

PHC for the Urban Poor: Second Urban Primary Health Care Project (UPHCP-II) Perspective

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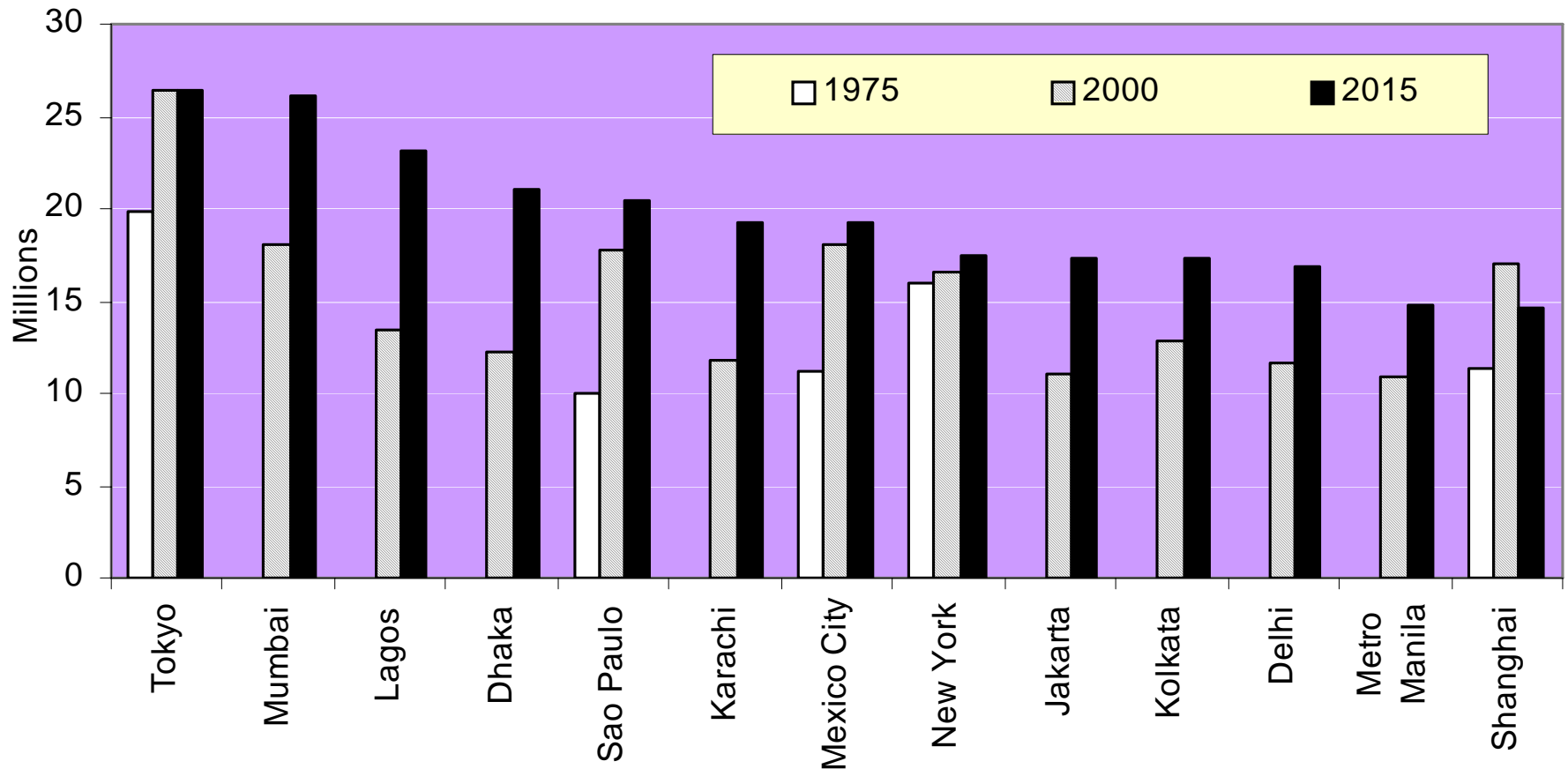
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Rapid Urban Population Growth

- The urban population is increasing by 6% per annum
- By 2010, the urban population is expected to be a third of the total population and is set to rise to 87 million by 2030.
- Of the urban poor in Dhaka, 48% live in slums while the rest live on the streets or at their work sites.

Dhaka-Fourth Largest City by 2015



Urbanization of Poverty

- Hardcore poverty (less than 1,805 kilocalories per day per head) :
 - decreased by 1.36 million households between 1991 (4.83 million) and 2000 (3.47 million) in rural areas.
 - increased by 0.53 million in urban areas (from 0.65 million in 1991 to 1.18 million in 2000).[\[1\]](#)

[\[1\]](#) Bangladesh Bureau of Statistics. 2003. *Report on the Household Income and Expenditure Survey (2003)*. Bangladesh.



Urban Primary Health Care- Mandate of Urban Local Bodies

- The Municipal Administration Ordinance of 1960,
- Pourashava Ordinance of 1977, and
- City Corporation Ordinance of 1983 assigned responsibility for provision of preventive health care and limited curative care in urban areas to the city corporations and municipalities.



Rationale for Public Financing of Urban Primary Health Care

- Urban explosion
- Urbanization of poverty
- Achieve Health MDGs
- Slums—potential foci for emerging communicable disease epidemics
- Lifestyle related noncommunicable diseases epidemic more likely



Urban Primary Health Care

- Publicly financed primary health facilities in urban areas modest at best and nil at worst in South Asia.
- 90 % of private health service provider work in urban settings.
- 2 PPP projects remain the two main contributors to urban health outside the commercial sector in Bangladesh:
 - The USAID project (under MOHFW) started in 1997
 - The ADB project under the Ministry of Local Government, Rural Development, and Cooperatives (MOLGRDC) started in 1999



Reaching the Urban Poor

- Little research in health seeking behaviour of urban poor
- Urban poor have different priorities, need for housing, clean water, sanitation, a clean environment, etc.
- Slum dwellers are usually migrants from rural areas and are mobile. Other urban poor, who are not well captured by the system, are also believed to be fairly mobile.

URBAN PRIMARY HEALTH CARE PROJECT-I

- UPHCP was launched to provide primary health care for the urban poor, particularly women and children
- The components of UPHCP include:
 - Provision of PHC through Partnership Agreement (3 - 500,000 Target Population)
 - Strengthening urban PHC and sanitary infrastructure
 - Building capacities of city corporation and municipality health departments and PA NGOs
 - Project implementation through operationally relevant research

UPHCP-1

- Implemented by Local Government Division of MOLGRDC
- Initially 4 city corporations (CCs) included—Dhaka, Chittagong, Rajshahi and Kulna
- Actual Service delivery contracted out to NGOs (QCBS, international tendering)
- 16 partnership agreements signed for a target population of 6 million



Lesson from UPHCP-I: Better Pro-Poor Targeting

- Contracting Essential Health Service delivery out to NGOs works, but
- Need for designed-in pro-poor performance standards & incentives
 - Minimum service utilisation quota for poor
- Essential Health Service Mix in urban setting ought to be different (ESP+)
- Need to include Sanitation, VCT, Nutrition and waste management
- Need for capacity building for management and additional services

UPHCP-II

- Expanded to 6 City Corporations and 5 Municipalities
- Part of HNPSW SWAp but with separate funding stream (ADB, DFID, SIDA, UNFPA, ORBIS, future EC support likely)
- New PAA NGO contracts to be in place from July 2006
 - Importance of seamless transition
- 7 capacity building support service packages contracted out (Management and training support, M&E, FM, MIS etc)



Reaching the Poor: UPHCP-II

- Baseline survey of project area to identify households below poverty line
 - Participatory poverty assessment
 - The “poor” are defined in the bid document
- Proximity of health facilities to slums
- Social mobilization and community involvement in service management
- Strong pro-poor monitoring and record keeping
- Piloting of Demand-Side financing and insurance schemes such as Health Cards



Performance Bonus

- **Performance Bonus:** The contractor will ensure that at least 30% of the clients served under the project will be ultra-poor, who will get free services. Both contractor records and **independent surveys and monitoring** will be used to determine the **gender and poverty focus**. Contractors not meeting the gender and poverty focus and enable gender equity and adequate female adolescent health focus targets will not be considered for bonus.

Estimated Cost of Providing Urban Health

Year	Population (million)		Project annual cost of providing urban primary health care to 50% urban population at different per capita cost (\$ million)				Project annual cost of providing urban primary health care to 100% urban population at different per capita cost (\$ million)			
	Total	Urban	\$1	\$3	\$12	\$30	\$1	\$3	\$12	\$30
2000	138	32	16	48	192	480	32	96	384	960
2005	153	38	19	57	229	572	38	114	458	1,144
2010	167	45	23	68	272	679	45	136	544	1,359
2015	181	54	27	80	322	804	54	161	643	1,609
2020	195	63	32	95	379	948	63	190	759	1,897
2025	208	74	37	111	445	1,113	74	223	890	2,225
2030	220	87	43	130	519	1,298	87	260	1,038	2,595



Conclusion

- Evidence and experiences from UPHCP-II will give better insights into framing of primary health care services performance-based contracts with pro-poor targeting