KfW Development Bank

# Ex-post evaluation
# SWAp Health, Nutrition and Population Sector Programme II, Bangladesh

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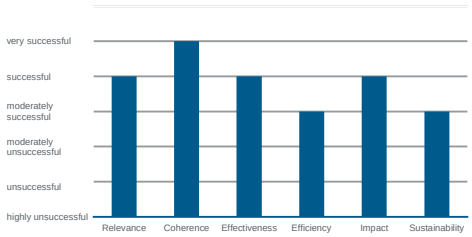
|---|---|---|---|
| **Title** | Health, Nutrition and Population Sector Programme II (basket funding), Bangladesh, 2011–2016 | | |
| **Sector and CRS code** | Health policy and administrative management (CRS code 12110) | | |
| **Project number** | BMZ no.: 2010 65 358, 2013 66 236, 2014 68 784 (Inv) and 2010 70 523 (CM) | | |
| **Commissioned by** | German Federal Ministry for Economic Cooperation and Development (BMZ) | | |
| **Recipient/Executing agency** | Ministry of Finance (MoF); Government of Bangladesh / Ministry of Health and Family Welfare (MoHFW); Government of Bangladesh | | |
| **Project volume/ Financing instrument** | Investment: EUR 49,921,636.02, budget funds grant (basket funding) and EUR 1,000,000 complementary measure (CM) | | |
| **Project duration** | Investment: 12/2011–10/2019; CM: 10/2011–12/2018 | | |
| **Year of report** | 2024 | **Year of random sample** | 2021 |

## Objectives and project outline

The FC programmes co-financed the national sectoral programme “Health, Population and Nutrition Sector Development Program” (HPNSDP, 2011–2016). This included measures aimed at improving the availability and use of patient-oriented, generally accessible and high-quality services for health, family planning and nutrition. It contributed to supporting national health policies, improving access to health care and improving the health status of the population. The FC complementary measure in the Tangail district was used to pilot the introduction of health insurance.

Overall rating:
**successful**




## Key findings

The FC projects’ objectives and indicators were largely achieved or exceeded, and most health-related SDGs improved during the implementation period. Therefore, the evaluated FC projects are rated as overall successful.

The measures and objectives of the overarching sectoral programme HPNSDP – and thus also the FC projects financing the basket – remain relevant. The selected basket funding instrument was suitable as an amplifier and accelerator (moderator effect). The comprehensive approach with numerous donors and the instruments used implied high coherence. This resulted in a comparatively fast, effective response capacity of the Ministry of Health and the donor community.

With regard to sustainability, the picture is mixed. At the health care facility level, sustainability appears to be average. The sectoral programme demonstrates good sustainability and has been continued in follow-up programmes. Health insurance is currently only operating in one district, but is sustainable there, and there is at least evidence at the time of the evaluation that a more extensive roll-out is being prepared. Integration into the new sectoral programme is planned, but no final decisions are yet available.

KfW was involved in the policy dialogue during HPNSDP as a recognised partner on an equal footing that clearly contributed the values of German DC. However, German DC withdrew completely from the healthcare sector in 2018. The national and international partners regret this step to this day. Taking these dimensions into account, sustainability is assessed as moderately successful.

### Conclusions

- Sectoral programmes have the potential to create moderation through the government’s joint approach with donors, i.e. they can strengthen the impact of individual measures and significantly increase their speed of implementation.
- Basket funding is a particularly suitable instrument for this, as it strengthens the responsibility of the partner country’s government.
- Consistent integration of health insurance in these kinds of sectoral programmes is recommended so that the disparity between impoverished and wealthy groups does not increase further.

# Ex post evaluation – Rating according to OECD-DAC criteria

## Overall context

The People's Republic of Bangladesh is still one of the poorest countries in South Asia, although economic development indicators show significant improvements. With a gross domestic product (GDP) per capita of USD 2,820 (2022) and USD 7,690 purchasing power parity[1] (PPP), Bangladesh has been a lower middle-income country since 2015, with double the GDP per capita since 2016 [1]. The Human Development Index (HDI) has improved steadily and reached 0.661 in 2021. The neighbouring countries India (0.633), Bhutan (0.666) and Nepal (0.602) are roughly at the same level, Myanmar (0.585) is lower [2].[2] After the independence from Pakistan, Bangladesh became a parliamentary democracy in 1972, but it can be described as fragile. Historically speaking, several military coups have been partly responsible for this, but the current political indices also show instability and lack of democracy. In 2023, the Fragile State Index (FSI)[3] was 85.2 out of 120 (rank 41), the Democracy Index (DI)[4] 5.99 out of 10 and the Corruption Perceptions Index (CPI)[5] 25 out of 100 (rank 147 out of 180). The FSI and DI have improved slightly in recent years while the CPI has deteriorated.

With a population of over 171 million inhabitants (2022) and a population density of 1,313 inhabitants/km$^2$, Bangladesh is one of the world's most densely populated countries. If city states are not included, it is even the country with the highest population density in the world. However, the growth rate is around 1.1% lower than in many other countries. Urbanisation continues to increase, and while the share of the urban population was still 30% in 2010, around 40% currently live in metropolitan regions. The government is seeking to decentralise responsibility and explicitly promote rural regions, especially with regard to health care [5], but the move to cities is uninterrupted and challenges urban development in more than just health care. The discrepancy between rural and urban communities is an example of the problem of inequality in the country. Although the economy is growing considerably and the Gini coefficient of income has improved slightly from 2000 (33.4) to 2022 (31.8) according to the World Bank [1], the Gini coefficient of wealth distribution in particular is still very high at 57.90 [6]. The lower 50% of the population have only about 4.8% of the wealth or 17.1% of the income [7]. Peripheral areas, women and children, religious minorities and indigenous groups have significantly lower chances of average income [8], educational opportunities [9, 10], security of food supply [11] and health care [12].

The first "Health and Population Program" (HPSP) ran from 1998 to 2003 with a total financing volume of USD 2.2 billion. The successor "Health, Nutrition and Population Sector Program" (HNPSP) ran from 2003 to 2011 with a volume of USD 5.4 billion.

The Health, Population and Nutrition Sector Development Program (HPNSDP, 2011–2016), which was co-financed from FC funds, had a budget of USD 7.7 billion. The World Bank bilaterally extended the term of the HPNSDP until June 2017 followed by the Health, Population and Nutrition Sector Program (HPNSP), which was scheduled to run until 2022 (but was then extended until 2024) and was originally budgeted for USD 14.7 billion. The government of Bangladesh was expected to bear 84% of the costs. It is important to emphasise that the share of the government of Bangladesh in the sector-wide approach (SWAp) I to IV increased from 62% to 84%, while SWAp III had a counterpart share of 73%.

HPNSDP was an attempt by the government of Bangladesh and the donor community to strengthen the health of the population, and vulnerable people in particular, by improving health care nationwide. The programme can be seen as a response to the structural challenges of the health care system of its time.

## Project summary

The FC projects of the Health, Nutrition and Population Programme II (Phase I of the preliminary appraisal with BMZ no. 2010 65 358, Phase II with BMZ no. 2013 66 236 and the increase with BMZ no. 2014 68 784) co-financed the overarching sectoral programme "Health, Population and Nutrition Sector Development Program"

1 "GDP per capita (current USD)" vs "GDP per capita, PPP (current international dollar)". The first is the nominal gross domestic product per capita, the second the real gross domestic product at national prices. The large difference indicates an unrealistic exchange rate.

2 Bangladesh borders India and Myanmar directly. In the following, the countries of Bhutan and Nepal are also considered to belong to the same region and are used for comparison.

3 See https://fragilestatesindex.org/country-data/. Germany: 24.6; India: 74.1; Nepal: 80.2; Myanmar: 102; Bhutan: 66.

4 See [3] Germany: 8.8; India: 7.0; Myanmar: 0.7; Nepal: 4.5; Bhutan: 5.5.

5 See [4] Germany: 79; India: 40; Myanmar: 28; Nepal: 33; Bhutan: 68.

(HPNSDP, 2011–2016) with the main components 1) Improving health care and 2) Strengthening health care systems. They were jointly evaluated in this evaluation report, as the FC contributions for the investment measures were paid into the joint basket from which the overarching sectoral programme was co-financed. In parallel to these FC projects, the piloting of the first health insurance system in Bangladesh in three sub-districts in the Tangail district was financed as a complementary measure (BMZ no. 2010 70 523).

The outcome objective of the HPNSDP sectoral programme and thus also of the co-financing FC projects was to increase the availability, quality and utilization of health, nutrition and family planning services. The target group of HPNSDP was the entire population of Bangladesh. A particular focus was placed on the health-relevant Millennium Development Goals (MDGs), MDG 1 (nutrition), MDG 4 and MDG 5 (child and maternal health), as well as MDG 6 (human immunodeficiency virus and acquired immunodeficiency syndrome, (HIV/AIDS) and other diseases).

The sector-wide approach was technically and/or financially promoted by international development partners, with the World Bank, Canada, Sweden, Australia, the United Kingdom, Germany and the United States of America directly participating in the basket. TC and FC worked together in a coordinated manner. The Bangladeshi Ministry of Health and Family Welfare (MoHFW) had overall responsibility for design and implementation and coordinated with the development partners. FC paid its contributions into a joint basket that served to finance MoHFW's investment expenditure (operational plans, OPs). Basket funding required uniform procedures for design, reporting, follow-up, procurement and financial management.

## Total costs

The total costs of the HPNSDP (2011–2016) amounted to approximately USD 7.7 billion or EUR 5.8 billion, including investment costs of approximately EUR 2.41 billion. The three FC projects contributed a total of EUR 49,921,636.02 (budgetary grant only) to the investments. FC also supported the preparation of health insurance through a complementary measure of EUR 1 million.

The sectoral programme (sector-wide approach, SWAp) was extended by one year shortly before the end of the term in June 2016 and increased by USD 150 million by the World Bank due to a significant financing gap shortly before the end of the financing period. This extension was no longer part of the joint basket funding and is therefore not taken into account in this EPE. The exact actual costs of HPNSDP could not be quantified, even during the final field visit. This is due to exchange rate fluctuations and the unscheduled extension until 2017.

*Table 1 FC share in HPNSDP [EUR million]*

| BMZ no. | 2010 65 358 Projects | | 2013 66 236 Projects | | 2014 68 784 Projects | | 2010 70 523 Projects | | Total Projects | |
|---|---|---|---|---|---|---|---|---|---|---|
| | (planned) | (actual) | (planned) | (actual) | (planned) | (actual) | (planned) | (actual) | (planned) | (actual) |
| Costs (total) | | | | | | | | | 5.78 | |
| Counterpart contribution | | | | | | | | | 4.22 | |
| Debt financing | | | | | | | 1.00 | 1.00 | 1.56 | |
| of which BMZ budget funds | 12.50 | 12.48 | 18.50 | 19.44 | 18.00 | 18.00 | 1.00 | 1.00 | 50.94 | 50.92 |

## Map/satellite image of the project country including project areas

The project's target area was the entire country, with priority placed on vulnerable groups, especially women, children and populations in peripheral regions. Figure 1 shows a map of Bangladesh including the eight administrative divisions (upazilas). The project region and the pilot upazilas for the health insurance are highlighted.

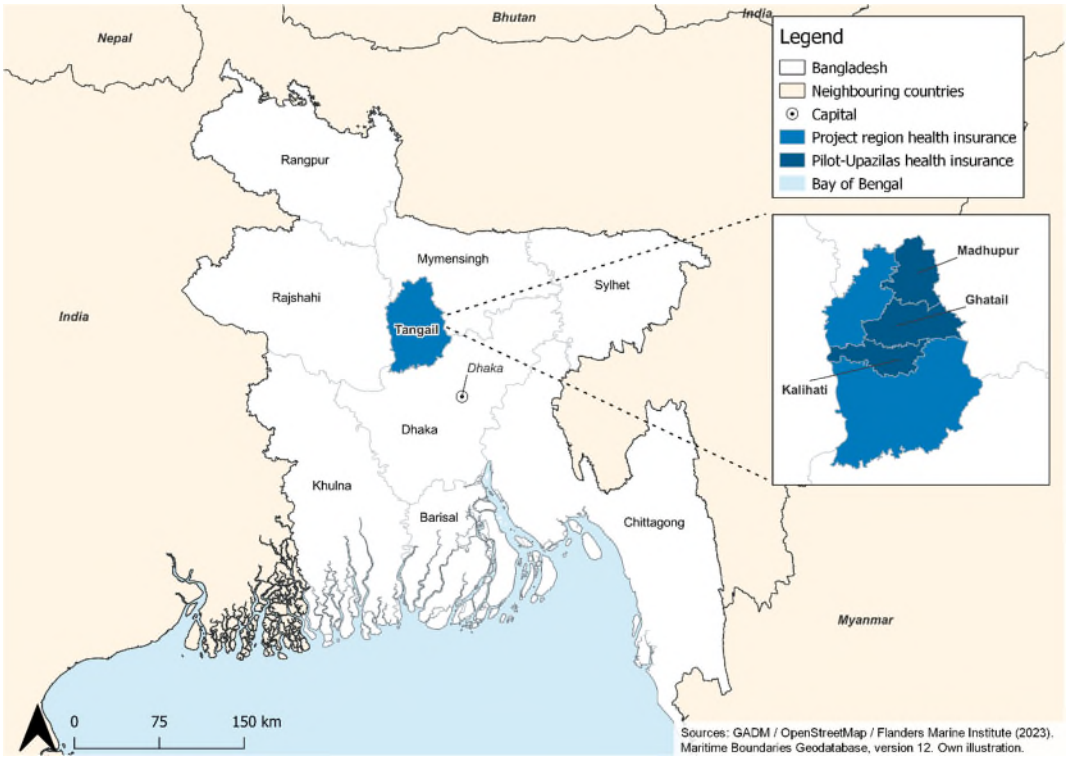



*Figure 1 Map of Bangladesh.*

## Rating according to OECD-DAC criteria

## Relevance

***Alignment with policies and priorities***

The sector-wide HPNSDP programme addressed both the improvement of health through specific measures (e.g. in the areas of reproductive health, children's health, nutrition) and the improvement of the overall system (e.g. through measures in procurement and financial management). The components were in the tradition of the predecessor programmes and largely covered the needs identified at the time. Based on the experience gained in Bangladesh and comparable countries, the measures seem to be generally suitable for achieving the objectives of national health policy.

The FC projects were an integral part of HPNSDP, so the objectives of the FC projects and the SWAp were identical. It is therefore not possible to separate the FC projects from the entire SWAp. First of all, it should be noted that the objectives, measures, implementation and results of the HPNSDP and the FC contribution fully complied with the guidelines of international health policy and German development cooperation, i.e., they were in line with the objectives of *Universal Health Coverage* (UHC) and with the principles of the Alma Ata Declaration and the Ottawa Declaration. Furthermore, the SWAp corresponded to the MDGs or *Sustainable Development Goals* (SDGs), in particular SDG 3 but also SDG 1, SDG 2 and SDG 5.[6]

HPNSDP also followed the objective of alleviating poverty, reducing inequalities, improving gender equality and inclusion of German development cooperation [13]. Although in principle the entire population of the country was the target group, many measures were explicitly aimed at women, children, people in peripheral regions or other vulnerable individuals and were generally suitable for reducing disparities in health and health care. Ultimately, HPNSDP was fully in line with national health policies, as was expected for a sectoral programme primarily supported by the government.

[6] See "Impact" section.

*Alignment with needs and capacities of persons concerned*

Bangladesh is the country with the highest population density in the world excluding city states and microstates. This results in numerous problems (e.g. air pollution, increased risk of infectious diseases, chronic degenerative diseases), which lead to a deterioration in the health of the population with a given health care budget. The megacity of Dhaka[7] in particular presents major health policy challenges, which are often still insufficiently addressed. Table 2 shows the main problem areas of Bangladesh's health care system. It becomes clear that HPNSDP explicitly addressed many of the problems.

*Table 2 Central problems of the health care system in Bangladesh.*

| Problem area | Problem | Description |
|---|---|---|
| Framework data | Population density | Bangladesh is the country with the highest population density in the world (excluding city states) [1] |
| | Disparity | Vulnerable individuals (poor, women, children, people in remote regions, minorities) have limited access to effective and quality-assured basic health care |
| | Decentralisation | Little progress was made with regard to decentralisation (local level planning failed) |
| | Urbanisation | Megacities with specific health problems (non-communicable diseases (NCDs), diarrhoeal diseases, hearing loss, stress, etc.: urban health) |
| Regulation | Cooperation and regulation | The private sector and the NGO/NPO sector are inadequately regulated; there is little cooperation (e.g. public-private partnership) |
| | Pharmaceuticals market | Insufficient regulation, in some cases significantly higher prices than on the world market |
| | Occupational health | Public and private health protection for employees, in particular in factories, is low thus far |
| Epidemiology | Infectious diseases | Increasing prevalence of dengue and other infectious diseases; coronavirus pandemic |
| | Non-communicable diseases | Sharp increase in heart attack, stroke, diabetes, etc. [1]. Bangladesh has a significantly higher diabetes prevalence than other countries in the region |
| | Climate damage | Major health problems due to flooding |
| | Refugee crisis | Health care for unstable populations |
| Governance | Evidence-based | Data is insufficiently used for management decisions |
| | Upkeep, maintenance of the infrastructure | Inadequate maintenance of infrastructure and medical equipment |
| | Procurement | Insufficient and expensive medication supply |
| | HR management | Insufficient quantity, qualification and motivation of employees, suboptimal allocation of personnel and disparities in staffing[8] |
| | Financial management | The country's financial management reform has little impact on the health sector (Strengthening Public Expenditure Management Programme, SPEMP).[9] |
| | Investment planning | New investments in infrastructure are largely based on normative aspects (e.g. hospital beds per population) and are primarily aimed at politically visible capacity expansion |
| | Health financing | Insufficient financing; catastrophic health care spending since the introduction of usage fees in health care facilities |
| | Ministry overlap and competition | Overlapping responsibility:<br>Ministry of Health and Family Welfare (MoHFW)<br>Ministry of Local Government, Rural Development and Cooperatives (MoLGRDC)<br>City Corporations |
| | Health care facility management | Lack of management training, low autonomy |

7 Dhaka is the capital of Bangladesh and the largest city in the country. It is considered the ninth largest city in the world and, with a density of 38,000 inhabitants per square km, one of the most densely populated cities in the world. The "core city" has a population of more than 10 million inhabitants, while the metropolitan region of Dhaka has more than 22 million inhabitants.

8 "The Bangladesh health system is facing several challenges including severe shortages across the health workforce. With a total population of 162.7 million, the number of registered physicians per 10,000 population was 6.33 (according to MoHFW data for 2016); the number of doctors working under the Directorate General Health Services (DGHS) per 10,000 population was 1.28; the number of medical technologists working under DGHS per 10,000 population was 0.32; and the number of community and domiciliary health workers working under DGHS per 10,000 population was 2.13." [14].

9 See [15]

Some epidemiological particularities also lead to current and expected future problems. In particular, the above-average rate of type 2 diabetes mellitus (DMT2) should be mentioned. The International Diabetes Federation estimates that in 2023 alone 12.5% of the adult population, and thus over 13 million inhabitants, had DMT2 [16]. More than 61% are probably not aware of this at all. Of course, the risk of DMT2 also increases in Bangladesh with age, lack of exercise and obesity; men have diabetes more often than women. However, it is striking that the risk is significantly higher in the highest income class than in the poor. At the same time, the residential area of Dhaka poses an increased risk [17]. The increasing trend is accompanied by a sharp increase in people who are overweight. In a comprehensive 2019 survey, it was possible to depict the prevalence of obesity, measured by a body mass index (BMI) of ≥30, of 18.2% of adults (women: 25.2%; men: 12.2%), with an increase in cities (21.7%) compared to the more remote regions (13.8%) [18]. The *World Obesity Federation* estimates the expected increases to be very high [19]. It is surprising that Bangladesh has the highest DMT2 values in the region.[10] This issue, which already existed or was foreseeable at the time of the appraisal of the FC projects, had not yet been adequately addressed in the overarching sectoral programme HPNSDP.

In addition to the health of the urban population, the provision of health care for the population in rural and, in particular, peripheral regions was and remains a major challenge. Figure 6 in Appendix 2 shows an example of the distribution of vaccinations (complete vaccination coverage starting at 12 months per district) and those infected by measles.[11]It is clear that there were significant differences between districts, with cities not always performing better than rural regions, which contradicted expectations. Rather, vulnerable groups (particularly the poor in slums) in cities are less well-served and more often ill than people in accessible rural areas, while the problem of providing health care and the rate of illness increases with periphery.

The disparity is partly caused by user fees in health care facilities, which also lead to catastrophic health expenditure (CHE). As shown in Figure 2 and Figure 3, out-of-pocket expenditure (OOP) as a share of health care expenditure increased from 2011 to 2021 from 68.18 to 72.99%, from USD 50.23 to USD 112.09 in absolute terms [1]. Bangladesh is thus one of the countries with the highest relative user fee shares in the region and worldwide.[12] The World Bank estimates that 55.3% of all surgical patients suffer catastrophic expenses [1]. However, the reduction of OOP expenditure was not explicitly the subject of the HPNSDP and was therefore not reflected in the indicators.

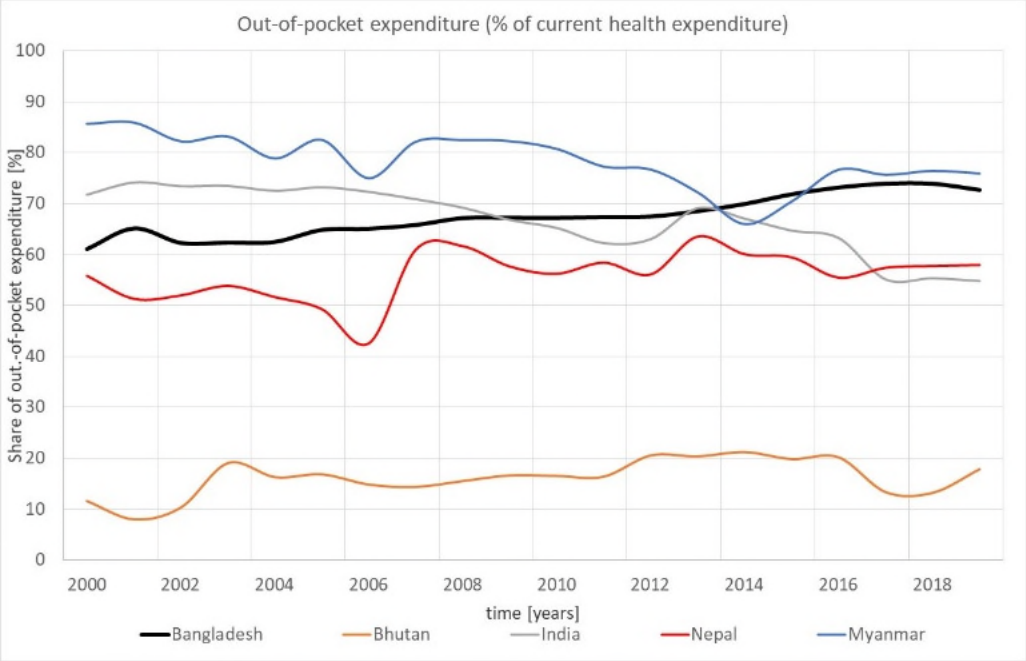



*Figure 2 Share of direct user fees in total health care expenditure. Source: [1]*

[10] India: 8.3%; Nepal: 6.3%; Bhutan: 10.4%; Myanmar: 6.6% [20].
[11] Incidence per 1 million population per district; both sets of data are from 2020; [21].
[12] Data status (latest) 2022: India: 50.6%; Nepal: 54.2%; Bhutan: 15.4%; Myanmar: 78.2%; South Asia: 53.4%; World: 16.4% [1]

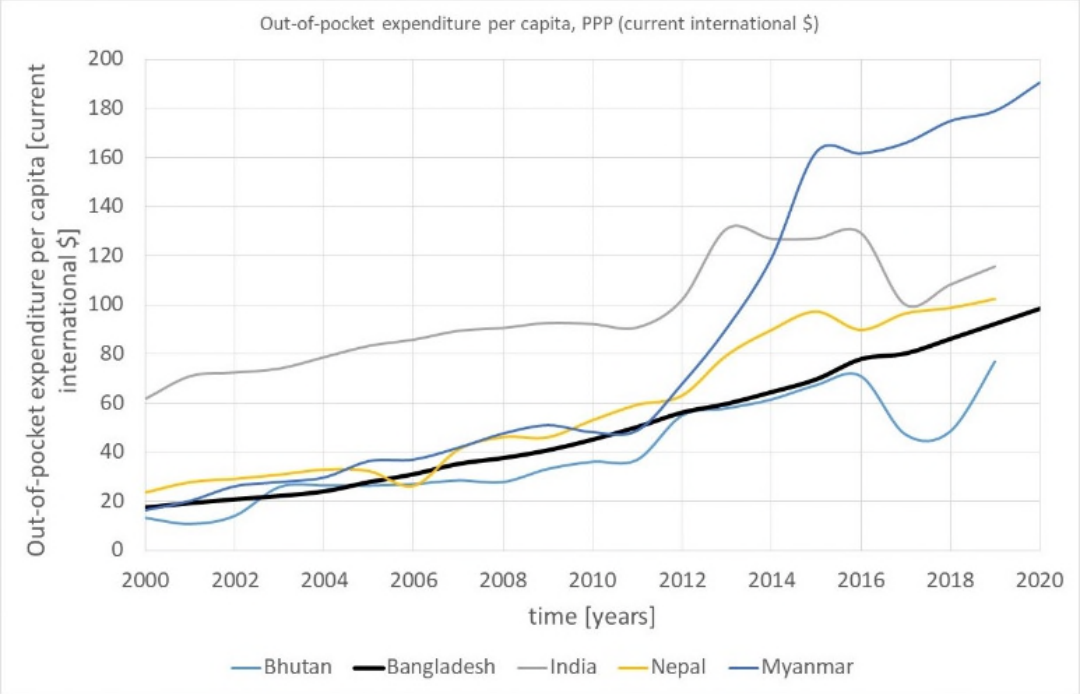



*Figure 3 Direct user fees for health, absolute, PPP. Source: [1]*

The SWAp explicitly addresses the disparity in health and health care by focusing the indicators on the poorer quintiles,[13] certain regions or diseases, i.e. on population groups whose unmet needs are particularly pronounced and whose capacities are low. Women represent the largest sub-group within the vulnerable group. The gender impact potential of the project is considered positive, i.e., a comparatively large proportion of the SWAp components addresses women, especially those of childbearing age. The portfolio of state-guaranteed free health services (basic package) also clearly focuses on the health of mothers and children.

In addition, the government of Bangladesh has attempted to introduce health insurance.[14] The "Social Health Protection Scheme" was first introduced in three pilot upazilas (Kalihati, Ghatail and Madhupur).[15] Impoverished households were registered and provided with health cards in order to receive health services without fees up to an amount of BDT 50,000 per household (at the time around EUR 570). As of February 2024, the insurance has extended to 12 upazilas within the Tangail district.[16] Of the 158,695 households considered impoverished, 150,980 were included, which corresponds to approximately 603,489 inhabitants, or 14.9% of the population of the Tangail district, or 0.4% of the population of Bangladesh.[17] The problem of user fees that are far too high – especially for the poor population – was therefore addressed in a pilot project in the Tangail district; the results can be found in the Effectiveness section.

***Suitability of project concept***

German-Bangladesh cooperation in the health sector pursued the overarching development policy objective of contributing to supporting national health policy, improving access to health care and improving health status. The programme objective of the HPNSDP was to improve the availability and use of patient-oriented, effective, efficient, fair, affordable, generally accessible and high-quality services for health, family planning and nutrition. This objective is undoubtedly still fully appropriate and relevant. The impact logic is also unchanged and plausible

13 Lower income group in Bangladesh (20%)

14 FC made an important financial contribution with the complementary measure BMZ no. 2010 70 523. In particular, this financed the consulting services of Oxford Policy Management (OPM) and Management4Health (m4h) (May 2015 – May 2018).

15 In Bangladesh, an upazila refers to an administrative office that is subordinate to the district.

16 "Tangail district is located in the central region of Bangladesh and is the largest district of Dhaka division by area and second largest by population size […]. The district consists of twelve upazilas namely Tangail Saddar, Saidpur, Basil, Madhupur, Ghatail, Kalihati, Nagpur, Mirpur, Gopalpur, Delduar, Bhuapur and Dhanbari." [22]

17 Inclusion was voluntary, so not all eligible households were actually included.

for the health care system in Bangladesh. However, it must be noted that a complete depiction of the impact system for an entire sectoral programme is generally impossible, which is why only a rudimentary description of the highly complex approach can be given here.

At the top level, the health effects (impact) are to be applied, which are presented here as examples. The impact is based on improved health services (outputs) and their use (outcome), which depends not only on the input to resources, but also on the speed and target-orientation of the coordination of health services and the resource-guiding processes in ministries and donor organisations. The basic principle here is the will to engage in political dialogue between donors and the government. This can lead to formats, forums and regulations, but also to trust and harmonisation within the sector, which in turn enables more rapid coordination. Conversely, the success of the SWAp can increase the government's ownership of the entire programme and the visibility of health care in the government. The central factor here is that the political dialogue on trust, speed and ownership as a moderator influences the success of the measures. The measures could actually stand on their own, i.e. be possible without sector dialogue within the framework of the SWAp, but the moderator effect increases their impact and accelerates their effectiveness.

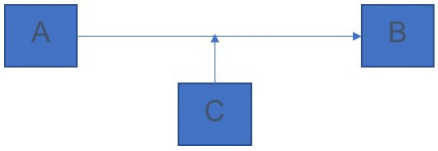



*Figure 4 Moderator effect (A: cause; B: effect; C: moderator). Source: Own data.*

The moderator reinforces the effect of the exogenous variable A on the endogenous variable B. For example, the effect of an investment amounting to X on the indicator "proportion of safe births" is reinforced by the fact that the funds used are well coordinated with other measures (e.g. state hospital planning) and no friction losses arise.

HPNSDP has chosen a very comprehensive system of indicators. Ultimately, a total of 158 indicators were defined at all levels for the OPs of both fields of action (1) improving health services and (2) strengthening the health system, the achievement of which was analysed annually in the *Pooled Fund Committee* and ultimately assessed by both the World Bank and the government of Bangladesh. The World Bank's final report from December 2017 [23] and the government's report from March 2017 [24] are available for this purpose. Figure 5 shows a copy from the World Bank's final report of the system of activities, outputs, outcomes and impact.

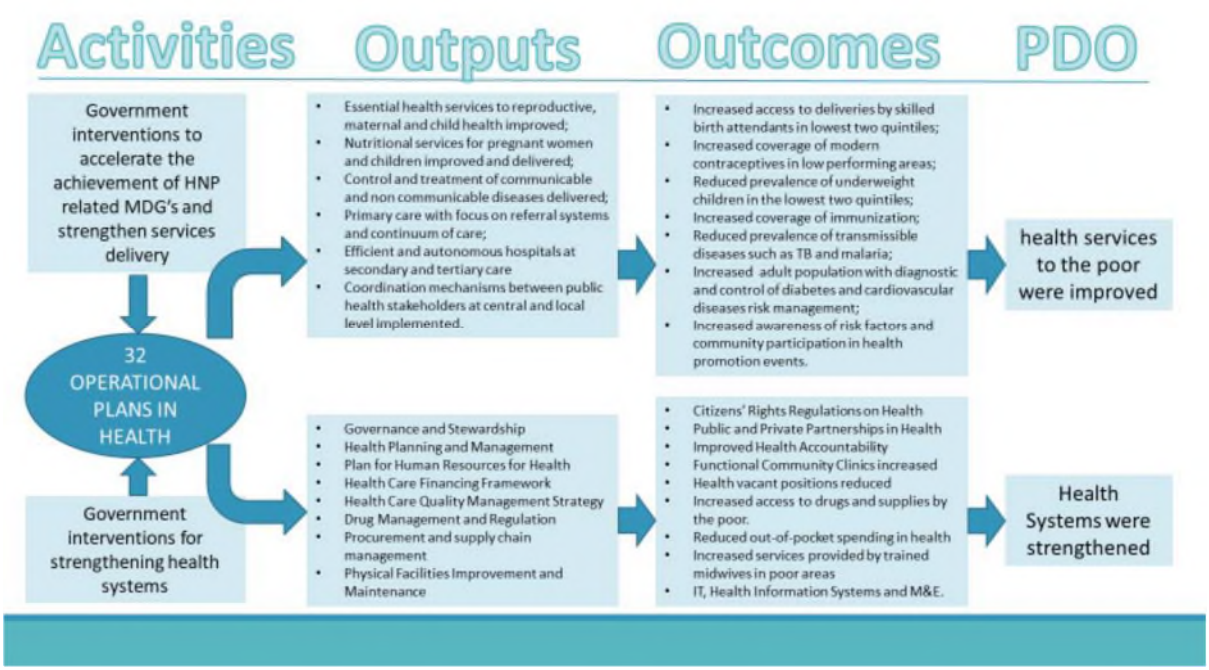



*Figure 5 Activities – Outputs – Outcomes – Project Development Objectives. Source: [23]*

The World Bank's final evaluation [23] states that the measures were generally appropriate to address the main health problems in Bangladesh. The suitability of the SWAp for harmonising and accelerating measures was also examined in the literature and explicitly affirmed for Bangladesh [25–27].

As part of this EPE, eight outcome indicators are to be examined as examples, which are characteristic of the programme and have corresponding relevance for the impact indicators. The first four relate to component 1, the following three to component 2 and the last indicator to the *Shasthyo Shurokhsha Karmasuchi* (SSK) health insurance introduced as part of the complementary measure, cf. Table 3 in the Effectiveness section. The outcome objective of the HPNSDP was also adopted for the complementary measure (BMZ no. 2010 70 523), but initially without its own indicator. An indicator for target achievement has been defined for the final inspection, which we use as indicator 8 in this EPE: "Number of insured households in pilot sub-districts". Under this health insurance, 150,980 impoverished households were registered and provided with an insurance card by 2023, allowing them to benefit from predefined health benefits in affiliated hospitals up to an amount of BDT 50,000 (approx. EUR 570) per year.

Above all, the SWAp itself requires good coordination between external development partners and beneficiaries in accordance with the Paris and Accra declarations. The intent is to increase the government of Bangladesh's ownership, align health policy with international development policy standards, increase the efficiency of development cooperation in the health care system, reduce transaction costs and increase mutual accountability. This objective is also still highly relevant. However, a SWAp-specific indicator, which measures, for example, the speed of coordination within the partners and with the government of Bangladesh, was not explicitly formulated.

***Reaction to changes/adaptability***

The HPNSDP SWAp did not need to be significantly adjusted during implementation. However, the follow-up programmes had to show their adaptability, as two external shocks forced them to react flexibly and quickly. The agreements between the donors and the government during the 2020/21 coronavirus pandemic went relatively smoothly, and the government was also able to react quickly to the rapid influx of Rohingya refugees with the help of the partners. The discussion partners also attributed this (but not completely and not by all) to the trust built up by the SWAp, whereby the jointly introduced coordination formats were decisively responsible for the speed and effectiveness of the measures.

***Rating summary:***

In summary, it can be concluded that the measures and objectives of HPNSDP – and thus also of the basket-funding FC project – are still relevant. It is plausible that the selected basket funding instrument was suitable as an amplifier and accelerator (moderator effect). The relevance therefore met expectations and is thus rated as good.

**Relevance: 2**

## Coherence

***Internal coherence***

TC and FC cooperated effectively and efficiently, i.e., a high degree of internal coherence between the projects evaluated here and the other activities of German DC can be assumed.[18] The FC and TC instruments worked well together and complemented each other. In the interviews, it was mentioned several times that FC and KfW were perceived as "working towards a common goal". The focus of HPNSDP (SWAp III) in the areas of family health, district health and capacity building is found in all projects at both institutions, whereby TC was particularly involved in the development of a health financing strategy, quality management and health information systems.

It appears that the FC projects to be evaluated in this EPE are based on the previous FC projects, which contributed in particular to the previous SWAps. During the intergovernmental negotiations in Berlin on 24/25 October 2016 and thus at the conclusion of the HPNDSP, it was decided that no new projects in the health sector in Bangladesh will be supported by German DC.[19] The partner government and the other donors regretted this very

[18] These are the projects with the BMZ nos. 2003 66 237, 2003 66 237, 2005 70 424, 2005 70 424, 2010 21 971, 2010 65 358, 2010 65 358, 2010 70 523, 2010 70 523, 2013 66 236 and 2013 66 236 in accordance with Table 10 in Appendix 2.

[19] Up to three priorities are to be chosen in priority partner countries [28]. The intergovernmental negotiations jointly agreed that, for Bangladesh, these are "Protection of our natural resources", "Sustainable economic development, education and

much. Since then, FC projects can only be partially or indirectly attributed to the health sector (e.g. drinking water supply), are part of the coronavirus emergency aid or refugee aid.

The programmes of the Health SWAp and Health Insurance are fully consistent with the international norms and standards to which German development cooperation is committed, in particular the right to health [13], gender equality [29] and climate change mitigation [30]. Promoting maternal health places a strong focus on health and gender equality in this context.

***External coherence***

The intent was for external development partners to cover 20% of the total costs or 65% of the investment costs. A total of USD 874.9 million was to be provided by external development partners, i.e. USD 508.9 million via a SWAp basket (Multi Donor Trust Fund (MDTF)) of the World Bank, Canada, Sweden, Australia, England, Germany) and USD 365 million via a Single Donor Trust Fund (particularly USAID). The SWAp was renewed by one year shortly before maturity in June 2016 and increased by USD 150 million exclusively by the World Bank. GIZ was associated as a partner, but its funds were not included in the SWAp budgeting.

There is no final audit report showing the amounts actually paid. The World Bank has only broken down its own investments in its final report; the Ministry of Finance has not provided a calculation of the costs in USD. Significant deviations may occur due to exchange rate fluctuations.

HPNSDP was assessed by both the World Bank [23] and the Government of Bangladesh [23] with regard to outcomes, impacts, processes and financing. Both evaluations conclude that the government of Bangladesh and the donors worked very productively and rigorously together during this phase. Scientific studies on the various SWAps in Bangladesh also draw a positive conclusion [25, 26, 31, 32]. The scientists conclude that the areas of harmonisation and coordination as well as Monitoring & Evaluation (M&E) needed improvement – an assessment that could not be corroborated by the interviews we conducted, as the SWAp was rated mostly positively in these interviews. Most of the discussion partners emphasised that the essence of the SWAps was in the coordination, which was so effective and convincing that a successor programme was designed and implemented based on HPNSDP. Overall, it was shown that sectoral programmes with basket funding are generally suitable instruments for harmonisation and coordination at sectoral level.

The SWAp IV was originally designed for the period 2017 to 2022 and extended until June 2024. It thus directly connected to the HPNSDP (= SWAp III) co-financed with FC funds. The impact objective of SWAp IV is consistent with the objective of HPNSDP and is defined as *"to ensure that all citizens of Bangladesh enjoy health and well-being by expanding access to quality and equitable health care in a healthy and safe living environment"*.[20] The most important external development partners were once again the World Bank, Sweden, DFID and other partners who already co-financed the basket in the SWAp III (HPNSDP), excluding Germany. The components of SWAp IV are also very similar to those of HPNSDP, but "Disbursement Linked Indicators" (DLI) were introduced, i.e., when a predefined target is reached (e.g. measles vaccination rate, acceptance of the strategic investment plan), a previously agreed amount was transferred.

The design for SWAp V[21] (again a SWAp with basket financing mechanism) is practically concluded. Although it is expected to be the last in Bangladesh as of July 2024, coordination mechanisms should remain in place to strengthen coherence. HPNSDP is seen as central to having paved the way for this and for having developed processes. Overall, donors are very satisfied with the sector-wide access and methodology of basket funding. However, they assume that SWAp V will be the last joint SWAp with a large financial investment from the donors, as Bangladesh has developed economically so that comprehensive financial assistance will no longer be necessary in the future. That being said, some external development partners still see a need for technical advice.

The nature of the SWAp is that the interventions and processes are consistent with the official policy of the country and the partners. Thus, the components of the HPNSDP[22] are identical to the objectives of the WHO [33], USAID [34] and the World Bank [35]. **The core of the SWAp is the sectoral dialogue that the external development partners have entered into with each other and with the government of Bangladesh.** This dialogue consisted of regular exchange and a number of institutions and processes. The external development partners met monthly to exchange information, to coordinate and to set joint priorities (Development Partner Consortium).

employment" and "Climate and energy, Just Transition". As a result, it was no longer possible to include health and social protection in the portfolio. However, the reasons for this were largely unknown to the interviewees. It is important to emphasise that the termination of the commitment in the health sector is not seen in any connection with the performance of HPNSDP.

20 https://openaid.se/en/activities/SE-0-SE-6-5217001001-BGD-12110.

21 See https://www.tbsnews.net/bangladesh/health/health-seeks-big-reforms-29-out-pocket-cost-cut-5-years-612510.

22 Cf. Figure 5 in the "Relevance" section.

Among other things, new initiatives were discussed in the consortium, such as the SSK project[23] to introduce health insurance. Coordination included not only those making deposits into the basket, but also explicitly technical cooperation. The spokesperson of the consortium acted as a representative of the development partners to the MoHFW. KfW also chaired the consortium during HPNSDP.

In addition, there is the *Local Consultative Group Health* (LCGH), in which all coordination between the Government of Bangladesh (GoB) and external development partners takes place under the chairmanship of the Minister of Health (or their Executive Secretary). It meets every six months and is divided into different working parties (e.g. family planning). The interview partners' satisfaction with LCG is high.

Within HPNSDP, the basket of joint financing is the central instrument. The corresponding trust account was managed by the World Bank, and the basket was called a Multi Donor Trust Fund in Bangladesh. The Pooled Fund Committee analysed the World Bank's results reports and decided on the funding capacity for expenditures. A Joint Financing Arrangement (JFA) was concluded with the Ministry of Finance (and the MoHFW) as the contractual basis for the SWAp financiers. GoB and the donors agreed annually on the corresponding financial flows. The Annual Program Review (APR) was carried out by the World Bank, the Pooled Fund Committee, the MoHFW and the audit department of the MoHFW. Other partners who support the SWAp but have not contributed to the pool (e.g. USAID, in particular with TB programs), were associated.

The World Bank took over the risk control for the SWAp III (HPNSDP) on a trust basis and received a fee of 3.5% of the financial volume in return. The follow-up included the appraisal of tender documents, the appraisal of contract award decisions, the monitoring of financial management and the analysis of the auditor's reports. According to the interviewees, the cooperation was largely seamless, including with the government of Bangladesh.

The Ministry of Local Government, Rural Development and Cooperatives (MoLGRDC) was responsible for providing basic health services in cities. According to the interview partners, the boundaries between the two ministries led to coordination difficulties. Overall, the MoHFW had a need for coordination with nine other ministries for SWAp III, which was sometimes a challenge.

Overall, it can be stated that the contribution of German development cooperation was necessary and sensible in order to achieve the objectives of HPNSDP, which in turn fully correspond to the international, German and Bangladeshi objectives. During the HPNSDP period, the government of Bangladesh would not yet have been able to provide the necessary financing for the health sector on its own and, in particular, to sufficiently finance the investment budgets. With the help of this FC contribution, health care for all population groups, in particular vulnerable people, was improved in line with the objectives of the WHO, the United Nations and global human rights.

***Rating summary:***

In summary, it can be stated that the HPNSDP's measures were consistent with the Bangladeshi government's own efforts. The comprehensive approach with numerous donors and the tools and processes used implied high coherence. This resulted in a comparatively fast and effective ability of the donor community and the Ministry of Health to react to external crises, which was highlighted by many interview partners. We assume that basket funding has intensified the beneficial effects of the SWAp. Consistency is therefore above expectations and is rated as very successful.

**Coherence: 1**

## Effectiveness

***Achievement of (intended) goals***

According to the programme proposal, the programme objective of HPNSDP was to improve the availability and use of patient-oriented, effective, efficient, fair, affordable, generally accessible and high-quality services for health, family planning and nutrition. The main components used for this purpose were 1) Improving health care (57% share of total costs) and 2) Strengthening the health care system (43% share of total costs), the individual measures of which are specified in more detail in Appendix 5.[24] The World Bank rated target achievement as good in 2017 [23]: over the entire period, out of the 158 indicators and sub-indicators, 102 indicators were fully

[23] SSK: *Shasthyo Shurokhsha Karmasuchi*, literally "Health Protection Programme".
[24] See Appendix 5.

achieved, 32 partially. Only 24 indicators are considered to be insufficiently achieved (below 50%) or not achieved. The problem here is that indicators of system development in particular cloud the otherwise very positive picture, in particular staff management, development of physical health care infrastructure, health financing, health education, documentation and data collection. This also led to the successor programme no longer formulating these indicators in this form, instead switching to disbursement-linked indicators in all components. Accordingly, disbursements were only made when certain results determined in advance had been achieved.

For this EPE, we focused on the latest available indicators, which best reflect the two main components 1) health care and 2) strengthening the health care system. Indicators one to four of component 1 and indicators five to seven as well as indicator eight for the complementary measure of component 2 are to be assigned here. Comparatively many values are no longer available after 2017 (end of the extension of HPNSDP or start of the successor programme HPNSP) [23]. Since the change from SWAp III to IV also implied a change in the indicators, the previous indicators were no longer updated in some cases. This applies in particular to component 2. Table 3 below shows the corresponding indicators at outcome level that were selected for the project and for which current statistics are still available.

*Table* 3 *Effectiveness – outcomes*[25]

| Component | | Indicator | Status at Project Appraisal (PA) | Target value PA | Actual value at final inspection | Actual value at EPE |
|---|---|---|---|---|---|---|
| Component 1 | (1) | Contraceptive use (Contraceptive Prevalence Rate;% women of reproductive age (15–49 years) [%] | 62% | 72% | 63% | 64% (2022) [36] not achieved |
| | (2) | Percentage of safe deliveries (births with professional care) [%] | 26% | 50% | 50% | 70% (2021–22) [36] achieved |
| | (3) | Vitamin A supplementation (percentage of children between the ages of 6–59 months who have received vitamin A in the last six months) [%] | 83% | 90% | 99% | 97% (2020) [1, 23] achieved |
| | (4) | Breastfeeding rate (percentage of infants exclusively breastfeeding up to six months) [%] | 43% | 50% | 65% (2018) | 63% (2019) [1, 23] achieved |
| Component 2 | (5) | Number of functional community clinics | 10,323 | 13,500 | 13,194 | 15,126 (2023) [1, 23] achieved |
| | (6) | Share of annual work schedules and budgets submitted in good time | 0 | 100% | 100% | 100% (2023) [1, 23] achieved |
| | (7) | Absorption rate of operational plans > 80% | 45% | 100% | 60% | 45% (2023) [1, 23] not achieved |
| Complementary measure | (8) | Inclusion figures (budgets) for health insurance pilot project | 0 | PCR: 100,000 | 77,000 | 150,980 (2023) [1, 23] achieved |

Source: PCR, PP, [1, 23, 36].

The achievement of the objective at outcome level can be summarised as follows for **component 1 (improvement of health care**):

Re (1): The indicator measures the use of contraceptives in women of childbearing age, from 15 to 49 years old. It corresponds to the standard indicator “Contraceptive Prevalence Rate” (CPR; %), as routinely surveyed in Bangladesh. Contraceptive use has been shown to have positive effects on fertility, maternal mortality and neonatal mortality. At the project appraisal, the value was 62% and the target was to increase to 72%. In fact, the CPR was 63% in the PCR and 64% in 2022, i.e., the target value of this indicator was not reached.

Re (2): The indicator measures the proportion of childbirths with professional care. Safe delivery has a positive effect on maternal and child mortality.[26] In the PA, only 26% of births were attended by professionals, in 2021–2022 the figure was 70%, i.e., it more than doubled and is thus well above the target value of 50%.

[25] The epidemiological statistics refer to the calendar year (January – December), while the administrative data refer to the fiscal year (July – June).

[26] Neonatal mortality*:* deaths of children within the first 28 days of life after birth. Infant mortality: deaths of children under one year of age. Child mortality (<5 mortality): deaths of children within the first five years of life.

Re (3): The indicator measures the proportion of children aged 6–59 months who have received vitamin A supplementation in the last six months.[27] Vitamin A deficiency is a health problem in Bangladesh, especially among children under five. Corresponding supplementation has a positive impact on the prevention of infant and child mortality, but the prevalence of chronic undernourishment and children at risk of underweighting may also be positively affected. Vitamin A supplementation is therefore a suitable indicator of the effectiveness of the dietary supplement component as a special feature of the SWAp in Bangladesh. A significant improvement can also be seen in this indicator. From a baseline value of 83%, the value increased to 99% by the final inspection and was 97% in 2019. Nevertheless, the value is significantly above the target value of 90%.

Re (4): This indicator measures the proportion of infants who are exclusively breastfed up to six months. Breastfeeding rates are central to infant mortality in children up to six months of age, but also to chronic and acute malnutrition. Less than half of the infants were breastfed long enough at the time of the 2010 programme appraisal (43%), the target being 50%. Here, too, the figures in the final inspection and EPE significantly exceeded the target at 65% and 63% respectively.

The achievement of the objective at outcome level is assessed as follows for **component 2 (strengthening the health care system)**:

Re (5): The indicator specifies the number of functional community clinics. Primary care is the backbone of the supply for the majority of the population and is highly relevant for assessing the effectiveness of the health system. An assessment is carried out annually to determine whether a clinic still meets the minimum requirements. During HPNSDP, the number of functional clinics increased from 10,323 to 13,194 and had thus not yet reached the original target of 13,500 in 2016. Since then, the number has increased to 15,126, i.e. above the original target value. It should be noted that the population of Bangladesh increased by an average of 1.1% p.a. during this period, while the number of functional community clinics increased by 1.9% p.a. from 2016 to 2023 (geometric mean in each case), i.e., the number of functional community clinics increased more than the population. This is certainly a great success.

Re (6): The proportion of annual work schedules and budgets submitted in a timely manner is an appropriate indicator to measure the administrative capacity in the health care institutions, districts and regions and thus a structural quality component of the health care system. There is a question as to whether the initial value of zero is realistic, but it is referred to as such in publications. Relatively quickly, all entities were able to submit corresponding budgets and work schedules, because since the start of HPNSDP, budget allocation has depended on this submission. According to the Department for Health Information Systems of the MoHFW, this has not changed, which can be described as the sustainable success of the programme.

Re (7): The absorption rate measures (here) the share of health care institutions' expenditures (according to OPs) in the allocation to the institutions according to the Annual Development Plan (ADP). Success is when more than 80% of the allocation has actually resulted in expenditures. Prior to the start of HPNSDP, it was a problem that the majority of the institutions were able to spend significantly less than their original budget, either because the official allocation could not be subsidised with funds or because the institutions were administratively unable to absorb these funds. The objective of 100% seems very unrealistic, even if this would not mean that all funds would really be available and that the institutions would also make full use of them. The expectation is only that all institutions spend more than 80% of the funds. Nevertheless, this seems to be a very high target that was never achieved. At 60%, the 2016 statistics are significantly below the target of falling back to the baseline of 45% (2023) after the phase-out of HPNSDP. This is a clear indication that the problems of the health system originally addressed by HPNSDP remain unchanged and that there has not been sustainable strengthening of the administration universally.

Re (8): The indicator was explicitly introduced for the complementary measure, which can certainly be understood as part of strengthening the health care system. It measures the number of households that were covered by health insurance in three upazilas of the Tangail district during the health insurance pilot project and were thus covered in the event of illness. The measure itself is the government's advice on piloting the insurance, the output is the existence of the insurance, so that the number of insured persons is to be understood as the outcome of this measure.

[27] "Vitamin A deficiency (VAD) predisposes children to increased risk of a range of problems, including respiratory diseases, diarrhoea, measles, and vision problems, and it can lead to death. Previous studies show that giving synthetic vitamin A supplementation (VAS) to children aged six months to five years who are at risk of VAD can reduce the risk of death and some diseases." https://www.cochrane.org/en/CD008524/BEHAV_vitamin-supplementation-for-prevention-of-disease-and-death-in-children-between-six-years.

At the time of the appraisal of the complementary measure in 2010, no household had corresponding insurance; 77,000 households were covered in 2018. In the three original upazilas, 81,649 households had health insurance at the end of 2023, and in all 12 upazilas taken into account by mid-2023, 150,980 households were covered. Table 16 in Appendix 2 shows the number of households included in each upazila by mid-2023. The KoboToolbox survey (see Appendix 6) shows that the patients with an SSK card who were surveyed assess their financial and health situation significantly better than the comparison group without a card.

The figure of 150,980 (households included, see Table 16) implies full target attainment. In the meantime, the MoHFW has taken over and expanded the insurance for the Tangail district. Currently, all upazilas of the Tangail district are included, with the expansion to six additional districts planned for 2024.

***Contribution to goal achievement***

The measures to strengthen the health system are to be understood as factors of the structural and process quality of the health care system, which are intended to have a positive effect on the quality of results (outputs, outcomes) of health care. It seems logical that the quality of results has increased precisely because the structural components have improved. It therefore seems comprehensible that functioning clinics, trained staff and good use of funds contribute to achieving the original objectives of the project, but empirical evidence cannot be provided. Similarly, the available data cannot be used to prove that the measures have reached all population groups and regions to the same extent. Despite several requests, no statistics were made available at the level of institutions or districts.

The first seven indicators at outcome level, which are derived directly from the SWAp, focus on the entire population. However, since the problems particularly affect the poor, this is also about useful indicators for measuring the distribution effect. Improving the average of an indicator that mainly concerns the poor also implies improving the situation of vulnerable people. Similarly, the strong focus on maternal and child health (MCH)[28] in component 1 is an expression of a focus on vulnerable groups.

The impact logic of the SWAp consists of external development partners and the government of Bangladesh investing considerable resources to achieve the above-mentioned goals. At the same time, the process of harmonisation between external development partners and with the government significantly strengthens the implementation capacity, achieving a greater impact. This brings together the financial and procedural aspects of the HPNSDP to generate the above-mentioned outcomes.

The demand side was somewhat neglected in HPNSDP. Although deficits in availability of or access to health care facilities (as opposed to many other low- and middle-income countries) play a comparatively smaller role in Bangladesh, affordability is a challenge for many people. In HPNSDP, vouchers were only offered for cataract surgery and professionally induced childbirths, but most services still involved high costs for poor population groups. This is where the complementary measure started: the aim of health insurance was to ensure that impoverished people receive free inpatient treatment in the event of illness, but this insurance has so far only been rolled out in the Tangail district.

Overall, there is no question that the selected measures contributed to the above-mentioned success. The World Bank's assessment also clearly shows the success and can be traced back to the components of the SWAp. It was not possible to achieve the significantly improved indicators by improving the situation of small groups. Rather, the majority of the population must have benefited from it. It is doubtful whether HPNSDP is solely responsible for the success. Rather, the economic development of Bangladesh over the past 13 years has contributed significantly to a larger proportion of the population being able to demand and finance health services. The fact that this demand meets sufficient supply is certainly partly due to the political will to implement the programme.

***Quality of implementation***

The SWAp was understood and supported by the partners. In particular, the Health Economics Unit (HEU) of the MoHFW provided the necessary expertise and commitment to lead the sectoral programme to success on the part of the Bangladeshi government, but it is insufficiently staffed. During the HPNSDP period, the Health Care Financing (HCF) Strategy (2012–2032) was adopted, with the HEU [37] as the lead agency. According to the strategy, the country intends to implement a portfolio of social security systems in the event of illness in the medium term, with the SSK being of particular importance for the poor. The parallel occurrence of demand-side interventions with supply-side measures (Health Financing Strategy) occurred primarily after HPNSDP.

[28] MCH: *mother and child health care.*

Overall, the quality of implementation continues to suffer from the low level of public allocations. The government spends only 3.1% of its budget (2020) on health, covering only 18% of health spending.[29] In 2011, at the start of the SWAp III, it was still 4.2% or USD 20.40, i.e., health care financing is deteriorating relative to the overall budget. However, the MoHFW is working on implementing the HCF Strategy. For example, SSK was incorporated into the health budget (fourth operation plan), currently including 12 upazilas in the Tangail district.[30] A total of six further districts and two city corporations are to be covered this year. It was possible to validate that preparations for the introduction of health insurance in Dhaka City are in progress (e.g. identification of impoverished groups, as well as establishing SSK offices and pharmacies in hospitals).

An evaluation of the SSK in the Tangail district in 2020 by USAID showed positive results. For example, OOP health spending decreased in households with health insurance compared to the control group, the proportion of households with catastrophic health spending was lower, and the quality of processes and outcomes of health institutions had improved [38, 39]. However, the number of people who benefited from health insurance during the pilot phase is negligible. From May 2016 to May 2018, 77,616 households (instead of the targeted 100,000) with approximately 310,000 individuals were registered and had insurance cards. The number of outpatient cases at the upazila health complexes from this group was 18,223, of which 2,221 were admitted to hospital. This meant that only 0.7% of the registered persons received inpatient care.[31]

Basket funding under HPNSDP largely worked as expected. As already shown, the World Bank took over administration for a fee of 3.5% of the volume. Follow-up and disbursement procedures were coordinated and uniform. As a partner of the Multi Donor Trust Fund, KfW, like all partners, signed an agreement with the World Bank, which in turn signed a financing agreement with the Bangladeshi government. However, there is a factor that seems to be more important than just the handling. This is the fact that the SWAp and, in particular, the intensive cooperation in basket funding led to building trust, accelerating processes and, in particular, to practised cooperation. Even if characteristics like these cannot be measured, the interviewees consistently state that the exchange of information, coordination, harmonisation and joint prioritisation worked very well. Consequently, most processes were transferred to the subsequent SWAp IV programme.

***Unintended effects (positive or negative)***

The continuation of catastrophic health spending in the poor population represents an unintended effect that could not be eliminated by SWAp III. OOP health spending increased from 2011 to 2021 both absolutely (per capita PPP) and relatively (% health spending). Specifically, the contribution adjusted for purchasing power increased from USD 50.23 to USD 112.09 and relatively from 68.1% to 72.99%. Although the indicators improved overall, the entire impoverished population was not able to benefit from this, as the SWAp only concerned public health care, which accounted for only a quarter of the total health care system.

There are still deficiencies in hygiene and waste management, which could have unintended effects on the environment, water and health. Particularly noticeable are the prominent deficiencies in the area of hygiene both in the internal processes (e.g. separation of sterile and non-sterile areas) and in the area of disposal. Global standards, which are often adhered to even in least developed countries (e.g. disposal of infectious or ethically relevant solid waste), are not recognised, and in some cases there is not even sensitivity to this issue.

***Rating summary:***

The outcome objective of increased availability and use of health services was largely achieved. It is noticeable that the indicators of component 1 (improvement of health care) were largely achieved in the long term, while the successes of component 2 (strengthening of the health care system) could not be sustained in some cases. Ultimately, however, the result quality of the outcomes from component 1 is to be weighted higher than the structural and process quality of component 2, so the effectiveness of these projects can still be described as successful.

**Effectiveness: 2**

[29] In addition to government financing of health spending and out-of-pocket payments, there are a number of private health insurance schemes for the wealthier minority. Charitable organizations also play a small role.

[30] See above: The Tangail district consists of twelve upazilas (Tangail Saddar, Saidpur, Basil, Madhupur, Ghatail, Kalihati, Nagpur, Mirpur, Gopalpur, Delduar, Bhuapur and Dhanbari) [22].

[31] Bangladesh has 0.96 hospital beds per 1,000 inhabitants (private and public) and 0.32 (public). Assuming an occupancy rate of 82% and an average length of stay of five days, the individual allocation risk is approximately 7% per year (for all hospitals) and 2.5% for state hospitals. https://www.tbsnews.net/bangladesh/health/govt-hospital-beds-less-10-who-recommendation-bbs-264364. This means that the admission rate for insured persons is far below average.

## Efficiency

***Production efficiency***

Overall, the efficiency of the health care institutions visited seems to be in need of improvement in many aspects (see Table 4), but in the case of a SWAp this is only one dimension. At least as important is the efficiency of the management of the ministries, but also their ability to manage the health care system and the corresponding equipment.

*Table 4 Health care facility management issues.*

| Functional area | Problem | Explanation |
|---|---|---|
| Guide | Doctors as managers | - Primary level: doctors without an opportunity for specialist training move to management; insufficient training; low motivation<br>- Secondary/tertiary level: specialists as managers without management training; no focus on efficiency<br>- MoHFW: often not from the health care system; high turnover |
| Hospital administration | Inefficient and overwhelmed | - In the modern sense, the profession of hospital administrator does not exist<br>- The introduction was discussed in Parliament, implementation is uncertain |
| Equipment and facilities | Basic equipment available, but no maintenance | - Repair is time consuming<br>- Preventive maintenance does not exist; less a financial problem than a mentality problem |
| Disposal | Hazard to the general public, personnel and patients | - Waste separation in the facilities works<br>- No sterilisation of infectious material.<br>- No appropriate treatment of ethically relevant waste<br>- Central waste disposal does not work |
| Hygiene | Even rudimentary hygiene rules are not followed | - Facilities are full of waste<br>- Separation of sterile and non-sterile areas does not work |
| Personnel | General complaints about staff shortages are not always understandable | - Personnel assignment is primarily based on number of beds and how many people are using the facility<br>- Facilities not generally under-equipped<br>- Sometimes relatively short working hours (e.g. patients from 9 am to 2 pm) |
| Quality management | Output quality is low | - Sometimes too few cases for learning effects (e.g. births in HFWC)<br>- No structured quality management |
| Materials | Medications and medical materials not reliably available | - Frequent stock-outs of essential medicines<br>- National shortage of long-term contraceptives<br>- Push system for medication supply in community clinics does not work. |
| Buildings | Deterioration of buildings | - Lack of maintenance, delayed repairs<br>- Vacancies, especially in rural areas, because state rent is higher than the comparable rent on the private housing market |
| Autonomy | Facility management strongly dependent on central offices | - No freedom of decision for personnel, procurement, etc. |

Source: Own data from interviews, observation.

Various HPNSDP measures were explicitly aimed at increasing production efficiency in health care facilities. This includes strengthening the community clinics and upazila health complexes through better planning, M&E, but above all improving staffing and training employees. The biggest problem for individual health care facilities is still referred to by many as staff shortages. In fact, our surveys also show that many positions are unfilled. On the other hand, the personnel situation in the institutions visited does not appear to be as “catastrophic” as it was sometimes portrayed. No reliable statistics on staffing could be found at the national level. However, the interview partners in the health care facilities assume that the situation has improved significantly in the last ten years. This should also lead to an increase in production efficiency. In some institutions, the number of staff already seems to us to be too high in relation to the scope of work (which, however, is not viewed the same way by those responsible).

It is striking that the managers of the health care facilities interviewed as part of this EPE are consistently medical professionals who, with one exception (officer of the armed forces), do not have sufficient management training. There was even a lack of basic overview of the dimensions of management (e.g. procurement management, quality management, process management, disposal/waste management, marketing, financing, investment, logistics, accounting and information management). Basic knowledge on management-relevant issues (planning, organisation, personnel selection, personnel management and systems of control) is currently only available in isolated cases.

Looking at the SWAp as a whole, it contributed to increased efficiency by reducing transaction costs, which would have increased if each donor had carried out their projects individually with the Bangladesh Ministry of Health. The common funding mechanism involved joint missions, coordination and disbursements, but also uniform follow-up and reporting, which eliminated time-consuming parallel coordination. Many interviewees viewed this as a significant advantage of the SWAp.[32] On the other hand, discontinuity appears to be problematic. For example, the Australian Government Department of Foreign Affairs and Trade (DFAT) had to withdraw its commitments made at the beginning of the sectoral programme following the change of government in Australia in autumn 2013 and reduce Australia's participation in the basket from the previously planned USD 31 million to USD 7.4 million. Finally, the withdrawal of German DC from the health sector of Bangladesh is perceived by the other donors as a break in the efficiency of the SWAp, which resulted in the loss of established relationships, harmonised processes and knowledge. This was mentioned in particular with regard to the SSK pilot.[33] The partners are not yet aware of the reasons why the German side did not continue SSK for at least two to three years, thus strengthening the efficiency of the measure. The management of SSK was entrusted to the private sector insurance company Green Delta, which, after superficial analysis, performed its task efficiently. However, Green Delta was excluded from the award of contracts for further upazilas, which meant that the insurance policies in the "new" upazilas had to start over completely, which prevented learning from previous experiences. This is likely to have led to significant losses in efficiency. A more in-depth assessment was not possible as part of this EPE.

Nevertheless, the SWAp should be described as comparatively efficient overall, and the transaction costs of 3.5% of the financial volume determined by the World Bank appear reasonable. There were also no excessive delays for the three investment programmes, with a total programme duration of 84 instead of 68 months (accompanying measure 86 instead of 68 planned months). A delay of around 1.5 years seems to us quite justifiable for such large and complex programmes.

***Allocation efficiency***

In its end-line evaluation for HPNSDP in March 2017, the World Bank presented a comprehensive efficiency analysis, with an explicit calculation of the loss of quality of life prevented by the programme. It calculated that HPNSDP averted the loss of 3.2 million disability-adjusted life years (DALYs). Assuming that the benefits are generated over a longer period of 20 years, the World Bank calculated a profitability of 19% [23]. Although these calculations cannot always be fully understood and the result appears to be set quite high, there should be no question that the allocation efficiency of the programme is good.

The question arises whether even more health, life and quality of life could have been gained using a different method of allocation. It is striking that accidents and chronic degenerative diseases have received very little attention, although they were already of great relevance in Bangladesh in 2011. Important instruments for improving efficiency were neglected. This concerns in particular the financing mechanisms (e.g. health insurance, telemedicine and hospital management), which could have increased the allocation efficiency.

One particularly striking fact is that HPNSDP focused almost entirely on public health facilities, although over three quarters of health care spending is in the private sector (2011: 71.0%; 2016: 73.93%; 2020: 76.6%) [1]. Both in rural and urban areas, private (for-profit) and non-profit health care providers are often the first choice for the population, including those in poverty. It is not the case that non-governmental organisations (NGOs) and private organisations were completely excluded during HPNSDP, but their relative importance as providers is much

[32] Example: "I have said that we work together. This practice wasn't like this before. Everybody used to work individually. It started after 2010, in the last 10 years. Before that, we never knew what UNICEF is doing, Save the Children, is doing. We didn't know anything. Now we know about all the projects and have information. Everyone is directly associated with the NTWC (Newborn Technical Working Committee). The government, development partners, professional bodies, everyone is there. If you want to do anything related to neonatal activity, you need a recommendation or endorsement from this organisation, then the government's permission is required. So everyone used to work individually at first. Now we are working together." (https://www.exemplars.health/topics/neonatal-and-maternal-mortality/bangladesh/how-did-bangladesh-implement ).

[33] In other words: "SSK was a newborn baby when KfW withdrew. It would have required several years of hand-holding."

greater than their importance in the SWAp.[34] It can only be assumed that the actors are not focusing on NGOs and private organisations. Allocation efficiency would probably have been increased through greater involvement of NGOs and private providers.

***Rating summary:***

Overall, basket funding was expected to achieve higher allocation efficiency than a traditional investment approach, as the community approach significantly reduced transaction costs. It is not possible to quantitatively determine this within the framework of this report. However, there are some approaches that would have led to an increase in efficiency from an ex post perspective (e.g. the increased consideration of non-communicable diseases and the introduction of health insurance at the national level). The key aspect here is that the partners have learned from the developments and misjudgements. This is evident in the further development of the SWAp as part of the subsequent programmes. Overall, we rate the efficiency as moderately successful.

**Efficiency: 3**

## Impact

***Overarching (intended) developmental changes***

The development policy objective of the project as per the programme proposal was to "contribute to supporting national health policy, improving access to health care and improving health status". Table 5 summarises the achievement of the objectives at impact level. These are the key indicators for HPNSDP in Bangladesh.[35]

There was no explicit definition of an impact indicator for the complementary measure. On the one hand, no specific indicators were established for the complementary measure during the programme appraisal. On the other hand, the indicators for HPNSDP are also suitable for the complementary measure.

*Table 5 Impact indicators*

| Indicator | Status at project appraisal (2011) | Target value at project appraisal | Actual value at project completion | Actual value at EPE |
|---|---|---|---|---|
| (1) Infant mortality rate [per 1,000 live births] | 52 | 31 | 28.3 (2016) | 22.9 (2021) [1, 23] achieved |
| (2) Child mortality rate [per 1,000 live births] | 65 | 48 | 32.4 (2016) | 27.3 (2021) [1, 23] achieved |
| (3) Neonatal mortality rate [per 1,000 live births] | 37 | 21 | 20.1 (2016) | 16 (2021) [1, 23] achieved |
| (4) Maternal mortality rate [per 100,000 live births] | 194 | < 143 | 176 (2015) | 123 (2020) [1, 23] achieved |
| (5) Fertility rate [children per woman] | 2.7 | 2 | 2.3 (2014) | 1.98 (2021) [1, 23] 2.23 (2022) [36] achieved[36] |

[34] "The Bangladesh health care sector comprises hospitals, clinics, diagnostic centres, clinical trials, outsourcing, telemedicine, and medical devices and equipment. Growing at a CAGR of 10.3% percent since 2010, the size of the health care industry has reached USD 6.76 billion in 2018 (in terms of spending on health care expenditure), doubling in the last eight years. The health care industry is dominated by the private sector with high growth in tertiary hospitals and diagnostic centres. At the end of 2019, there were 255 public hospitals, 5,054 private hospitals and clinics, and 9,529 diagnostic centres under the registration of the Directorate General of Health Services (DGHS). The number of hospital beds available in public hospitals amounted to 54,660, whereas the same figure in private hospitals amounted to 91,537, bringing the total number of beds to 143,394 at the end of 2019." (https://bida.gov.bd/healthcare).

[35] The eighth key indicator for HPNSDP ("Prevalence of HIV in most at risk population") was not taken into account for this EPE for three reasons. Firstly, HIV prevalence in Bangladesh (consistently) is already relatively low at <1%. Secondly, the HPNDSP's measures have little impact on HIV prevalence; it remained virtually unchanged from 2011 to 2016. Thirdly, the impact indicator relates to persons at risk, but no definition has been made of who is considered a "person at risk". In fact, the figures in 2011, 2016 and for the PCR refer to the overall population, not to an at-risk population. As a result, the use of the indicator in the EPE does not appear to be expedient.[35]

[36] In some cases, the values of international statistics (e.g. WHO, World Bank) differ from the statistics in Bangladesh. For example, the World Development Indicators for 2021 indicate a fertility of 1.981, while the Demographic and Health Survey shows a value of 2.3.

| | | | | |
|---|---|---|---|---|
| (6) Chronic malnutrition in children < 5 years old [%] | 43.2% | 38% | 36.4% (2014) | 23.6% (2022) [36] achieved |
| (7) Underweight children < 5 years old [%] | 41% | 33% | 33% (2014) | 22.0% (2022) [36] achieved |

Source: PP, PCR, [1, 23, 36]

Re (1): Infant mortality. The infant mortality rate indicator measures the number of children per 1,000 live births who die before reaching their first birthday. It is a well-suited impact indicator for the impact of the measures. It is easily measurable and included in national and international statistics. At the start of the programme, the value was 52, while the target was ambitious at 31. In fact, the programme exceeded the target at 28.3 at the end of the project, and the positive trend continued (22.9 at EPE). The reduction of 56% can be regarded as a great success.

Re (2): Child mortality. The under-five mortality rate indicator measures the number of children per 1,000 live births who die before reaching their fifth birthday. It is a well-suited impact indicator for the impact of the measures. It is easily measurable and recorded in national and international statistics. Child mortality fell from 65 to 32.4 between project preparation and appraisal and project completion, before falling to 27.3 by the EPE. This has exceeded achievement of the target of 48, and the reduction of 58% is remarkable.

Re (3): Neonatal mortality. The neonatal fatality rate indicator measures the number of children per 1,000 live births who die within the first 28 days after birth. This indicator is also well suited and measurable. It is to be taken from national and international statistics. For this, too, the original target of 21 was already achieved at the time of project completion and was exceeded at the time of the evaluation. Here too, the reduction of 57% is considerable.

Re (4): Maternal mortality rate. The maternal mortality rate measures the deaths of women per 100,000 live births that occurred during pregnancy or 42 days after the end of pregnancy and that are directly related to pregnancy or birth. It is a standard indicator that is easily measurable and can be found in all national and international statistics. From the initial value of 194, the statistics fell to 176 by the time the project was completed, which was above the target value. However, the original target of 123 was achieved by the evaluation. The reduction of 37% between PP and EPE is lower than for the other indicators, but is still significant.

The indicators (1)–(4) represent an interdependent system. These are “hard” indicators that measure mortality and thus directly affect the lives and quality of life of the population. The developments shown are often described as exceptional and exemplary, e.g. “*Bangladesh was selected as an Exemplar due to rapid reductions in neonatal and maternal mortality rates. Bangladesh had the fastest decline in neonatal mortality of any country in the South Asia region, and the speed of its decline in maternal mortality is comparable to other neighbouring Exemplar countries, such as India and Nepal*” [40].

Re (5): Fertility rate. The total fertility rate represents the average number of children per woman if she lived until the end of her fertile phase and corresponded to the age-specific birth rate. It is an indicator that represents the fertility component of population growth well and is easily measurable. It is reported in national and international statistics. The value at the project appraisal was 2.7, the target was 2.0 and thus slightly below the level of the stable population (ceteris paribus). At the end of the project (however, the figure is from 2014), the statistics had fallen, but were still significantly above the target at 2.3. The target was achieved by the EPE (value from 2021) (1.98). The reduction of the birth rate by 27% is considered a great success and represents an important basis for stable economic, social and societal development in the future.[37]

Re (6): Chronic malnutrition in children < 5 years old. The indicator measures the percentage prevalence of chronic malnutrition in children under five years of age (stunting). Children are considered chronically malnourished if they have growth retardation for their age, which is measured by the ratio of body size to age. If the value is at least two standard deviations below the median of the WHO Child Growth Standard, a child is considered chronically malnourished. The value is easily measurable and is routinely recorded nationally and internationally. The baseline of chronically malnourished children under five years of age was 43.2%. The target was 38%. At project completion (2014 value), it was 36.4%. It continued to fall to 23.6% by 2022. There are also different

[37] Here, we are following the internationally validated statistics of the World Development Report.

sources that assume that it has deteriorated again since 2020, but is still below the target value.[38] The reduction from 2010 to 2019 is in any case considerable.

Re (7): Underweight children < 5 years old. The indicator represents the percentage prevalence of underweight children under the age of five (underweight). Children are considered underweighted if their weight is more than two standard deviations below the median of the weight at the appropriate age. “Weight-for-age” is a reliable and well-established national and international nutritional indicator for children. The initial value was 41%, the target was 33%, which was also achieved by the end of the project. By 2022, the corresponding value continued to fall to 22.0%. This is to be regarded as a great success, even if the values have deteriorated somewhat again in the following years according to interview partners. Indicators (6) and (7) together provide an important tool for measuring the nutritional situation in children.

Some HPNSDP measures have a direct impact on these impact indicators. Although there seems to be a plausible link between intervention and impact factors, clear allocation is not possible. There have been many changes in macro-political terms and for individual parameters in the period since project preparation and appraisal, so a linear and clear allocation of interventions and impacts is not possible. With a contribution of less than one percent of HPNSDP’s budget, it is also impossible to expect the FC contribution to have a separable, measurable impact.

***Contribution to overarching (intended) developmental changes***

The nature of the sectoral programme is that it encompasses in principle all programmes and measures in the health sector. Thus, theoretically, all impacts would have to be directly attributable to HPNSDP if the health care system could be separated from general social and economic developments.

As the current SDG report for Bangladesh shows [42], the country has a score of 65.9 and a ranking of 101/166, meaning that it is still significantly below the average, but SDG 3 (Good health and well-being) shows mainly positive trends. The situation only worsened in subjective well-being. The SDG 3 sub-objectives[39] are mainly supported by HPNSDP.

The survey with KoboToolbox in three upazila health care centres in the Tangail district (see Appendix 6) also clearly shows that the population currently assesses the subjectively perceived situation of health care significantly better than ten years ago. 89% of all respondents with and without health insurance card rated it as better, only 5% said it was better before. The differences in answers to this question between persons with and without a health insurance card are not significant. On the other hand, the effectiveness of insurance in terms of the use of health care facilities is very clear: 40% of respondents without an insurance card stated that they or their relatives had already forgone a visit to a health care institution for financial reasons, whereas this was only 17% for SSK insured persons (cf. KoboToolbox analysis).

The biggest problems remain geographical and social disparities. Table 6 shows, for selected indicators, the major differences arising from place of residence (urban-rural), region (divisions), educational level and wealth quintile.

*Table 6 Disparities between different groups in Bangladesh.*

| Characteristic | Groups | Married < 16 years | Total fertility rate | Teenage pregnancy [%] | All contraceptives [%] | Modern contraceptives [%] | ANC [%] | Professional childbirth [%] |
|---|---|---|---|---|---|---|---|---|
| Residential area | Urban | 24.0 | 2.1 | 15.2 | 66.5 | 55.6 | 95.4 | 82.2 |
| | Rural | 27.9 | 2.4 | 18.8 | 63.0 | 54.4 | 91.5 | 65.2 |
| Division | Barisal | 29.7 | 2.5 | 14.2 | 64.8 | 54.0 | 91.1 | 60.9 |
| | Chattogram | 19.5 | 2.6 | 16.1 | 57.5 | 49.0 | 91.4 | 66.4 |
| | Dhaka | 26.8 | 2.2 | 17.8 | 63.0 | 53.2 | 95.4 | 76.0 |
| | Khulna | 31.9 | 2.2 | 23.2 | 66.5 | 56.3 | 95.4 | 86.0 |

[38] “Compounded by the global food crisis, high inflation and foreign currency shortages deepened the vulnerability of the poor people, rolling back some of the gains made prior to 2020. WFP surveys found that 12 percent of the population was food insecure as of December 2022, an improvement from 29 percent reported in July. However, the improvements were unequal: 26 percent of low-income households continued to experience food insecurity for six months in a row, from July to December” [41].

[39] 13 sub-objectives and 28 indicators.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Mymensingh | 23.8 | 2.7 | 15.5 | 66.1 | 59.0 | 88.8 | 57.1 |
| | Rajshahi | 42.2 | 2.0 | 20.9 | 70.0 | 60.8 | 95.1 | 72.4 |
| | Rangpur | 33.3 | 2.5 | 24.7 | 70.7 | 61.3 | 91.7 | 66.3 |
| | Sylhet | 9.2 | 2.3 | 6.6 | 52.8 | 44.3 | 84.5 | 59.2 |
| Education | No educational qualification | 49.0 | | (16.1) | 62.6 | 50.9 | 75.7 | 48.2 |
| | Primary education incomplete | 37.3 | | 16.8 | 70.2 | 60.0 | 84.9 | 47.7 |
| | Primary education completed | 45.4 | | 15.8 | 66.8 | 57.6 | 88.8 | 55.9 |
| | Secondary education incomplete | 36.3 | | 10.1 | 64.4 | 56.6 | 93.9 | 69.9 |
| | Secondary education or higher education completed | 8.0 | | 10.7 | 59.4 | 49.7 | 97.5 | 85.8 |
| Wealth quintile | Lowest | 36.4 | 2.8 | 23.1 | 68.6 | 60.6 | 83.6 | 47.0 |
| | Second | 32.2 | 2.4 | 20.2 | 65.2 | 56.5 | 90.0 | 60.3 |
| | Middle | 26.4 | 2.3 | 17.5 | 64.5 | 55.3 | 94.2 | 73.3 |
| | Fourth | 25.5 | 2.1 | 18.2 | 63.9 | 54.3 | 97.1 | 80.9 |
| | Highest | 15.2 | 2.0 | 10.1 | 58.4 | 47.8 | 98.9 | 90.5 |

Source: [44]

The Demographic and Health Survey 2022 also specifies other indicators. There is a wide range for all indicators depending on population characteristics. Rural populations tend to be in a more difficult situation than urban ones, Dhaka and Khulna are better served, and people with low education and the poor have higher risk factors and poorer health. The impact of wealth is particularly dramatic. For example, the proportion of professional births in the richest quintile is over 90%, and in the poorest quintile is below 50%. However, when comparing the values with previous reports, it is noticeable that the range has reduced slightly in some areas. For example, the difference in fertility between rural and urban regions was still 0.5 percentage points in 2011 and only 0.3 percentage points in 2022. Between the regions, the total fertility rate was still 1.2 in 2011, and “only” 0.7 11 years later. The difference between the richest and poorest quintiles was 1.2 in 2011 and 0.8 in 2022 [36, 43]. It fell from 3.7 to 3.5 for the residential area and from 24.6 to 17.9 for the division. On the other hand, it rose from 4.4 to 10.8 for training and from 3.4 to 10.2 for wealth. Overall, there is a tendency toward improvement, but disparity is still a major problem.

***Contribution to overarching (unintended) developmental changes***

The complementary measure helped to ensure that the successful pilot approach in the Tangail district is now also being considered nationwide; an extension is initially being discussed for the capital Dhaka.

***Rating summary:***

In summary, it can be stated that the impact indicators of HPNSDP and the associated FC project were achieved or exceeded. Health-related MDG 4 (reducing child mortality), MDG 5 (improving maternal health) and MDG 6 (combating HIV/AIDS, malaria and other diseases) and SDG 3 (Good health and well-being) have also improved for the most part during this period. The support of impoverished groups and people in peripheral regions is likely to have contributed to the identification of citizens with their nation, although this could not be quantitatively assessed, and it was not possible to fully eliminate the inequality. Health insurance for impoverished groups at least has the potential to have further positive effects. Overall, we therefore assess the overarching developmental impacts as successful – the effects of HPNSDP on the health of the population are plausible. The effects of the FC measure, which is less than 1% on a pro rata basis, are unlikely to be attributable even though the majority of the interviewed partners confirmed this.

**Impact: 2**

## Sustainability

***Capacities of persons concerned***

SWAp III (HPNSDP) actually covered (unlike in many other countries) the entire public health sector, i.e. not only the investment costs (EUR 2,406 million), but also the operating costs (EUR 3,374 million). The funds from the development partners were recorded in the Bangladeshi budget, which was beneficial for the government's ownership and thus also for sustainability. This procedure was also maintained in the subsequent sectoral programme (SWAp IV).

Merging projects of external development partners and the government of Bangladesh required significant financial and personnel capacities from the ministries and was a major challenge. First of all, it should be noted that SWAp III was planned very well and in detail in 2011. Various cost and financing scenarios were established. At the time, something known as the "low-cost variant" was chosen as the basis for the budget, i.e. the scenario with the lowest estimated costs, which from the outset contained a financing gap of EUR 405 million.

The biggest sustainability problem of sector financing is likely to be whether the Bangladeshi government can raise sufficient counterpart funds to finance the sector sufficiently in the long term [44]. There are different, contradictory tendencies here. Firstly, it should be noted that the government of Bangladesh has a major revenue problem, i.e., the tax rate is comparatively low and the tax revenue is very low compared to Bangladesh's GDP. With the exception of Myanmar, they are significantly below those of neighbouring countries. However, this rate is increasing slightly.

The share of health care expenditure in total government spending decreased from 5.2% to 3.1% from 2000 (first available dates) to 2020 (last available dates) [1]. However, since economic output (measured as GDP per capita, PPP, current international dollars) and thus national revenue have grown from Int$ 1,574.53 p.c. to Int$ 6,596.04 p.c. in absolute terms, the government spends significantly more on health overall. Adjusted for purchasing power, government health spending per capita increased from USD 8.01 to USD 23.97 from 2000 to 2020. As a result, it can be concluded that, despite considerable problems with public finance, sector funding increased noticeably overall, but the declining importance of health in the national budget makes sustainability seem problematic.

In the sub-section "Quality of implementation", it was already pointed out that the deteriorating financing of the health care system implies significant problems for health care and thus for the health of the population. The inclusion of the SSK in the government budgets (fourth operation plan) is an important step in the right direction, but far from sufficient.

It is difficult to estimate management capacities at different levels. The general conclusion of the interviews is that Bangladesh's governance still has weaknesses, but the general tendency is positive. Particular praise was given to the professionalism of the individual employees and the leadership of the Health Economics Unit at the MoHFW, which was of great importance for the implementation of HPNSDP and SSK. At the same time, however, the department is far too small and has insufficient capacity to fulfil all its tasks when the number of districts with SSK increases.

From the perspective of patients, the situation demonstrates a tendency towards deterioration, which can be seen in the OOP health care expenditure in absolute terms (per capita PPP) and relatively (% of health care expenditure). While USD 50.23 was still spent in 2011, the amount adjusted for purchasing power increased to USD 112.09 p.a. by 2021. The relative share increased from 68.18% to 72.99%.

***Contribution to support for sustainable capacities***

Overall, the government of Bangladesh has been able to implement this major programme with the help of external development partners.

However, annual figures should not obscure the fact that there were often significant delays within a year. For example, it has been reported several times that hardly any investments were made in the first months of the financial year. Instead, "spending fever" arose shortly before the end of the financial year, i.e. from April to June,

which is a sign that planning needs to be improved.[40] The financial year in Bangladesh's health care sector runs from July to June of the following year.

It is striking that the absorption rate varied greatly between the individual OPs. It achieved very high values in the fight against communicable diseases, in buildings (physical facilities development) and in pre-service education (96%, 97%, 97%), in Human Resource Management (HRM), Management Information Systems and Drug Management (strengthening drug administration, management), the values were modest, respectively (58%, 68%, 58%, 48%). It is particularly regrettable that over half of the funds allocated to health economics and financing within component 2 were not used (absorption rate only 48%) [24]. It also corresponds to the perception of most interview partners that SSK was never fully integrated into the SWAp. HPNSDP certainly could also have already supported SSK, the successor programme surely. The integration of this health insurance into the sectoral programme is planned to initially take place in SWAp V.

For the assessment of sustainability, it is also important to emphasise that the financing situation has changed across the SWAps. In the same period, the financing share of external development partners has fallen from 38.4% to 16.3%, i.e., independence has increased, which can be seen as clear evidence of improved sustainability. Overall, several interviewees emphasised that the government's financial and administrative capacity to carry out complex programmes has increased in recent years. This allows the donor community to focus on tasks outside the SWAp, e.g. innovation, climate action and health, i.e., SWAp V is expected to be the last. Bangladesh is no longer expected to need financial support for its core health care system tasks.[41] This is not an expression of lack of sustainability, but of adaptability. However, the process of adjustment and coordination led to the ability to return to equilibrium in the event of crises (coronavirus pandemic, refugees/migration). This was highlighted by the interview partners. It is likely to be important to maintain coordination and adjustment among the external development partners and with the government of Bangladesh even after the end of the last SWAp.

***Durability of effects over time***

It is difficult to assess individual measures of HPNSDP, as the 2016/17 programme has ended and most investments can therefore no longer be immediately effective (e.g. equipment depreciated, buildings are again in need of renovation, personnel relocated). This is why eight health care facilities were visited as part of the evaluation and interviews and a facilities tour were carried out here as part of a KoboToolbox survey. Table 7 shows the facilities visited.

Table 4 (under Efficiency) shows the problems found on site. With a focus on sustainability, it can be noted that the virtually complete absence of preventive maintenance led to a reduction in the useful life and thus to a lack of sustainability of buildings and equipment. Management training for managers focuses on administration (e.g. public procurement procedures) and neglects systemic management, which led to operational management solely as compliance with state stipulations without strategy or sustainability.

The sustainability of the SWAp instrument itself is already evident in the fact that SWAp IV followed the end of HPNSDP immediately, which in turn will be followed by SWAp V in 2024. The forums, reviews and consultations proved to be useful and sustainable. It is to be assumed that they will continue after the end of SWAp V.

The assessment of the sustainability of the SSK requires differentiated consideration. First of all, it should be noted that all interview partners assume that the problem of social protection in the event of illness in Bangladesh is urgent and important (see also under Effectiveness, Efficiency). The issue of catastrophic health expenditures in the event of illness is a high priority and the instruments of the health financing strategy continue to have a high priority. There was also an increase in the number of insured persons as well as the included upazilas.

Table 16 shows that in 2022, eight further upazilas followed within the Tangail district, significantly expanding the original expansion to three upazilas and the district hospital. The number of households with health insurance increased from 81,649 to 150,980, although the newly included upazilas have significantly fewer households. At the same time, at least the latest evaluation of SSK by USAID in 2020 showed quite positive effects (e.g. on the prevention of catastrophic health expenditure) [38, 39].

However, these positive effects within the Tangail district contrast with the extremely low rate at which health insurance is expanding throughout the country. The original idea was to contribute to the financing strategy and

[40] The World Bank reported an absorption rate of 74.5% for the 2019/20 financial year (78.3% for the operating budget, 68.8% for the development budget). Different calculation bases are likely to be decisive here. However, both figures indicate potential for improvement in MoHFW's financial management [14].

[41] With a population of over 170 million and annual health spending of nearly USD 9 billion, sums at the average level of development aid would not be able to make a significant difference. It therefore makes sense to focus them in the future on innovations that are not (yet) part of the state health care system.

create a kind of “blueprint for the whole country”. It is surprising that this has not happened so far, even though all the interviewees emphasise that social protection in the event of illness is highly relevant, particularly for poor groups. There are many reasons for this, e.g. the low personnel capacity of the Health Economics Unit, the complex remuneration system according to a Diagnosis Related Group (DRG) system, the limitation to inpatient cases, the concentration on public health service providers, the initial exclusion of chronic degenerative diseases, etc. Above all, however, the innovation did not find any promoters during the implementation of SWAp III, neither in the government nor within the external development partners.[42] SSK remained effective within its original target region, but has not yet experienced a roll-out and has therefore not yet sparked innovation for the entire country. While SSK was only described as partially sustainable at the end of the project, there are signs at the moment that SSK could still develop the originally intended innovation effect. In the course of 2024, SSK is to be implemented in at least six further districts and two city corporations as part of SWAp V. In some new districts or city corporations (especially Dhaka South and Dhaka North), the identification of poor population groups and the preparation of administrative structures in the health care facilities for SSK patients have already been initiated. In addition, the number of diagnoses covered was increased from originally 50 to now 110 (and thus the non-communicable diseases (NCDs) are now also included), which significantly increases the attractiveness of SSK. The financing of other services, such as patient transport and services from third-party providers, insofar as they were prescribed by the treating hospital, is also positive. However, if coverage expands even further, this is likely to overwhelm the Health Economics Unit as the leading agency. The Health Financing Strategy envisages the development of a “National Health Protection Authority”, which should bundle all social protection activities in the event of illness. So far, this agency does not exist and the government does not seem to be taking any steps in this direction. It remains to be seen whether SSK can develop sustainably under the condition of HEU’s structural overload (and lack of government willingness to develop an independent agency).

Since the start of the first sectoral programme, profound changes have taken place and external shocks have challenged the health system. For example, the refugee crisis had a severe impact on Bangladesh and its health system from 2017. An estimated 850,000 Rohingya came from Myanmar as refugees, which still requires considerable efforts [45]. From 2020 to 2022, the country was confronted with the coronavirus pandemic [46], particularly during the 2021 delta wave [47]. The long-term challenges for health care are the progressive urbanisation in the megacities, the demographic and epidemiological transition, climate change and the associated increase in dengue.

***Rating summary:***

The FC projects for co-financing HPNSDP represent a systematic unit and were therefore also evaluated in an EPE. They may be separated financially, but not substantially. When it comes to sustainability, the picture is mixed. At the health care facility level, sustainability appears to be average. The SWAp system has good sustainability; SWAp III was continued in the subsequent SWAp IV programme. SSK is currently only operating in one district, but in a sustainable manner, and there are at least indications at the time of the evaluation that a more extensive roll-out is being prepared. Integration into SWAp V is to take place, but no final decisions are yet available on this. Taking these dimensions into account, sustainability is assessed as moderately successful.

**Sustainability: 3**

## Overall rating

On the basis of the above, it can be concluded that the impacts of HPNSDP were highly significant for the population of Bangladesh. The health-related indicators have improved significantly since 2011, and their target values set at the programme appraisal were largely achieved. It can also be stated that they were also successful for the SWAp instrument and basket funding. Some elements of component 2 (strengthening the health system) are not satisfactory, and the piloting of health insurance is not yet meeting expectations, as it is still functional and relevant in the Tangail district, but has not yet expanded throughout the country. However, with a share of less than 2% of the total FC budget, this cannot distort the overall picture of a result that still fully meets expectations.

This shows that HPNSDP and thus also the co-financing FC projects – in relation to its original objective – meet expectations. If the focus is broadened, it must be noted that an earlier introduction of health insurance, greater

[42] One interview partner referred to SSK (from the point of view of the other development partners) as an “orphaned child”. Another highly relevant partner described the investment in SSK as “money down the drain”. Accordingly, SSK was not included in SWAp IV.

efforts to combat OOP payments and the promotion of private health services would have made an even greater impact possible. Overall, we rate the FC projects co-financing HDNSDP as successful.

**Overall rating: 3**

## Contributions to Agenda 2030

HPNSDP and the German DC contribution were directly focused on MDG 4 (Reduce child mortality), MDG 5 (Improve maternal health) and MDG 6 (Combat HIV/AIDS, malaria and other diseases) as well as SDG 3 (Good health and well-being)[43], i.e. ensuring a healthy life for all people of all ages and the promotion of their well-being. The corresponding indicators are mostly positive, as shown in the "Impact" section. The focus on vulnerable individuals (mothers, children, impoverished groups) is also in line with the 2030 Agenda. The SWAp used the national systems by definition, implemented national routines and coordinated the donors.

HPNSDP has not yet been explicitly aligned with environmental objectives. This is surprising, as Bangladesh is more affected by global climate change than many other countries, especially by the rise in sea level [48]. Although the contribution of the health care system in Bangladesh to this is minimal, it would have been possible and sensible to give greater consideration to the environmental impact of the health care system. As part of HPNSDP, waste management standards have been developed and implemented in health care facilities, but not across the board. USD 20 million was set aside for this purpose [23]. Compared to the total volume, this is almost negligible. In fact, waste management proved to be a major issue during project visits to health care facilities.

## Project specific strengths/weaknesses and general conclusions/lessons learned

Strengths and weaknesses of the project included:

- SWAp III during HPNSDP built on existing experience from SWAp I and II; the control systems were established and could be used.
- The government of Bangladesh developed ownership for the SWAp and basket during HPNSDP. The process of harmonisation is also deemed successful by the government, even if basket funding is no longer expected to be pursued in the future under SWAp V. HPNSDP was the "high time for the SWAp" when the government's management capacity was already professional enough to carry it out, but the financial capacity was not yet sufficient to handle this task alone. The fact that the new SWAp V is expected to be the last is not proof that the sectoral programmes have failed, but of the positive development within the government of Bangladesh.
- The highly relevant topics of health insurance and climate change were not taken into account in SWAp III HPNSDP, but are expected to be included in the new SWAp V from 2024. This would be an opportunity for German DC to contribute expertise and important impetus.
- The sector dialogue led to mutual trust, which contributed to improved implementation of the measures. Speed and effectiveness were significantly increased through close cooperation.
- The piloting of social health insurance for impoverished groups was well planned and implemented. Due to the lack of ownership on the part of the government of Bangladesh and external development partners, it has so far not been able to develop its effect for the whole country and is still existing within a niche. This is expected to change with SWAp V; it is an integral part of it.
- This is particularly problematic in the context of the fact that only around one quarter of health care is public and three quarters private. The nationwide introduction of health insurance could effectively contribute to reducing the high out-of-pocket payments of around 73% of health care spending (2020) and help to alleviate poverty.

[43] Particularly 3.1 Maternal mortality, 3.2 Child mortality, 3.3 Infectious diseases, 3.4 non-communicable diseases, 3.7 Access to sexual and reproductive health care, 3.8.1 Coverage of essential health services, 3.b Vaccines and medicines, and 3.c Health worker density and distribution. Little coverage was given to: 3.5 Substance abuse, 3.6 Road traffic accidents, 3.8.2 Hedging against financial risks and 3.9 Environmental medicine, 3.a Tobacco control and 3.d Early warning, risk reduction and management of national and global health risks.

## General conclusions and lessons learned:

The FC measure not only makes an important development policy contribution to improving the health situation of the population in Bangladesh, but also to the country's efforts to harmonise external support. The policy dialogue linked to basket funding ensures greater participation in the formulation of sectoral policies and the implementation of reforms. This significantly increased the efficiency, effectiveness and visibility of the German commitment. The SWAp has the potential for moderation, i.e., it can strengthen the effect of individual measures and significantly increase their speed of implementation. Basket funding is a particularly suitable instrument for this, as it strengthens the responsibility of the partner country's government. However, there is still no consistent integration of demand-side instruments (especially health financing), so there is a risk that the disparity between the poor and the rich or urban centres and the periphery could increase further.

In the sector (MoHFW, external development partners), there is still a lack of understanding of the fact that German DC has withdrawn from the health sector. German DC should have at least assisted with the introduction of health insurance until the "teething problems" had been overcome.

## Evaluation approach and methodology

### Ex post evaluation methodology

Ex post evaluations follow the approach of a rapid appraisal, i.e. a data-supported, qualitative contribution analysis resulting in an expert opinion. Effects are attributed to the project considering plausibilities, based on thorough analysis of documents, facts and impressions. This includes – if possible – the use of advanced technology (e.g. satellite imagery, online interviews, geocoding). There is a follow-up on possible conflicting information, attempting to eliminate inconsistencies and to base the rating on information that – to the extent possible – has been confirmed through different sources (triangulation).

Data sources and tools for analysis: Literature (see appendices), project documentation, various databases (e.g. World Development Indicators).

Interview partners: Interview partners online before the mission: 10 interviews of 60 minutes each, mainly with external development partners (8), consultants (1) and scientists (1); conversation partners during the mission: Ministry of Health (7),[44] Health Economics Unit (5), Ministry of Finance (3), University of Dhaka (2), Heads of Health Facilities (>25), Others (3).

Assessments and experiences were collected from patients in three upazila health care complexes. The spot survey was conducted by employees and students of the University of Dhaka (Department of Health Economics) under the supervision of the appraiser using KoboToolbox. Table 7 shows the facilities visited.

*Table 7 Facilities visited*

| | Dhaka | Tangail district |
|---|---|---|
| Tertiary hospitals (specialised hospital) | Shaheed Suhrawardy Medical College and Hospital (1,350 beds) | |
| General hospital | Kurmitola General Hospital (500 beds) | Tangail General Hospital (250 beds) |
| Small hospital | | Kalihati Upazila Health Complex, (50 beds)<br>Ghatail Upazila Health Complex (50 beds) |
| Dispensary | Sher-e-Bangla Nagar Outdoor Dispensary | Dighail Kandi Health and Family Welfare Centre |
| Community clinic | | Shahpur community clinic |

Source: Own data.

The analysis of project effects is based on the logic defined at project appraisal and documented within the impact matrix, which may be updated for the purposes of the evaluation. The evaluation report argues which factors contributed to the observed effects and why – as well as the probable extent of the project´s contribution (contribution analysis). The context of the project is taken into account concerning its influence on the results. The conclusions are put into perspective regarding the availability and accuracy of the available data. An evaluation concept is the frame of reference for the evaluation.

This method provides a balance between cost and usefulness, generating evaluation findings with appropriate effort and expense. Also, it allows for a systematic success rating across the FC projects. Thus, an isolated ex post evaluation cannot fulfil the requirements of a scientific assessment in the sense of a strict causality analysis.

The following aspects caused limitations for the evaluation: No budgets and revenue surplus calculations could be obtained for health care facilities.

[44] Numbers in brackets indicate the number of interviewees.

## Rating methodology

Projects are rated on a six-point scale for each of the OECD DAC criteria. The scale is as follows:

**Level 1** very successful: result that clearly exceeds expectations

**Level 2** successful: fully in line with expectations and without any significant shortcomings

**Level 3** moderately successful: project falls short of expectations but the positive results dominate

**Level 4** moderately unsuccessful: significantly below expectations, with negative results dominating despite discernible positive results

**Level 5** unsuccessful: despite some positive partial results, the negative results clearly dominate

**Level 6** highly unsuccessful: the project has no impact or the situation has actually deteriorated

The overall rating on the six-point-scale is compiled by weighting all six individual criteria as appropriate to the project in question. Rating levels 1–3 of the overall rating denote a "successful" project while rating levels 4–6 denote an "unsuccessful" project. It should be noted that a project can generally be considered developmentally “successful” only if the achievement of the project objective (“Effectiveness”), the impact on the overall objective (“Impact”) and the sustainability are rated at least “moderately successful” (level 3).

The annex to this report is available upon request.

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