



GENDER EQUALITY RESULTS CASE STUDY

BANGLADESH

SECOND URBAN PRIMARY HEALTH CARE PROJECT

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Bangladesh: Second Urban Primary Health Care Project

Summary

DEVELOPMENT AIMS AND IMPACTS. The Urban Primary Health Care Project strengthened and expanded primary health care infrastructure and services with a focus on the urban poor. The project provided preventative and curative services, including access to immunization, reproductive health services, limited curative care, nutrition-related services, community outreach on health issues, and assistance for women survivors of violence. In project areas, there were significant improvements in key indicators, including under-5 mortality, maternal mortality, total fertility, child malnutrition, and control of sexually transmitted infections.

ADB PROCESSES AND MANAGEMENT TOOLS. During the project design phase, a gender action plan (GAP) was developed. This plan provided analytical background and set out a series of initiatives to strengthen attention toward gender equality issues and improve access of women and girls to health services. In addition to the GAP, other approaches that contributed to the project's gender equality performance were pro-poor targeting particularly women and children, public-private partnership health service delivery model, and creation of awareness among adolescent boys and girls. Specific indicators to track progress were included. The project increased access to health services (health facilities were constructed close to poor communities, with a target of providing 30% of services to identified low-income families), increased women's access to health services (70% of beneficiaries were females), and contributed to improvements in maternal mortality ratio.

Main Aims of the Project

With rapid urbanization in Bangladesh, the urban poor faced many unmet primary health care (PHC) needs. In 1998–2005, the Government of Bangladesh implemented the Urban Primary Health Care Project with the support of the Government of Bangladesh, Asian Development Bank (ADB), United Nations Population Fund (UNFPA), Nordic Development Fund. For this project, nongovernment organizations (NGOs) were contracted as agents to deliver urban PHC, resulting in significant gains and a decision to continue with an expanded initiative.

The second phase of the project was approved for 2005–2012 (later extended to 2014), with support from ADB, the Department for International Development of the United Kingdom, the Swedish International Development Cooperation Agency, and the United Nations Population Fund. In this phase, contracted NGOs continued to provide PHC services.

The overall purpose of the Second Urban Primary Health Care Project was to improve access to and utilization of efficient, effective, and sustainable high-quality PHC services for the urban poor areas covered by the project, with particular focus on women and girls. The project covered six city corporations and five municipalities.¹ See Box 1 for basic information on the project.

The Second Urban Primary Health Care Project had four objectives, which were to

- strengthen and expand provision of PHC services;
- strengthen urban PHC infrastructure;
- build capacity of city corporations, municipalities, and partners (NGOs) in managing provision of PHC services in urban areas; and
- improve project implementation and conduct operationally relevant research.

Box 1: Project Basic Facts

Loan/grant Numbers:	2172/0008/0009/0010
Loan approval:	May 2005
Closing date:	September 2014
Executing agency:	Local Government Division of the Ministry of Local Government, Rural Development and Cooperatives
Overall project cost:	\$91 million
Financing:	ADB loan: \$30.0 million ADB grant: \$10.0 million
Government of Bangladesh:	\$18.0 million DFID: \$25.0 million Sida: \$5.0 million UNFPA: \$2.0 million ORBIS International: \$1.0 million
Gender classification:	Effective gender mainstreaming

DFID = Department for International Development of the United Kingdom, Sida = Swedish International Development Cooperation Agency, UNFPA = United Nations Population Fund.

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

Source: Development Project Proforma/Proposal of Government of Bangladesh.

¹ The specific project sites were six city corporations (Barisal, Chittagong, Dhaka, Khulna, Rajshahi, and Sylhet) and five municipalities (Bogra, Comilla, Madhabdi, Savar, and Sirajgonji).

Key Gender Equality Health Issues and Approaches

One of the key health issues identified during project planning was maternal mortality. In 2005, Bangladesh had a maternal mortality ratio (MMR) of 300 per 100,000 live births. There were low rates of antenatal care and births in health facilities. Therefore, maternal and child health was seen as a crucial issue to address when delivering urban PHC.

In view of these issues, the range of PHC services included (i) reproductive health care (safe motherhood and contraception, prevention of reproductive tract infection); (ii) mother and child health care; (iii) immunization; (iv) management of common and minor diseases and injuries; (v) control of endemic diseases, for example, tuberculosis, pneumonia, and diarrhea; (vi) diagnostic services; (vii) management of emerging problems, for example, HIV/AIDS and dengue; (viii) health education and behavior change communication; (ix) services related to violence against women; (x) normal delivery and Cesarean section delivery through comprehensive reproductive health care centers and primary health care center; and (xi) primary eye centers. A health center offers some of these services such as in the case of *Khulna Mukti Sheba Sangstha* (see Box 2).

Box 2: Health Services of *Khulna Mukti Sheba Sangstha*

According to Kazi Nurun Nabi, the project manager of a health center run by nongovernment organization *Khulna Mukti Sheba Sangstha*, the center covers an area with a population of over 200,000, 40% of them living in 22 slum areas. A key focus of the center is on slum dwellers and poor garment workers who have migrated from impoverished rural areas to the city in search of employment.

“The number of slum women coming to the health center for delivery and other health care has risen to over 70%, almost double the number a few years ago,” said Nabi, referring to a baseline survey. “Five years ago, only 45% of mothers practiced exclusive breastfeeding of their babies for 6 months. Now it has climbed to 70%, higher than the national average.”

The services of the center include family planning and immunization.

Source: Collected by the Bangladesh Women’s Chamber of Commerce & Industries for this gender case study.

Improving PHC in urban settings has obvious gender equality dimensions, given the prominent challenges relating to maternal and child health. Improving maternal health through improved prenatal and antenatal care, attended births, emergency obstetric facilities, and community outreach is a crucial gender equality issue in PHC.

Yet, gender mainstreaming in PHC involves more than just ensuring safe births and health care for mothers. Gender differences and inequalities are relevant in urban PHC for numerous reasons:²

² See, for example, World Health Organization. 2010. *Gender, Women and Primary Health Care Renewal: A Discussion Paper*. Geneva; ADB. 2006. *Gender Checklist: Health*. Manila.

- Given the biological differences, women and men face different health risks, conditions, and needs. This is broader in scope than maternal health, as there are gender differences related to the incidence and progress of specific diseases and issues relating to aging.
- Gender roles and differences influence health status. How society values women (girls) and men (boys) differently and the accepted norms of male and female behavior influence health problems and outcomes. For example, preference for a male child can influence allocation of scarce household resources, including food and money, for health care. Women are the overwhelming victims of gender-based violence.
- Gender norms affect health-seeking behaviors and the use of health care services. Women and men often have different attitudes toward medical care (including preventative care), and women may not be able to access health care if the services are not seen as culturally appropriate. Furthermore, women may not have the resources to pay for health care services and, in some cases, require the permission of a male relative.
- Health care workers of both sexes should have harassment-free workplaces and enjoy equitable opportunities for advancement. They should also be trained to understand and address gender inequalities and differences in PHC.

To promote women's health, there is a need to provide women-friendly health care services (see Box 3). Good practices to ensure women's access to PHC and to address gender equality issues include³

- appropriate location and timing of services that are comfortable for people of all ages (including the elderly and the youth);
- outreach to men for preventative care as well as sexual and reproductive health care;
- availability of care for survivors of gender-based violence;
- minimal wait times;
- low- or no-cost services;

Box 3: Women-Friendly Health Care Services

Women-friendly health care services have been defined as services that

- are available, accessible, affordable, and acceptable;
- respect technical standards of care by providing a continuum of services in the context of integrated and strengthened systems;
- are implemented by staff motivated and backed up by supervisory, team-based training, and incentive-linked evaluation of performance; and
- empower users as individuals and as a group by respecting their rights to information, choice, and participation.

Source: *Women-Friendly Health Services: Experiences in Maternal Care*. Report of a WHO/UNICEF/UNFPA Workshop, Mexico City, January 1999. World Health Organization, United Nations Children's Fund, and United Nations Population Fund.

³ Footnote 2.

- integration of services (e.g., women being able to get their children vaccinated and also access family planning on the same visit);
- confidential attention (visual and auditory privacy);
- ensuring services integrate women's rights to receive appropriate information and support women's ability to make informed decisions regarding care and treatment;
- health care providers trained to avoid gender stereotyping and able to address health needs of women and men;
- services that meet the diverse needs of women and men (older women, teens, people with disabilities, etc.); and
- health information systems that include the collection and analysis of sex-disaggregated statistics.

Project Plan for Involving Women and Addressing Gender Disparities

A primary focus of the project's PHC services was maternal and child health. During the project design, 75% of the project beneficiaries were anticipated to be women and children, and 90% of the health care services were based on an essential services package that focused on maternal and child health.

The project included a gender action plan (GAP) developed during the design phase, and it outlined specific activities and indicators for each project component.

Overall, the GAP aimed for a reduction in infant mortality rate and MMR. It included delivery of preventative, promotional, and curative health services to women (with an emphasis on poor women), as well as the provision of nutritional supplements to the moderately and severely malnourished. Other elements in the GAP included

- improved reproductive health care facilities (including basic and comprehensive obstetric care facilities and antenatal checkup);
- provision of first aid, counseling, crisis support, and referral to legal counseling for female survivors of violence and under threat of violence;
- development of awareness programs and disseminating information through media to encourage women to access health care services;
- increased employment opportunities for women as health care providers and managers (targets were established for the percentage of health care workers who were women);
- setting a target to reserve half of the constructed community toilets for women;
- training project staff and service providers toward understanding the health needs of the urban poor, focusing on the needs of women and girls;
- prevention of communicable diseases through environmental safeguard measures and proper management of sanitation programs such as community latrines, solid waste disposal, and clinical waste management;
- encouraging women's participation in PHC design through the involvement of female ward commissioners in community programs and the training of women community health volunteers; and
- sex disaggregation of data.

The project also employed an intermittent gender equality specialist until 2010. The deputy project director was named as the “gender focal point.”

One component of the project mobilized behavior change among communication workers. These workers carried out visits to urban slums and provided information on project facilities, good hygiene practices, children’s immunizations, and reproductive health care. They organized “courtyard” meetings with mothers and their in-laws, as well as male family members, to talk about family welfare and health care.

Key Achievements

Since 2001, Bangladesh has made significant improvements in the MMR due to changes within and outside the health sector. Overall, MMR fell from 322 deaths per 100,000 live births in 1998–2001 to 194 deaths per 100,000 live births in 2007–2010. This was a result of increased access to health care, as well as increased incomes and improved education levels of women.⁴

Overall, the project contributed to poverty reduction by improving the health conditions of the urban poor. Specific results in the project areas (compared with the project baselines) are as follows:⁵

- Under-5 mortality rate was reduced by 25.6%.
- MMR was reduced by 41.3%.
- Total fertility rate was reduced by 16.7%.
- Child malnutrition was reduced by 10.1%.
- Sexually transmitted infection prevalence was reduced by 87.9%.

Of the 26.5 million contacts, 79% were women and 21% were men. Approximately one-third of each service, especially maternal and child health care, was accessed by the urban poor, exceeding the planned target of 30%. An example of women served was Sheuly Begum (see Box 4).

The project is considered innovative for the public–private partnership that contracts out PHC to NGOs or voluntary organizations.

Specifically relating to maternal health, the project achieved important and significant results. Maternal mortality dropped by over 40%. The project initiatives that contributed to this improvement include (see table on page 8 for specific details)

- an approximately 300% increase in the number of deliveries in hospitals or health care clinics;
- a sixfold increase in the total number of antenatal care checkups and an eightfold increase in the prenatal care checkups during 2006–2011;

⁴ S. El Arifeen et al. 2014. Maternal Mortality in Bangladesh: A Countdown to 2015 Country Case Study. *The Lancet*. 384 (9951), pp. 1366–1374.

⁵ Project Completion Report. Asian Development Bank. 30 September 2014.

Box 4: One Woman's Story

Sheuly Begum, a 25-year-old homemaker, panicked when she went into labor with her second child 2 weeks late. Her husband, a 35-year-old security guard, immediately took her to a clinic, which was a 15-minute drive by a rickshaw in Dhaka's congested Pallabi area.

In the next 24 hours, Sheuly gave birth to a healthy boy without any complications, thanks to the doctors at the *Al-Haj Jahurul Islam Matri Sadan* (maternity center). This clinic is run by *Khulna Mukti Sheba Sangstha*, a nongovernment organization working in partnership with the government under the Urban Primary Health Care Project.

Kamrun Nahar Dolly, a doctor at the maternity center, said another day of delay could have been disastrous either for the baby or for Sheuly, or both. "The baby could have died inside the uterus. Or Begum could have suffered fistula," said Dolly.

"The doctors here have saved me and my baby. I'm grateful to them," said Sheuly seated on a bed covered with a clean white sheet, cuddling her 5-day-old boy.

Source: Project officials of the Second Urban Primary Health Care Project.

- counseling provided to husband and other family members on the importance of safe deliveries; and
- improved health care access for poor women, given the provision of free health care to poor families, and the construction of health care centers close to poor neighborhoods.

Also, there were gender equality results in three other areas: expanded use of contraception, services for women victims of violence, and increased opportunities for women's employment in the health care sector:

- The proportion of married women of reproductive age using modern contraception reached 65.1%.
- The behavior change communication workers identified women experiencing domestic violence during their work with communities or during consultation sessions at the clinics. Community supervisors and counselors provided counseling to the women and their families. In some cases, the community leaders (such as the ward commissioners) were able to provide support. In other cases, women were referred to NGOs that provide legal aid and support, such as the Bangladesh National Woman Lawyers' Association.
- Women's employment in the health care sector in the project areas grew, with 30% of managerial positions and 70% of service provider positions held by women at the end of the project. Female staff also benefited from the training offered by the project, comprising 60% of participants in the in-country training but only 20% in training offered outside of Bangladesh.

Main Outputs and Achievements Relating to Gender Equality

Activity	Indicator/Target	Achievement
Output 1: Provision of Primary Health Care through Public–Private Partnership Agreements and Behavior Change Communication Marketing		
Identify the poor people through poverty assessments and household listings and ensure availability of services to them	<ul style="list-style-type: none"> • Project beneficiaries increase from 30% to 60% (70% women and children) • 30% of each service provided free of charge to urban poor (75% women and children) 	<ul style="list-style-type: none"> • Patient flow in health care facilities in project areas increased by 266% in 2011–2012 compared with 2006–2007 • Pro-poor targeting was 40% in 2010–2011 (women 78%, children 21%) (number of poor patients: 42.3 million)
Provide counseling to parents and adult members of households on safe delivery	<ul style="list-style-type: none"> • More than 10% reduction in morbidity and mortality among children 	<ul style="list-style-type: none"> • Counseling increased by 948% during FY2006–2011
Improve access to basic curative service	<ul style="list-style-type: none"> • Women and girls access at least 60% 	<ul style="list-style-type: none"> • The proportion of women and girls accessing curative services was about 80%
Provide counseling and motivation to husbands and adult members of household to ensure safe deliveries for women	<ul style="list-style-type: none"> • Increased delivery at health care facilities by at least 20% • More than 40% women who need postnatal services receive them 	<ul style="list-style-type: none"> • 275% increase in safe deliveries in hospitals or health care clinics during FY2006–2011 • 408% increase in counseling and motivation to husbands and adult family members (2011–2012 compared with 2006–2007)
Conduct awareness sessions and door-to-door counseling, and ensure condom supplies	<ul style="list-style-type: none"> • Minimum of 6,000 yearly awareness sessions conducted on promotion of condom use by males, 10%–15% increase in use expected 	<ul style="list-style-type: none"> • 2,280 awareness sessions (11,983 participants) were conducted per year
Conduct training for staff on gender-based violence	<ul style="list-style-type: none"> • 100% of PHCCs and CRHCCs have at least two trained staff on gender-based violence 	<ul style="list-style-type: none"> • 175 dedicated staff of PMU, PIU, city corporations, municipal corporations, PHCC, and CRHCCs received training on violence against women in 7 batches; 55 female ward counselors from 24 project areas received training
Output 2: Urban Primary Health Care Infrastructure and Environmental Health		
Strengthen women and baby-friendly health care infrastructure facilities (breastfeeding corner, separate toilet, etc., for both service provider and recipient) in poor areas	<ul style="list-style-type: none"> • 144 PHCCs and 23 CRHCCs constructed in or near poor communities • More than 75% women and children and 25% men receive services • At least 50% of toilet blocks are reserved for women 	<ul style="list-style-type: none"> • 134 PHCC and 18 CRHCC buildings were constructed near slums or densely populated areas to improve access and coverage of PHC services to the urban poor • 78%–80% of clients were female • 50% of community toilet blocks were reserved for women
Output 3: Building Capacity and Policy Support for Urban Primary Health Care		
Strengthen the capacity of local governments to plan, finance, budget, monitor, and supervise urban PHC services	<ul style="list-style-type: none"> • Provide training to city corporations and municipalities in urban PHC, PHC management, health financing, and health management information systems • Establish dedicated units in each city corporation to handle these functions 	<ul style="list-style-type: none"> • Most of the training arranged by the project involved participants from local government institutions such as city corporations and municipalities. Training included planning financing, budgeting, monitoring, and supervision. Most of the

continued on next page

Table continued

Activity	Indicator/Target	Achievement
	<ul style="list-style-type: none"> All behavior change communication and awareness training materials include strategies to address health-related complications with all family members, not just women 	training courses were conducted inside the country, but some were organized outside the country.
Promote women's employment and leadership in the health sector in recruitment and management	<ul style="list-style-type: none"> 30% women in management positions and 50% as health service providers 50% women in in-country and 30% women in out-country training courses 	<ul style="list-style-type: none"> 30% managerial and more than 70% of service provider positions were held by women 60% of participants in in-country training courses and 20% in out-country training courses were women
Promote women's participation in health care institutions and forums	<ul style="list-style-type: none"> At least 50% women members in WPHCC forums, at least 30% forums chaired by female ward counselors 	<ul style="list-style-type: none"> WPHCCs were formed and headed by ward counselors and co-chaired by female ward counselors. Three women members from slum dwellers and poor groups were included. User forum was formed with both poor and nonpoor maintaining gender equity.
Promote gender-inclusive monitoring and evaluation and research	<ul style="list-style-type: none"> All project-related tools, formats, and documents include sex-disaggregated data 	<ul style="list-style-type: none"> Gender-inclusive management information system was developed, and reports from partner nongovernment organizations included sex-disaggregated data. The quarterly report of the project shows the sex distribution of beneficiaries. Gender-relevant research activities on improved hygiene education, community-based safe motherhood, violence against women, improving weaning practices, and sexually transmitted diseases were completed.

CRHCC = comprehensive reproductive health care center, FY = fiscal year, PHC = primary health care, PHCC = primary health care center, PIU = project implementation unit, PMU = project management unit, WPHCC = Ward Primary Health Care Committee.

Source: S. Bari. 2012. Improving Health Care Services for Poor Urban Women in Bangladesh. In ADB, ed. *Gender and Urban Poverty in South Asia*. Manila. Modified by information in the project completion report.

Project Features that Contributed to Gender Equality Performance

The project formulation and design included intensive national and local consultations with key stakeholders, particularly on the needs of the poor and the vulnerable, especially women. There were stakeholder participation and a review of lessons from the first phase of the project.

Three main approaches contributed to the project's success: pro-poor targeting, particularly women and children; the public-private partnership delivery model; and the GAP.

Pro-poor targeting. The project plan targeted delivering 30% of all PHC services (including medicines) free of charge. Participatory poverty assessments, based on social and economic indicators, were used to identify poor households, who were provided with health cards that entitled them to free services. These assessments were updated annually by the partner NGOs. Project-monitoring systems recorded the percentage of services used by these poor households.

- **Public-private partnership delivery model.** A key element of the project was partnering with private sector and nongovernment organizations (NGOs) for the delivery of health services. Project staff identified this element as one of the key features that contributed to gender equality results.⁶ This was affirmed in a study that found the NGO-run facilities and programs to have improved health service coverage, equity, quality, and efficiency.⁷ Nonetheless, further assessment needs to be done on this model.
- **Gender action plan.** The project design included a GAP. This plan played an important role in setting out specific activities and indicators relating to gender equality dimensions and results.⁸ The GAP included background information on gender equality concepts and the various commitments of the Government of Bangladesh to gender equality.

Another approach is the creation of awareness among adolescent girls and boys as narrated in Box 5.

Box 5: Awareness among Adolescent Girls and Boys

Creating awareness among adolescent girls and boys about sexually transmitted infections (STIs), HIV/AIDS, reproductive tract infection, and family planning methods was another striking feature of the project. The learning sessions for adolescent health care for 15 boys or girls in a group were held for 3 months.

Each Sunday, a group of about 15 young girls, mostly from nearby schools and slums, gathered on the second floor of the center to listen to health workers about the physical and biological changes adolescents witness; how STIs, HIV, and AIDS occur; and how to cope with changes.

“I’ve learned here about the benefits of using clean sanitary napkins when I’m on period,” says Sufia Akther, a 13-year-old girl from the nearby Bholashantytown that houses several thousand people. “I did not know that it is important to change the napkins after everyday use.”

Boys participated in a separate session held every Tuesday.

“Before coming here I had no idea about HIV or AIDS,” says Saifuddin Ahmed, a 16-year-old slum dweller who earns a living by operating a tricycle rickshaw in Dhaka’s northern Mirpur area. “Now I know how to keep myself protected from a deadly disease like AIDS,” says Ahmed. He said he used to feel shy talking about STIs. “I thought these are the subjects not to be discussed publicly. Now I feel free to share the knowledge with peers.”

Source: Project officials of the Second Urban Primary Health Care Project.

⁶ S. Bari. 2012. Improving Health Care Services for Poor Urban Women in Bangladesh. In ADB, ed. *Gender and Urban Poverty in South Asia*. Manila: ADB.

⁷ A. Heard, D. K. Nath, and B. Loevinsohn. 2013. Contracting Urban Primary Healthcare Services in Bangladesh—Effect on Use, Efficiency, Equity and Quality of Care. *Tropical Medicine and International Health*. 18 (7). pp. 861–70.

⁸ ADB. 2009. *Project Gender Action Plans: Lessons for Achieving Gender Equality and Poverty Reduction Results*. Briefing Note. Manila.

Lessons Learned

Lessons learned during the course of the project include⁹

- **Improving women's access to PHC.** Locating health care facilities in the vicinity of poor, urban households can make health care more accessible to women and their families. Pro-poor targeting can also increase access for the poorest families, including households headed by women. Engagement of NGOs and the private sector through public-partnership agreements with local governments is effective in expanding health care coverage to poor communities and providing employment and leadership opportunities for women in the health sector.
- **Improving awareness and knowledge of good health care practices.** Courtyard meetings and door-to-door counseling are effective ways to raise awareness and support the adoption of good health practices, including hygiene, child health, and reproductive health.
- **Improving women's participation, employment, and leadership in the health sector.** Preparation of a gender action plan ensures that health projects are designed with an understanding of gender-based constraints to women's participation and with procedures to overcome these constraints.
- **Improving data management.** For the implementation of gender-inclusive policies and programs, it is necessary to ensure that data management information systems track sex-disaggregated statistics.

Other lessons that can be drawn from the gender performance of the project include

- The basic steps the project took to view maternal and child health in a broader context (such as work with men and other family members on attitudes to safe delivery) could be expanded. It is important to address men's involvement and participation in reproductive health care. Younger unmarried women have different needs compared with married women in the middle of their reproductive years. Also, there are a multitude of factors that determine whether women seek health care and whether the health care provided actually meets their needs.
- It is important to address the health care needs of all women, not just pregnant women. Although maternal health is a crucial issue, women's health needs go beyond prenatal and postnatal care. A gender analysis or approach in PHC involves understanding how and why women's and men's health care needs differ and how to ensure that women and girls receive appropriate and equitable care from health care institutions.
- Questions related to partnership with NGOs that can be further explored to deliver strong gender equality results are as follows: What are the comparative advantages offered by NGOs in terms of addressing a broad suite of services related to reproductive health care and how can these be maximized? How can NGOs be encouraged to promote women as health care managers at senior levels and support their participation in decision making at all levels (internally and within the community)?

⁹ Footnote 6, pp. 67-68.

- The project completion report includes a brief summary of activities, outcomes, and challenges, but it does not match the level of detail provided in the original GAP. There is no comprehensive documentation on the challenge areas, whether all the recommended activities were undertaken, or whether there were any unanticipated results.

Challenges

The project completion report identifies the following challenges:

- The various committees that deliver high-quality health care services to the poor still lack awareness and understanding of gender equality dimensions. For example, the members of the Ward Primary Health Care Coordination Committees are not well informed regarding their roles, responsibilities, and obligations to provide women and children with equitable access to urban PHC.
- There is still a lack of gender- and child-friendly infrastructure with sufficient space. An evaluation of the project notes that both newly constructed centers and some of the buildings rented by NGOs do not meet current good practice guidelines (in terms of confidentiality, infection prevention, patient flow, etc.).¹⁰
- A shortage of female management staff suggests that women health care workers experience a discriminatory barrier in the profession despite the growing number of female doctors and health care workers in lower management levels. Further attention to this issue is advised.

This case study was produced by the Bangladesh Resident Mission in consultation with executing and implementing agencies. It builds on information included in the project progress reports and related gender action plan updates as well as on direct consultations with executing and implementing agencies and beneficiaries, and inputs from Asian Development Bank project officers.

¹⁰ A. O'Connell et al. 2012. *Report of the End of Project Review. Urban Primary Health Care Project II, Bangladesh.* Independent Consultant Team.

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