accountable to the state, it has to get things done through a provider organization (NGOs) that is capable and motivated to fulfill the goals. Mission-orientation of NGOs as well as - health workers appointed by them may reduce incentive problems (Besley and Ghatak 2003) in a non-profit organization. However, in cases where the NGOs have multiple goals that may not be congruent with government objectives, the question will arise, how to solve the problem of accountability and ensure that NGOs will fulfill their obligation? Selecting the right type of partner as a provider having both similar missions and technical capability is, therefore, important. The selection should be based on a competitive bidding process. The criteria of selection have to be explicitly defined – targeting the poor, cost recovery, provision of quality care for the general population, etc.

**Finance:** In addition to criteria of selection, a great deal depends on specific issues related to finance. There is a need for regular flow of funds or inputs for the service provider in order to meet the demand for services, especially targeting the poor. NGOs as service provider organization must have some discretion in the use of funds to match local needs while broader allocations are guided by health policy of the government.

**Performance** – activities chosen are decided according to the contract as mentioned above.

**Information** - channels: policy makers must have regular flow of information about the access, and quality of services provided. Independent evaluation agencies, information provided by NGOs, Government/donor evaluation through monitoring are some possible channels. Reports of partners, independent agencies and public sector bureaucrats (local government) can provide relevant information. Efficient service delivery is also affected by feedbacks from clients that respond both individually and collectively through civil society organizations. This can be an important channel for information. Hence, the contracts should leave room for client participation.

### **Enforcement**

#### *Evaluation by policymaker/donor*

Remuneration and outcomes issues relate to provider organization and the policymaker, and between provider organization and frontline providers. Contracting out mainly concerns the former. The failure of the provider organization to fulfill the contract may lead to termination or non-renewal of the contract. The latter relationship refers to daily administration and overall management of services at the facility level. It requires a balance between flexibility and compliance to standard rules. The incentives for health providers work through opportunities for advance and fear of punishment. Similar mission orientation such to serve the needy as it is for the provider organization as a whole may also work.

*Is there a need for monitoring? How much monitoring? How regular and thorough should the monitoring be?* One of the arguments behind contracting out to mission-oriented organization is that close monitoring may not be needed as the organization (agent) has the same objective as the principal. A system of monitoring of broad indicators while leaving the day to day administration to the provider organization may be adopted.

*What to monitor?*

Depending on the type of services specific indicators of monitoring may be determined.

- Output-based – how many are vaccinated, how many received treatment for specific illness, for example. These are clinic-based information. There will be some selection bias but on the other hand, there is no easy solution to that problem.
- Outcome-based – information on changes in infant mortality among the population served by provider organizations may be collected through household surveys. *Two* things are important here – one is that it would be interesting to see if for example, the inputs (e. g. vaccination) lead to the desired outcomes (reduced morbidity and mortality) for a sample of children that can be tracked. The other thing is whether the presence of a specific type of provider (through externalities and/or different accountability structures) could have an effect on health outcomes in the catchment population.
- Performance-based–activities may be measured in terms of client satisfaction with information collected through exit-point interviews with patients and/or household surveys. Again care has to be taken with respect to selection bias.
- The failure of the provider organization to fulfill the contract may lead to termination or non-renewal of the contract.

The discussion above indicates that contracting out is not a costless process especially if the mission preferences of the principals and agents do not match. It involves transaction costs related to selecting, contracting, disbursement of funds, account-keeping, monitoring, evaluation and renegotiation, etc. Current empirical literature on the evaluation of service provision through contracting out by the government in many countries lacks a focus on the issue of transaction costs involved in the new institutional arrangements.

### III. Urban Primary Healthcare in Bangladesh

*Health infrastructure*

Considering the importance of ESP in the context of Bangladesh, government has assumed both financier and provider roles. Government health services are provided by a four-tier system of government-owned and -staffed facilities. The Ministry of Health and Family

Welfare is comprised of two separate directorates – the Directorate General of Health Services (DGHS) and the Directorate General of Family Welfare (DGFW).

- i. The union-level (just above the village) - family welfare clinics provide services towards reproductive health.
- ii. Thana or upazila level (sub-district) health complexes provide ESP and some referral services.
- iii. District-level health complexes provide primary, secondary and tertiary care.
- iv. Medical collages and hospitals in large cities operate.

While the rural population is served through union, thana and district level infrastructures, municipalities are responsible for publicly financed health service provision in urban areas.

#### *Urban primary healthcare and partnership with non-profit private sector*

The organization of publicly funded health services in urban areas is similar to the overall health infrastructure in the country. The DGHS is responsible for curative care and some aspects of public health such as immunization. The DGFW looks after family planning services and some maternal and child health services, such as prenatal care. The DGFW, accountable to MOHFW, operates stand-alone maternal and child welfare centers and some family planning clinics in the cities, and the DGHS operates a few small dispensaries also accountable to MOHFW, and the city corporations which operate separate dispensaries are accountable to LGD. In addition to Government agencies, health services are provided by the private sector consisting of non-for-profit NGOs (often donor-supported) and for-profit clinics and dispensaries.

The publicly-funded health infrastructure is considered to be more deficient in urban areas than in rural areas. The reasons as reported by the Asian Development Bank (ADB) are:

“1. inadequate physical infrastructure; 2. uncoordinated and limited efforts at addressing urban PHC; lack of capacity within the health departments of the city corporations; and 4. insufficient public funding., The four city corporations currently (in 1997) operate a total of 36 dispensaries and MOHFW another 36, or about one facility for every 132,000 population. In rural areas by contrast, the Government has provided one dispensary for every 20,000 population“. (ADB 1997 Report).

Due to inadequate public sector health facilities in the urban areas the health standard of the urban poor is worse than in rural areas in Bangladesh (The Fifth Five-Year Plan 1997-2002). One of the important features of health sector reforms in Bangladesh is the introduction of pluralism in service provision by contracting out some of the service provision to the *not-for-*

*profit* private sector. Partnership with the NGOs in primary health care provision is becoming increasingly important in urban areas, and is facilitated by the fact that many donor-supported NGOs have been in operation for a number of years. Two major NGOs responsible for urban care are NSDS supported by USAID- and UPHCP mainly financed by ADB and other donors.

Rationales behind partnership are several (World Bank 2005). NGOs are considered to be more motivated to serve the poor, and are able to reach the poor. Not being under the direct control of government bureaucracy, their organizational structure is more flexible, and they can adjust their services to the needs of clients. Flexibility also means that NGOs can gradually introduce some payment and/or insurance system for primary health care to be financially sustainable in the long run. It can also improve service delivery because payment for services increases client power and strengthens the direct route of accountability between clients and providers. However, the goal of sustainability has to be balanced with the goal of reaching the poor, not an easy task. Available literature confirms that NGOs perform better than government-run facilities. There is low absenteeism among doctors who also provide better quality of service (Cockcroft A. et al, 2004; 2007).

Questions that may arise are: Why is absenteeism in NGO clinics lower than in government facility? Is it due to better matching of mission preferences? Are NGO workers more motivated to serve the poor? Are they less interested in pecuniary rewards or are they forced to work there because alternative opportunities lack? Is the scope for community/client participation (in planning, design, monitoring, matching of health needs) greater in NGOs-run facilities than in govt. facility? Do NGOs have different organizational structure allowing more flexibility, less hierarchy and open communication among health workers and the management personnel? We investigate these issues with a focus on UPHCP.

#### **IV Urban Primary Healthcare Project (UPHCP)**

UPHCP, an innovative project for the delivery of a package of preventive, promotive and curative health services to the urban poor, was started with a loan from the Asian Development Bank (ADB) in 1998. Other donors (DFID, Nordic Development Fund) also contributed through ADB. The project was supposed to be implemented in phases, with five years in each phase. The main objective of the health project is to provide ESP services and curative care with a focus on women, children and on reproductive health. The targeted

geographical areas are slums of Rajshahi and Khulna, Chittagong and Dhaka, divisional towns and cities.

UPHCP 1: it has four components (Source: ADB 1997 report – the original proposal).

1. Partnership agreement: The project has 15 partnership agreements with NGOs which are to be selected through competitive bidding process. Each partner NGO will have a catchment population of 500, 000 who will be served through many health facilities. Each facility or center is to serve a population about 50,000.
2. Strengthening urban PHC infrastructure –
3. Building capacity of City Corporations and their partners – Integrated supervisory system (ISI) will be developed.
4. Support for project implementation and operationally relevant research – project implementation unit (PIU)

There are some policy goals with respect to financial resources and institutional structure. The partner NGOs are supposed to mobilize resources through user fees charged for some services. Institutional changes relate to the role of city corporations. The city corporations while remaining accountable to the MOHFW, will have the overall responsibility for the delivery of PHC in the project cities. They will comply with the written standards, protocols, and guidelines of MOHFW and provide reports to MOHFW on national programmes such as immunization and family planning.

#### *Implementation arrangements*

The Project Organization Chart in the appendix of the report indicates the governance structure and accountability relationships. The executive agency is Local Government Division (LGD) represented by city corporations. Both LGD and the Project Director (PD) are accountable to the MOHFW and ADB while four deputy directors accountable to PD. Accountability to different stakeholders may also be traced through the organization of Project Steering Committee and Coordination Committee.

#### **UPHCP 2** (Report of the ADB president, p. 14)

Overall objective of UPHCP2 is similar to the first phase with minor changes in the components:

1. Provision of primary health care through partnership agreements and behavior change communication and marketing
2. Urban primary health care infrastructure and environmental health
3. Building capacity and policy support for urban primary health care
4. Project implementation and operationally relevant research

Increased coverage – the project will finance 24 partnership agreements, each covering 200,000-300,000 people. .... The partnership agreement will ensure that at least 30% of each service will be provided free to the poor. The organizational structure under UPHCP2 is slightly different from UPHCP1. New terms or features are:

### **National Urban Primary Health Care Committee (NUPHCC)**

The chief project coordinator will be a joint secretary-level officer of LGD or higher, and There will be Project Management Unit (PMU) and PIU instead of only PIU as was under UPHCP1. Project performance monitoring and evaluation under UPHCP2 – “The LGD and PMU will establish a comprehensive project performance monitoring and evaluation system (PPMES) acceptable to ADB and other co-financiers. The PPMES will 1. assess technical performance; 2. evaluate delivery of planned activities; 3. measure project impacts; 4. measure social and economic benefits with a focus on the poor, women and adolescents; 5. monitor health-related MDGs. PPMES indicators will serve as a basis for project implementation. These are:

- Impact
- Outcome
- Outputs

## **V. Performance of UPHCP**

### *V.1 Reports submitted by partner NGOs*

There are 10 partners (8 NGOs in 10 areas) involved in Dhaka.

- Bangladesh Women’s Health Coalition (BWHC– UPHCP PA 1
- BWHC PA 2
- Bangladesh Association for Prevention of Septic Abortion (BAPSA) PA 3
- Population Services and Training Center (PSTC) PA 4a
- Shimantik PA 4b
- Nari Maitree PA 5
- Marie Stopes Clinic Society (MSCS)
- Unity through Population Services (UTPS) PA 7
- PSKP PA 8

- UTPS PA 9 and 10

The reports submitted by the partners contain an executive summary, PHC, BCC and satellite services, information of medicines, financial report, monthly meetings, violence against women activities and recruitment during the quarter and other activities. Table 2 below provides information on selected indicators. (City Corporation, Dhaka, Second UPHCP, Quarterly Performance Report (July-September, 2005). Information on catchment population received from the partners directly through interviews.



Table 2 Report on selected indicators of service provision by 10 partners

No. Services provided	116221	88558	140848	49499	53018	42841	Marie Stopes (MSCS) 65207	71879
Total clients	43702	38,394	50,159	37,907	28,133	23137	41556	51524
Full free clients	7566	9,530	9,564	11,811	8342	2220	?	21958
Partial free clients	1545	1,077	3,460	4,780	6013	4392	?	15715
Paying clients	34591	27,787	?	21,316	13878	16525	?	13851
<i>Catchment population</i>	<i>339,000</i>	<i>15,634</i>	<i>400,000</i>	<i>303,850</i>	<i>281,000</i>	<i>361,000</i>	<i>309,000</i>	<i>281,000</i>
Total expenditure	3,694,829	2,524,776	2,829,699	3,033,498	1,872,906	1366764	3,430,233	1743558
Total income	Fund received 1,588,144	812,413 No source	1,182,060 No source	701,771 No source	646,055 Not from PMU	796195 PMU?	?	578734
Cost recovery	43%	?	42%	?	?	?	Tk 55.25 ?	?
Sources of income	?	?	?	?	?	Medicine, service charge and lab	?	?

Source: Based on information collected during interviews with provider organizations

While all partners report according to the general guidelines details differ. For example, in presenting financial accounts not all partners explicitly show the share of income in total expenditure.

Given the low level of service delivery in urban areas at the start of the period, there has been substantial progress made by the NGOs in terms of increased access, improved quality and enhanced awareness among the population about health behaviour as well as facilities available. Access has been measured in terms of number additional clinics and patients served, and service charges that are nominal (compared to the private facilities) especially for the hard-core poor. The poorest of the poor are identified in terms of income and some basic-needs indicators by the field assistants in each command area through a process whereby the members of each household are offered identification cards that indicate different

socioeconomic condition. A good number of partners have been able to increase income through different channels.

### *V.2 Evaluation by Donor/s*

According to the President's report (The Second UPHCP, 2005, p.28,) significant progress has been made and there are lessons to be learned from UPHCP1. The project has contributed substantially by expanding health services for the urban population including the poor. As a result, "ADB's country strategy supports delivery of PHC services in urban areas over the medium term, and building local government to deliver high-quality services to the urban poor, particularly women and children, in partnership with NGOs. The country assistance program evaluation (CAPE) in 2003 highlighted the need for stronger collaboration with NGOs, more effective empowerment of local communities, and support for accountable and transparent local government bodies in ADB's future programs" (President's Report, p. 3)

The lessons to be learned are:– better pro-poor targeting, adequate provision of medicines, support for quality assurance, greater emphasis on behaviour change communication, the need for environmental health improvement and institutional mechanisms for greater involvement of city mayors. Partnership with private sector/NGOs has worked well. The report further comments that there is no impact assessment of UPHCP related to general health. However, this may be difficult when other determining factors are also involved. More visible progress has been made in output indicators – rate of immunization, service provision to urban population and also the poor. Client satisfaction has increased. Some difficult areas have been identified such as:

- Low utilization in targeting the poor, depth of coverage, and quality of care
- Infrastructure problems due to land scarcity and funds
- Local government –coordination problems
- Financial sustainability problems – balancing user fee and free service for the poor, lack of urban healthcare fund from local government
- Institutional sustainability – project management is needed under LGD; more funds for recurrent budget over long-term.
- More concrete program targets – targets for inputs, output, and outcome included in addition to impact; and health service use disaggregated by poverty to be monitored for pro-poor targeting. (Source: Appendix 3 in the President's report for lessons learned).

**It should be noted that the report makes no comment on the costs of contracting out. The role of client participation and citizen voice has not been highlighted either.**

### *V.3 Evaluation by external organizations*

An external private firm, Mitra and Associates, regularly evaluates the project through facility-based and household surveys

The facility survey is based on staff interview, inventory taking and observation of 106 PHCC and 16 CRHCC and 106 outreach centres, interviews with 122 physicians, 226 paramedics and 222 BCC workers.

Main components in investigations are.

- Facility characteristics with respect to availability of services and inputs
- Quality of care
- Maternal health services
- Child health services
- Family planning
- STD/RTI/HIV
- Violence against women

#### **Availability:**

The reports focus on the services related to reproductive health and women. There has been an increasing trend since the baseline period in most of the services except in STD/RTI where both initial and current levels are low in spite of an increase. With respect to availability of listed items (running water, telephone, clean facility, electricity), only four out of 16 have all of them. The problem is with telephone but there is no comment on mobile and radio coverage. Availability of physician for 24 hours in CRHCC indicates a decrease in the second phase from the first one although an increase is observed since the previous survey. Availability of listed equipment and medicines is not universal but varies a lot among centers. For example, anti-malarial drugs are available on in 49% of the health centers (p. 16). There are wide variations in the availability of contraceptive methods in different UPHCP partners. However, there has been an increase in the second phase contrary to decrease (for certain methods) in the first phase. More than 80% of the health centers offer expanded programme of immunization (EPI) services, however, hepatitis B vaccination is offered by only 41% of

the centers. “The project has invested lots of resources in establishing pathological laboratory in each of its centers to offer all routine blood and urine tests, screening tests for high-risk pregnancies, and test to diagnose TB and STD/HIV (*but*) 30% of health centers do not have any lab facilities:” (P. 20)

### **Quality of care:**

The aim of the survey was to observe 30 patient consultations at the PHCC from each of 16 UPHCP partners (10 in Dhaka and 6 in other cities). The assessment related to the following issues:

1. The extent to which providers’ consultation and treatment adhered to the standard practices
2. The service providers’ knowledge and skills regarding basic primary health care services.
3. Caregivers’ perceptions of the health care facilities and services
4. Caregivers’ retention and understanding of health education, advice offered by the providers.

There has been a decrease in consultation time in the second phase, and less than satisfactory performance in giving education/information related to medicines (clients’ understanding) although there has been improvement in instructions given. Client satisfaction is investigated in terms of providers’ attitude, facility cleanliness, operating hours and waiting time. A high level of satisfaction has been observed.

### Maternal health service

There has been a steady increase in the physicians’ knowledge since baseline but not with respect to paramedics and BCC workers.

Child health: In general, physicians were found to be more inclined towards taking a thorough history than doing a complete physical examination for all types of diseases. With respect to EPI services, paramedics are more aware of the immunization schedule than physicians and BCC workers. It is of concern that many of the service providers lack correct knowledge about EPI schedule that might affect the quality of EPI services. A steady rise in family planning services has been observed.

STD/RTI/HIV/AIDS services: Although lab facilities are not yet established in half of health centers, there has been a steady rise in lab test services. The counseling and treatment services have more or less remained same at a very high rate of 90%. (p. 57)

Violence against women:

The available services (in all but one center in Chittagong) include treatment of victims, counseling, legal assistance or referral to any other legal aid organization. There has been an increase in referral practice and average number of service recipients since the previous survey but a slight declining trend is observed for treatment and counseling that the final survey compared to mid-term.

### **Household survey (2005) indicating the impact of the project**

Fertility and childhood mortality: A comparison between estimates of infant and child mortality rates in baseline survey period and the 2005 household survey indicates that there has been a significant improvement in child survival in all four cities. However, no disaggregated data by poverty level are provided.

Contraceptive use rate varies widely among the zones of the cities but all zones have shown increased use of family planning methods since the baseline survey in 1999. The 2005 household survey documents higher rate of receiving advice regarding preventive and general care related to pregnancy and childcare during antenatal contacts than observed in the baseline survey in all the cities.

Child health: More than 70% of children of age 12-23 months in the four cities can be considered to be fully immunized. However, although the level of coverage for BCG and the first two doses of DPT are more than 88%, the proportion of children who go on to receive the rest of the vaccines falls off. The problem was mentioned above with respect to EPI schedule.

*Maternal mortality:* The survey estimated the maternal mortality ratio (MMR) for the UPHCP area as 150 per 100,000 live births. This is much lower than the national estimates (322) and in urban areas (262).

### *Knowledge and utilization of UPHCP Clinics*

While more than 90% of the respondents know about a health facility in the community providing health and family planning services, only 25-28 % of them stated that they knew of UPHCP supported clinics. Utilization (30-38 overall) is higher in Dhaka among those are aware of its availability.

### **World Bank Studies**

*Comparative Advantages of Public and Private Health Care Providers in Bangladesh (Dec. 2005)*

GOB and WB have undertaken this study to gather information on comparative advantages of public and private for-profit and not-for-profit health provider/facilities. The dimensions of performance covered are perceived and technical quality, price, accessibility, cost, subjective performance and value. The study, however, does not provide information specifically related to UPHCP. On the whole, “the study concludes that there are good prospects for contracting-out certain services at specific administrative/facility levels. At the upazila level NGO facilities yield the best value indicators, as well as the best in terms of accessibility from the patients’ perspective. Thus, in principle government could purchase from NGOs, for preventive, promotional, or simple curative services, at low additional cost and with large quality improvements compared to public provision. At the national level, private facilities present quality than public facilities for all six services studied, offering the prospect for possible contracting-out arrangements. However, government would have to negotiate volume discounts with private providers to get them to lower their prices to levels that are more in line current public sector delivery costs.”

**One major weakness of this study is that it does not consider information on the transaction, management and monitoring costs associated with contracting although this has been recognized in the theoretical part of the study (in page 11) as a major weakness of other evaluations of private contracting.**

Another World Bank study (2005), *NGO Contracting Evaluation by R. Cortez* ) evaluated the following models of partnerships:

1. Direct contracting and management by GOB or a government entity (UPHCP and NNP)
2. Contracted manager to manage NGOs (NSDP and BPHC)
3. An autonomous trust for developmental and social service activities (Dhaka Ahsania Mission)

4. NGOs receive direct funding from donors (BRAC, DSK, Gona Shaysthaya Kendro)
5. Not-for-profit registered company (PKS and SDF)

Both facility-level data and exit-point interviews of patients are used.

*The criteria used and results (from Tables 2.4 and 2.5 in Cortez)*

- Facility-based characteristics – best for UPHCP
- Worker satisfaction – not high for UPHCP
- The bidding experience and selection process – worst UPHCP
- Flexibility of contracts – lowest score for UPHCP
- Supervision and regular monitoring - mediocre performance for UPHCP
- Maintenance of service quality, training and other partnership – next best for UPHCP
- Quality assurance and client satisfaction – highest score for UPHCP

According to the recommendation of this report, an independent management agency may be entrusted with overall implementation, monitoring and evaluation of the contract. The so-called management contract seems to have become very popular among donors in recent years but there are several problems – not the least, extra costs and an extra “layer” in the organization. These are largely overlooked.

## **VI. UPHCP as a service delivery institution – an institutional analysis**

### *Field work report*

So far we have discussed the performance of UPHCP in service provision as reported by the partners themselves, and evaluated by external organizations including the principal (government/donors). The evaluation does not specifically consider the strengths and weaknesses of UPHCP in terms of its organizational set-up and cost-effectiveness. This section is devoted to this issue based on information from the field visits by the author and the study of available reports on NGOs/UPHCP. The analysis applies the conceptual framework developed in Section II. First we discuss the results of field visits.

### *VI. 1 Opinions and problems recognized by partners themselves expressed during in-depth interviews (Appendix Table 1)*

- There is a focus on hard-core poor but it is difficult to implement. There are problems in reaching the very poor especially women where family circumstances play a role and young women are incapable of making

decision about seeking health care.<sup>3</sup> Sometimes very poor patients are referred to government hospitals for free treatment. Some NGOs have partnership with the private sector for specialized services at subsidized rates for the hardcore poor.

- Inadequate diffusion of information about UPHCP is mentioned by several NGOs. Many poor people are not aware that the facilities are intended for them and they can get quality care with nominal charges. There is a problem of attitude to NGOs which are usually looked upon by people as foreign organizations not directly accountable to the people. The partnership between the government and NGOs, especially the government's key role in ensuring service delivery should be highlighted to the people through more publicity (as expressed by PSTC).
- Marie Stopes is the only NGO reporting underutilization of funds.
- Pressure for subsidized treatment from the non-poor patients is reported by several health facilities.
- Daily management is said to be affected by UPHCP in 3 out of 10 cases. Recruitment is decided by a recruitment board where the city corporation has a say. Salaries and other matters are decided by NGOs and PM. High turnover rate among doctors especially in the very poor areas (in 30% of the cases) is observed. There are vacant posts in some clinics in spite of unemployment among doctors in Bangladesh.
- Record-keeping in patient histories is sometimes difficult due to floating population and clients losing their cards. It suggests that the facilities are more concerned in keeping records on number of clients and number of services provided to comply with the instructions given by LGD than on information on medical history of individual client.
- Community participation takes place only through complaints and comments from the clients. There are no comments on other forms of participation. In two cases, the participation by the elected member of the community in the meetings is mentioned.

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<sup>3</sup> Our survey of households in rural areas of Bangladesh show that in 90% of cases women do not make decision about seeking healthcare.



- Lobbying by the non-poor for the reduction of service charges is mentioned by 30% of the respondents. Sometimes very aggressive behaviour among clients occurs, and conflicts are reported to arise.
- With respect to discretion about utilization of funds, there is more flexibility in case of minor items. Changes involving large sum need the approval of the city corporation. Regular disbursement has been reported by most partners.
- Monitoring – regular, clear-cut indicators as understood by the respondents. However, the management of performance indicators is considered to be efficient in only 50% of the cases.
- In some clinics, there are problems with infrastructures as well as cleanliness.

Our overall observation is that services are mainly directed to prevention, promotion and reproductive activities, and less on curative care for the general population.

### *VI.2 Accountability, governance and cost effectiveness*

Is the institutional arrangement including the organizational design good for efficient service delivery? Efficiency may be considered in terms of:

- access and quality of primary healthcare for urban population especially the very poor;
- transaction costs in contracting out and the potential for expansion

Evaluation reports, both external and internal and our own observation suggest that service delivery has improved in urban areas of Bangladesh because of UPHCP. Clients are satisfied with the quality of services and the goal of targeting the very poor is achieved by most NGOs under UPHCP. The second criterion is difficult to achieve because transaction costs seem to be high that may create problem for scaling up. The reasons behind these positive and negative features of UPHCP may be explained in terms of accountability relationships discussed in Section II above.

### **Delegation**

The channels of accountability in UPHCP work as follows:

- GOB/MOHFW (policymaker) accountable to citizens
- GOB accountable to donors
- LGD accountable to MOHFW
- NGOs (provider organizations) accountable to LGD
- Facility-level health workers accountable to NGOs

Selecting the right type of partner has been facilitated by the availability of motivated NGOs in Bangladesh. However, there are NGOs of different capability and commitment to deliver required services. This makes selection process lengthy and costly. Cortez study found worst performance of UPHCP in terms of bidding experience and selection process. However, Loevinsohn (undated paper available at World Bank website) found that “The competitive bidding process used under the UPHCP was successful in keeping the cost of contracts low.” In UPHCP, timely contracting out through efficient bidding process is important: but some delays occurred in the bidding process and delay in starting the UPHCP1 that led to delay in the initiation of the Second Phase. However, service delivery has not suffered because of the timely extension and disbursement of additional funds during the transition period as reported by service provider NGOs during our interview.

One question raised in Section II is, *Are policymakers separate from the service providers?* The institutional set-up of UPHCP indicates that the MOHFW and DGH are separate, but the City Corporation is intimately connected with the partners and sometimes with frontline health providers (See Appendix Table 2 Project Management Setup). It appears to be a government-run project rather than non-public sector project. The accountability relationship between the City Corporation and NGOs as provider organization breaks down. Too much involvement of the City Corporation in the sphere of management entails additional cost that can also take huge proportion with the expansion of the project (see costs estimates of consultant firms in the appendix).

There are many unanswered questions related to transaction costs and long term financial sustainability of the overall project. How much are the transaction costs involved in contracting out? How do they compare with public sector provision through local government organizations? Since the project is largely dependent on donor funds, question arises with respect to alternative sources of funds, for example, government budgetary allocation. Given the limitation of fiscal resource, NGOs are encouraged to charge the clients (those who can afford) for some of the services. According to Loevinsohn, many NGOs employ user fees that cover 5 to 20 percent of their costs, and “the average cost per beneficiary for the winning bidders was 35% lower than what had been estimated during the design of the project” (Loevinsohn, *ibid*). The question is, to what extent can health expenditures be financed through user fees without conflicting the goal of reaching the poor? The possibilities of

financing PHC through public finance and user fees are discussed in donor reports with a pessimistic scenario. Costs were also involved in bidding and selection processes, especially due to delays in the second phase, and in monitoring and evaluation. But there is no explicit concern among policymakers and donors about the costs of implementing the projects especially the problem of scaling up. It is not clear whether the average cost per beneficiary that was found to be low among the winning bidders (Loevinsohn) included the transaction costs.

While we do not have figures, transaction costs appear to be higher in partnerships compared with public sector provision. This is because accountability channels are fewer in direct provision by the government than in contracting out.

- GOB/MOHFW to citizens and donors
- LGD to MOHFW
- Facility-level administrators and health workers accountable to LGD/MOHFW

The government and the line ministry are accountable to its citizens for basic health care services. The line ministry (MOHFW) delegates this responsibility to lower level of administration who further delegates it to health facility management and health workers. Fewer channels may imply lower costs by reducing the problem of multiple principals, multiple tasks, and measuring and attributing outcomes of different agents. Under UPHCP manpower need for Project Management Unit (PMU) and Project Implementation Unit (PIU) is quite substantial (See Appendix Table 3.)

## **Finance**

Sufficient and timely disbursement of resources under UPHCP is expressed by all partners.

**Performance:** defining the range of activities to be performed is clear with a bulletin board in front of each facility building.

**Information** about service delivery – the indicators for monitoring are clearly defined and reporting is regular although there is discrepancy in the reporting system when it comes to details. In the project proposal, impact, outcome and output-based indicators are identified. However, the partners reported mainly facility-based output indicators.

How well do the channels of information work for monitoring and evaluation? A standard procedure (PMU, PIU) exists that has been followed uniformly by all partners. The weakest link in the information chain is client opinion as discussed below.

### **Enforcement**

Client participation in UPHCP is not visible. No explicit concern is expressed by the partners in the contract about client participation in designing service provision although the ADB reports mentioned that all stakeholders were present during the initiation stage. There is very little follow-up discussion on community participation in health care planning and implementation in the reports of donors and the line ministry. All facilities have the provision of collecting clients' opinion about the quality and access of the services. How much feedbacks they provide is not known, however.

Links between remuneration and outcomes - Are there clearly stated tasks to be performed by NGOs? Yes. Are punishment and reward clearly linked to the services that are agreed to be provided? The answer is yes, because the failure to comply with the contract and to fulfill the objectives may lead to the termination of contract and no renewal for the next period.

#### *Incentive structure for frontline providers:*

- Opportunities for advance – uncertain about job security; high turnover rates.
- Fear of punishment – it is not overwhelming, and the relationship between the management and health workers seems to work well except that turnover rates among doctors are high, not necessarily due to bad relationship but due poor pay and carrier prospects.
- Why are NGOs more efficient in service delivery? Can the govt. run facilities learn from them? Possible answers are:
  - More direct relationship between provider organization and health providers that makes it difficult for health workers to engage in private practice.
  - They may enjoy more freedom, flexibility and better financial incentives than doctors in government facilities. We have, however, observed problems of vacancy and high turnover rate.

- Both NGOs and their health workers work with a narrow set of tasks and specific goals unlike the bureaucrats in health ministry and health workers with less transparency and clarity of purpose.
- Altruism and motivation to serve the poor may be additional explanation. Often success depends on the availability of motivated leaders.

## **VII Summary and Conclusions**

UPHCP is efficient in reaching the poor and urban population in general. It is a unique institution in so far as deep involvement of local government in project implementation is concerned. While this has contributed to high performance it should be noted that it is highly resource-intensive, and it raises the question of emulating it on a large scale. At present, the NGO sector accounts for less than 10% (World Bank 2005) of service delivery.

One major problem with the project is its total lack of concern about transaction costs involved in contracting out, monitoring, evaluation and consideration of other alternatives of service delivery. Questions that should be considered are:

Does the local government have the ability (both financial and human resource-wise) to expand its contracting out activities? What will be the costs of other alternatives such as the local government taking the responsibility of service provision (ESP) through its regular personnel (with civil service status) as it is done in many industrial countries. Policy documents are not clear about the future role of NGOs versus direct government provision. Is contracting out a temporary solution until the government learns to gather experience in service delivery management? Or the intention is to have pluralism with respect to service providers?

At present, there is too little diversification or pluralism since local government facilities in the urban areas are being marginalized with many of their functions are handed-over to the NGOs. Instead of replacing the services of govt., NGOs can work as another alternative that would increase consumer choice, foster competition and improve quality and access. Proper incentive mechanisms may be devised to attract patients.

Sustainability issues: – user fee coexisting with exemption rules for the poor but enjoyed largely by the non-poor is a problem. Rumours about corruption with medical supplies,

subsidized services provided to the non-poor are heard but no reliable study is yet available. UPHCP's sustainability is questioned by the general public since UPHCP is a donor-driven project, and can disappear as soon as donors withdraw their support. There is also a sense of lack of ownership because of the involvement of NGOs which are considered by people as foreign entities. This can create a problem for active participation of clients/citizens in holding the service providers accountable. As reported by one of the provider NGOs, in Bangladesh, people expect the government to provide basic health services not the NGOs. Lastly, the lack of job security for health workers reflected in high turnover rates and vacant positions of doctors in some areas also affects the sustainability of an institution.

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## VIII Appendix

Table A1. Interview questions and results

Interview Questions	Type of NGO							
	BWHC P-01	BWHC P-02	BAPSA P-03	PSTC P-4a	Shimantik P-4b	Nari Maitree P-5	Marie Stopes	UTPS P-07
1. What kind of care do you provide? a. preventive, curative, maternity care b. others, specify	A Comments – HIV awareness work area- Hotels & Brothels	a. Specialization in TB in Aga Sadek Road.	a.	a. With a focus on population issues and training	a.	a.	a.	a.
2. Are majority of your patients male or female and children or both? a. male b. female & children c. both	B	b.	b.	b.	b.	b.	b.	b.
3. What is the income status of your patients? a. middle class b. poor c. hard-core poor d. Mixed	D Sometimes very poor patients are referred to Government hospitals for free treatment. They also have partnership with the private sector for specialized services at subsidized rate for the hardcore poor.	b. & c.	a., b. & c.	b.and c. with only 19% cost recovery	d.	b.	d.	b.and c.
4. What is the catchments population?	3,39,000	156,347	400,000	303,850	281,000	361, 000	309, 000	281, 000
5. What is the number of your staffs? a. PM b. CM c. Doctors d. Nurses e. Admin f. Others g. Counselor h. BCC worker	a. 1 b.1 c.14 d. 13 e. 20 f. 56 g. 22 h.26 ?????	a. 1 b. 1 c. 14 f. 41 g. 10 h.28	a. 1 b. 0 c. 14 d. 4 e. 1 f. 12 g. 1 h. 27	a. 1 b. 0 c. 18 d. 6 e.1 f. 58 g. 6 h. 9	a. 1 b. 1 c. 6 d. 3 e. 0 f. 6 g. 1 h. 4	a.1 b.1 c.14 d.21 with paramedics and BCC workers? f. 75 g. 1	a.1 b. 1 c. 12 d. 22 including paramedics total 108	a. 1 b. 1 c. 14 d. 19 e.

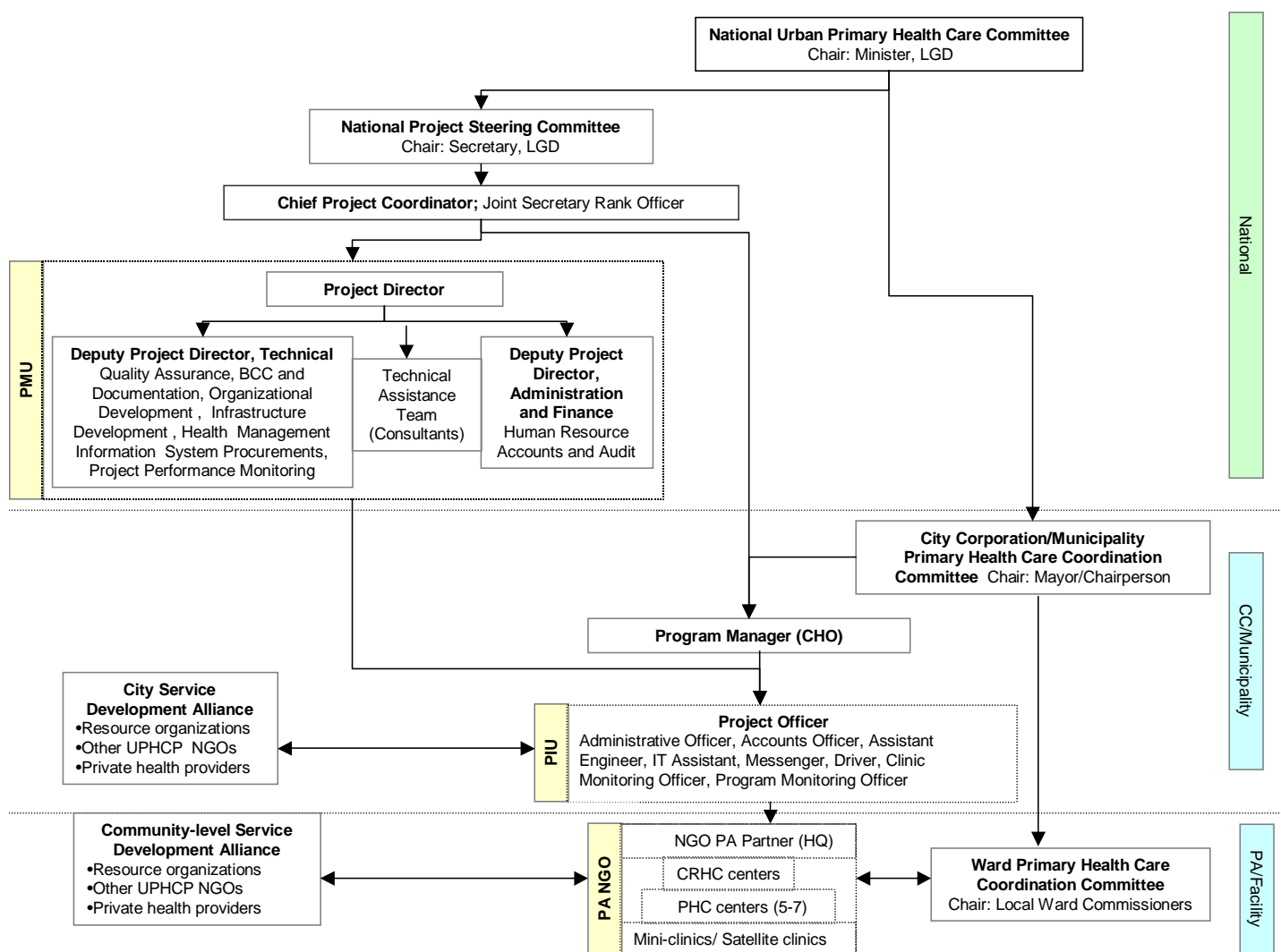


6. Who is responsible for daily administration of work schedule? a. PM b. CM	a.	Medical officer	CM/Medical officer helped by admin	a.	b.	PM for overall CM for clinic-based work	CM	CM
7. Who is responsible for daily management of inventories and medical supplies? a. CM b. store keeper c. Accounts officer	a.	Medical officer	Admin. Officer	C,	Counselor	Assistant administrator	CM other post	Store manager I CMC Lab technician in PHC
8. Is daily management influenced by UPHCP? a. yes b. no	a. Manually	b.	a.	b.	a.	b.	b.	Zonal health office of City corporation
9. Who makes the decisions about hiring of the staffs? a. PM b. Recruitment board c. Jointly	b.	b.	b.	b.	b.	b.	b.	b.
10. Who makes the decisions about salary? a. NGO b. UPHCP c. Jointly	a.	a.	a.	a.	a.	a.	No comments	a.
11. Who makes the decisions about promotions, transfers, bonus, increments, etc? a. PM b. UPHCP c. NGO	a.	a.	a.	a.	a.	a.	a.	PM
12. What is the degree of turnover of doctors? a. High b. Low	a. High turnover especially after BCS exam.	a. Two posts are vacant.	No comments	No comments	a.	No comments	b.	b.
13. How systematic is your management of patient histories? a. Detail b. ?	a.	a. Difficult to maintain because of floating population	a. They are efficient but trouble arises due to loss of card by patients. A.	a. community awareness program	a. ????????? ?????	?	a.	a.
14. How do you record Patient	a.	c.	b.	b.and c.?	a. & c. Also there	b.	a. c. and d.	b.

response? a. Log book b. Complain box c. Verbally d. Hot line				greater acceptance by people the partnership approach with local govt involvement	is a questionnaire for clients			
15. How does the Civil Society respond? a. Directly b. Through elected members c. Both	c.	No comment	c.	No comments	No comment	No comments	No comments	No comments
15. Do the clients engage in lobbying? a. Yes b. No comment	a.	a.	a.	No comments	b.	No comments	No comments	No comments
16. Who does the lobbying? a. Rich b. Poor c. Hardcore poor	a. & b.	a. & b.	a. very aggressive		No comment	No comments	No comment	No comments
17. How are funds allocated? a. mobilization fund and submission of quarterly expenditure	a.	a.	a.	a.	a.	a.	a.	a.
18. From where do the funds come? Comments	From local Government and UNFPA	From local Government and other donors.	From local Government and ADB	GOB ADB NDF UNFPA	Local Government	Local government and donors	Local govt.	Local government
19. Are the disbursements regular? a. Yes b. Sometimes irregular	a.	a.	a.	a.	a.	a.	a.	a.
20. What is the length of delay? a. less than a month b. more	a.	a.	a.	a.	a.	A.	a.	a.
21. How much discretion over fund utilization? Comments	More for minor items, otherwise approval needed	More for minor items, otherwise approval needed	Some	Some	Some	some	Some	Some

22. Do you have standard auditing system? a. Yes B. No	a.	a.	a.	a.	a.	a.	a.	a.
23. Do you have standard prices for different services? a. Yes b. No	a.	a.	a.	a.	a.	a.	a.	a.
24. Are some services free for your patients? a. Completely free b. Partially free	a. for hardcore poor, otherwise b.	a. for hardcore poor, otherwise b.	a. for hardcore poor, otherwise b.	a.	b.	b. a.for hardcore poor	b.	b.
25. What kind of contract do you have with UPHCP? Comments	Five year contract for the first phase, waiting for second phase.	Do.	Do	Do	Do	Do	Do	Do
26. What is the mechanism for monitoring? a. UPHCP b. Internal c. External firm d. All	d.	d.	d.	d.	d. Quality assurance fund	d.	d.	d.
27. Do you have specific performance indicators? a. Yes b. No	a.	a.	a.	a.	a.	a.	a.	a.
28. How systematic is management of performance indicators? a. Highly efficient b. Moderate c. Poor	a.	b.	b. ?????????? ??	a.	a.	b.	No comments Special quality control mechanism	a.
29. How is the utilization of service facilities? a. Fully utilized b. Under utilized c. Over burdened	a.	a.	a.	a.	a.	a.	b.	a.

## A2. PROJECT MANAGEMENT SETUP



**Table A3. Manpower for Project Management Unit (PMU).**

SL	Description	No	Grade
1.	Project Director	1	4
2.	Deputy Project Director (Technical)	1	5
3.	Deputy Project Director (Finance & Admin.)	1	5
4.	Senior Accounts Officer	1	6

5.	Epidemiology and Nutrition Officer	1	6
6.	Executive Engineer	1	6
7.	MIS and Data Management Officer	1	6
8.	HRD Officer	1	6
9.	Sr. Monitoring and Quality Assurance Officer	1	7
10.	Logistic and Store Management Officer	1	9
11.	BCC & Research Officer	1	9
12.	Assistant Engineer	1	9
13.	Accounts Officer	1	9
14.	Administrative Officer	1	10
15.	Accountant	1	14
16.	Computer Operator	1	13
17.	Office Assistant	1	16
18.	Driver (Ambulance )	6	16
19.	Security Guard	2	20
20.	Messenger	1	20
21.	MLSS	3	20
	Sub Total t -	29	

### **Manpower for Project Implementation Unit (PIU)**

#### **PIUs : City Corporation Based**

<b>SL</b>	<b>Description</b>	<b>No</b>	<b>Grade</b>
22.	Project Officer	06	6
23.	Sr. Monitoring and Evaluation Officer	06	7
24.	Accounts Officer	06	9
25.	Upper Division Clerk	06	14
26.	Assistant Engineer	06	9
27.	Computer Operator	06	13
28.	Driver (Ambulance)	08	16
29.	Messenger	06	20
30.	MLSS	06	20
	Sub Total	56	

**Table A4. COST ESTIMATES OF CONSULTANT FIRMS**

<b>Cost in US\$</b>							
<b>Package</b>	<b>Person months</b>		<b>Personnel costs</b>		<b>Other costs</b>		<b>Total</b>
	Inter.	Local	FC	LC	FC	LC	
1. Behavior change communication		72		158,400		2,841,600	<b>3,000,000</b>
2. Management support for PMU							<b>2,334,000</b>
• Health System management Specialist/Advisor	78		1,404,000				1,404,000
• STTA International	20		360,000				360,000
• Program Support Expert		78		195,000			195,000
• STTA Domestic		150		375,000			375,000
3. Management capacity building and staff training in quality PHC							<b>1,960,000</b>
• Improving Management Capacity (Local Courses, Workshop, Seminars, etc)		36		79,200		660,800	740,000
• Staff Training for Quality PHC Services (Training, System Development, Fellowship, Study Tours, etc.)		36		79,200		660,800	740,000
• Overseas study tour and training					480,000		480,000
4. QA and supportive supervision		72		158,400		766,600	<b>925,000</b>
5. HMIS development and implementation		108		237,600		962,400	<b>1,200,000</b>
6. Project performance monitoring and evaluation		144		316,800		1,003,200	<b>1,320,000</b>
7. Financial management and performance audit contract		72		158,400		591,600	<b>750,000</b>
8. Construction supervision and resettlement		40		88,000		417,000	<b>505,000</b>