

## Bangladesh: Health and Population Sector Programme

### Ex-post evaluation

<b>OECD sector</b>	13030 – Population Policy and Family Planning	
<b>BMZ project ID</b>	1) 1998 65 353 (Tranche 1)      2) 2000 66 043 (Tranche 2)	
<b>Project-executing agency</b>	Ministry of Health and Family Welfare, MoHFW	
<b>Consultant</b>	EPOS Health Consultants	
<b>Year of ex-post evaluation</b>	<b>2005</b>	
	<b>Programme appraisal (planned)</b>	<b>Ex-post evaluation (actual)</b>
<b>Start of implementation</b>	1) IV/1998 2) III/ 2002	1) I/2000 2) III/2002
<b>Period of implementation</b>	1) 5 years 2) 1 year	1) 4 years 2) 1 year
<b>Investment costs</b>	Total programme (SWAP): US\$ 2.8 billion	
<b>Counterpart contribution</b>	approx. 65% financed by the government approx. 35% financed by the community of donors	
<b>Financing from FC funds</b>	1) EUR 23.0 million 2) EUR 5.1 million	1) EUR 23.0 million 2) EUR 5.1 million
<b>Other institutions/donors involved</b>	Donor consortium in the framework of SWAp (pool and parallel financing): World Bank, DFID, CIDA, SIDA, USAID, UNFPA, UNICEF, JICA, EC, WHO, KfW/GTZ  In the sub-sector, population policy: CIDA, SIDA, USAID, UNIFEM, KfW	
<b>Performance rating</b>	3	
• <b>Significance/Relevance</b>	3	
• <b>Effectiveness</b>	3	
• <b>Efficiency</b>	3	

### Brief Description, Overall Objective and Programme Objectives with Indicators

The FC programme comprised the procurement and distribution of oral contraceptives (pills) as part of the family planning component of the sector-wide Health and Population Sector Programme (HPSP). From 1998 to June 2003 and including a stopgap phase up to 2005, the HPSP was implemented by a donor syndicate led by the World Bank. The German part of the programme was implemented under a parallel finance facility in two tranches (EUR 23 million and EUR 5.1 million) in FC-TC cooperation. The FC programme (i) obtained about 30% (175 million cycles) of the quantity needed to meet nationwide demand for oral contraceptives and distributed these via government institutions, (ii) supported the executing agency with consultancy services in acquisition, quality assurance, monitoring pill distribution and in reporting and (iii) was scheduled to contribute co-finance for the donor syndicate's programme office and take part in HPSP sector dialogue via the TC project. The TC project concentrated on the conceptual design of further training programmes in basic health. A sequel project, a programme contribution to the next health SWAP, the Health, Nutrition and Population Sector Programme (HNPSPP) is currently in preparation by the KfW development bank. Key programme data are appended in Annex 1.

The development objective of the HPSP was to improve the state of health of the total population in Bangladesh with a special focus on women, children and the poor by providing essential health service packages (ESP) and through sector reforms. The overall objective of the FC programme was to make a contribution to stabilizing or reducing the fertility rate (and hence population growth) in the

family planning component of the FC programme. Indicators were increase in contraceptive use (prevalence rate) from 49% (Tranche 1) and 54% (Tranche 2) resp. to 60% (2004) and the stabilization or reduction of the total fertility rate of 3.3 (Tranche 1) and 3.2 (Tranche 2) resp. The programme objective was to ease access to family planning services by means of a (quantitatively and qualitatively adequate) nationwide supply of low-dosage contraceptives (pills) especially to peripheral facilities (government basic health stations) and their use by the target group, i.e. women of child-bearing age accounting for poor and underprivileged groups.

### **Programme Design/Major Deviations from Original Programme Planning and Main Causes**

At the end of the nineties, the Bangladeshi government amalgamated individual projects supported by 126 donors and 66 individual components nationwide under the fourth health plan into a sector-wide programme (SWAP), the HPSP. The objective of the HPSP was to provide essential service packages (ESP) to poor people and women. It also supported health care reforms at district level (community clinics and hospital improvement initiative), coordination amongst administrative levels, efficiency improvements in sector planning (setting up a management information system, gearing efforts more towards poverty reduction and gender, reducing informal charges) and in procurement (including reducing loss of material) as well as the improvement of health finance. Implemented from 1998 to 2004 and worth US\$ 2.8 billion (US\$ 1.6 billion of this for the ESPs including family planning), the HPSP was the first and largest SWAP worldwide. Through pool (World Bank, CIDA, DFID, EU, the Netherlands and SIDA) and parallel (BMZ via FC and TC, UN, USAID, ADB) finance, the donor community shouldered almost one third of the total costs of the HPSP. Family planning activities were primarily (approx. 60%) financed from the HPSP pool with additional parallel finance from USAID (social marketing) the KfW development bank (oral contraceptives in the state sector) and UNFPA.

Ninety-four per cent of the FC funds were allocated for the procurement of low-dosage contraceptives (pills), 5% for consultancy services and 1% for co-financing HPSP administrative costs (EUR 0.53 million for the HPSP programme administration and monitoring office, the Support Office - HPSO).

Over the entire term of the programme, about 30% of the oral contraceptives to meet demand nationwide was obtained with FC funds and 20% with HPSP pooled funds; these pills were distributed within the state system. In addition, 45% of the oral contraceptives were provided by NGOs (through social marketing primarily financed by USAID with a broader product range) and the remaining 5% were distributed by the private sector. Almost everywhere, modern contraceptives are formally available free of charge from the state-funded hospitals and family workers and against payment via social marketing in very many pharmacies. The FC programme was designed as a cooperation programme of German financial (FC) and technical (TC) assistance.

No major amendments were made to programme design. Savings from the first tranche of the FC programme were used to obtain almost 6 million more oral contraceptives than originally planned. The consultancy services to support procurement worth altogether EUR 1.2 million were financed from the first tranche and used for both tranches. The implementation of the FC programme was delayed slightly due to various difficulties in the administration and in HPSP sector reforms.

We have no indications of any improper use of funds. At present, residual funds are still available from Tranche 1 amounting to approx. EUR 36,000. These have been earmarked for the purchase of contraceptives in the sequel project currently in preparation. If contrary to present expectations problems arise with this, KfW will prepare a separate report.

### Assessment of Overall Design of the HPSP and FC Programme

The HPSP concentrated on the nationwide provision of the essential services packages (ESPs). The World Bank draft Implementation Completion Report rates the overall impacts of the HPSP as 'moderately unsatisfactory' only. Particular criticism was levelled at the unsuccessful poverty targeting and the lack of gender focus, the quality of the services provided and the insufficient implementation of sector reforms (particularly decentralization, the merger of family planning and health divisions in the ministry, procurement, personnel policy).

Based on the HPSP design, the FC family planning programme centred on serving the needs of fertile women on as broad basis as possible. The donors involved in family planning (FP) and the MOHFW agreed on the demand-driven provision of various contraceptives as to quantity, methods and/or products. With the low-dosage pills for the state sector, the FC programme fitted into the logistics of this overall programme so that the procurement and distribution of the oral contraceptives financed under FC was carried out with an appropriate allocation of tasks and in a generally coherent

nationwide system (alignment).

Under this system, contraceptives were distributed in the country to meet demand. However, the FC programme neglected the rationale and long-term need to focus on underprivileged or poor target groups whose unmet needs in family planning are particularly large:

- The ratio of unmet needs is particularly pronounced amongst very young women between 10 and 20 (i.e. 23.3% amongst 10-14 year-olds and 15.1% amongst 15-19 year-olds), while this amounts to 12.3% amongst 20-35 year-olds and only 6.8% for the 40-44 year-old women.
- Higher ratio in the regions Chittagong and Sylhet (and in smaller measure also on Dhaka), where social marketing distribution channels are poor and least progress in the family planning sector has been achieved. The ratio of unmet needs is above average in these regions: in Sylhet, 20.6% and in Chittagong 17%.

While the HPSP generally reduced the number of family workers, target group outreach was also insufficient for the young women, as these young women seldom attend the new government community clinics. They need special educational and awareness measures (such as home visits that include their husbands or discussions on the topic at school) that go beyond the government TV advertisements, which were otherwise very successful. Pills, as financed in the FC programme, are this group's preferred contraceptive.

These results show the need to improve family planning programme targeting as part of the HPSP. A pro-poor resource allocation was discussed in detail between the ministry and the donor community, but no agreement was reached on practicable implementation during the term of the HPSP. This deficit could not be remedied under the FC programme, either.

Sector dialogue for the FC-TC cooperation programme was to be conducted based on a consensus amongst BMZ, the embassy, GTZ and KfW on the TC project. The TC project (1998.2187.7) was, however, engaged in a completely different subsector (personnel qualification) and had not planned sector dialogue on family planning as an output or activity either. The final report of the TC project (2004) advised against implementing another phase.

### **Key Results of Impact Analysis and Performance Rating**

Since its foundation in 1975, Bangladesh has succeeded in reducing poverty (measured against US\$ 1 per capita - purchasing parity power) from 49.7% of households in 1991 to 40.2% in 2000 (PRSP Bangladesh, 2005). With a population of 135.2 million and a per capita income of US\$ 421 (2004), however, the country still numbers among the poorest in the world. Due to the high annual population growth of currently 1.9%, the MDGs by 2015 will only be reached in part, despite progress primarily in the social sector and in reducing income poverty.

The significant progress in Bangladeshi social development (improvement in the Human Development Index by 23% between 1990 and 2002) is above all due to successes in the health sector (see Annex 5, Table 1). The infant mortality rate (IMR) has been lowered from 153 per 1000 live births in 1974 to 65/1000 in 2004. At the same time, child mortality up to the age of 5 has been reduced from 133 (1989) to 88 per 1000 (2004). Mortality in childbirth was reduced by 36% between 1986 and 2000, but remains high at 320 per 100.000. Average life expectancy has improved considerably from 45 (1975) to 68 (2005). Despite many problems with transparency, effectiveness and efficiency in the sector, the country has succeeded in implementing initial sector reforms such as the creation of rural health services with barefoot doctors and family planning workers. Before 1997, the public share of the health and family planning programmes was primarily financed by the donors through subsidies. Added to this were very high contributions by the end users, since practically no medical insurance system exists and most health services are provided by the private sector. Under the HPSP, the government has taken initial steps towards more sustainable and effective sector finance.

Due to external factors such as economic growth, poverty reduction and greater gender equality most indicators in the health sector also improved during the HPSP (Annex 5, Table 2). However, many of its scheduled structural reforms were less successful. The last HPSP Annual Programme Review (APR) of May 2005 finds fault in particular with regard to the following: (1) deterioration in the quality of service in the government sector, (2) insufficient target-group focus on the poor and young women, specific rural regions and the capital Dhaka, and (3) the slow implementation of sector reforms (including problems in sector coordination particularly between family planning and the other health sector, private sector involvement, sustainable contribution finance and decentralization). The

government and the donor community have evaluated the HPSP as moderately successful in response to the APR 2005 and merged it into a sector-wide sequel programme (Health, Nutrition and Population Sector Programme, HNPSP, 2005-2010). The HPSP was primarily concerned with the nationwide distribution of ESPs, to a small extent also with catering in particular for underprivileged target groups. The sequel programme, HNPSP, which has an even larger budget (US\$ 4.3 billion, with the share of ESPs in total expenditure at about 78%) will attach more importance to quality features in order to enhance developmental efficacy.

The population of Bangladesh has tripled since 1960. If the current reproduction rate stabilizes by 2010, the country will have 250 million inhabitants in 2050. This poses the government with large problems. It therefore intends to lower the total fertility rate (TFR) by a substantial margin. Family planning (FP) is highlighted as a particularly important and successful sector in the national poverty reduction strategy paper (PRSP) and in national health policy. In the eighties in particular, population growth was almost halved. In the final HPSP report, impacts in the family planning subsector, are rated better than those in the sector as a whole.

Below we assess the programme applying the key criteria **effectiveness, relevance or significance** and **efficiency**:

In agreement with other donors as part of the HPSP, the FC programme was active in the public sector and contributed to an increase in the use of oral contraceptives from 21% in 1997 to 26% in 2004 (Annex 5, Table 4). The ratio of women who wanted to use any kind of modern contraceptives but did not have access to them (unmet needs) diminished from 15% to 11.3% during the HPSP. There has been a distinct reduction in the share of the pills distributed via the state (FC segment) in favour of social marketing (SM) from 83% in 1993 and 74% in 1997 to 56% in 2004 (Annex 5, Table 3). This shift from the free public sector to the private or NGO sector against payment is in principle a positive development, because it raises the financial sustainability of the entire system.

Among other things, the HPSP aimed to improve the health of particularly poor sections of the population. However, this objective was not satisfactorily attained in the overall programme for lack of appropriate alignment, the reason why the free oral contraceptives were not distributed to specific target groups in the FC programme either. Considering the large number of needy women (particularly young women in specific regions) the programme failed to reach, this lack of focus makes for a major deficit. By focusing on the measures, the access of women with unmet needs to family planning services could have been increased considerably overall.

Owing to other priorities, the participation of the FC programme in sector dialogue on the relevant topics was low. In the other segments, FC repeatedly pressed for the introduction of user fees and contributed via the consultant to improving procurement in family planning and in the health sector as a whole. However, the FC programme did not make adequate use of its scope for taking active part in sector dialogue and contributing its experience in the family planning subsector.

Altogether, we assess the **effectiveness** of the FC programme as sufficient (subrating 3).

Since the beginning of the HPSP (1997), the contraceptive prevalence rate (CPR) amongst women between 15 and 49 (taking modern and traditional methods together) has risen to approx. 58.1%. In comparison with other developing countries, the CPR figure is relatively low. However, the application of modern family planning methods was already widely successful in the 80s and 90s and is attributable in particular to the broad dissemination of the pill. According to the Annual Progress Review 2005, the total fertility rate (TFR) has declined from 3.3 to approx. 3.0 (Annex 5, Table 5). Hence the FC programme has met the overall objective indicators. At present, the growth rate of the Bangladeshi population is 1.9%, a little higher than the average in Asia without China (1.6%) but almost on a par with the average of all developing countries (1.8%) and much lower than Pakistan (2.4%), for example.

Despite this positive development, the HPSP evaluation - leaving aside the unsatisfactory focus on young women in underprivileged regions - criticized other weak points in family planning that also apply to the FC programme (see Annex 4): (a) insufficient involvement of the private sector and NGOs in the overall HPSP programme, (b) pointed criticism by the users of the quality of public services, (c) problems in procurement, due for example to badly trained personnel and lack of management information systems, (d) the absence of a strategy geared to social equity or the unsuccessful implementation of such a plan for promoting poor and underprivileged target groups and regions; and (g) insufficient attention to gender aspects, including the failure to implement the gender strategy

developed for the subsector.

Altogether, the FC programme as part of the donor programme has made an important contribution to serving the market for oral contraceptives in Bangladesh. As inadequate gender and poverty targeting in the HPSP have detracted from the contribution to overall objective achievement, we grade the **relevance and significance** of the FC programme as sufficient (subrating 3).

As to **efficiency**:

- The procurement of oral contraceptives was carried out efficiently. Despite the confinement of the call to tender to Germany, the pills were obtained at a very low world market price. The average price (excluding shipment and storage charges in the country) amounted to EUR 0.13 per pill cycle. Thanks to price savings in contraceptive procurement and logistics, the FC programme was able to obtain and distribute a total of 174.5 million cycles of low-dosage oral contraceptives instead of the scheduled 169 million.
- The oral contraceptives were efficiently distributed throughout the country. The logistic capacities were supported by the FC consultant and the Deliver Project financed by USAID. The FC programme has improved the performance of the logistic system in family planning through regular monitoring of stocks. The efficiency of the logistic system has improved considerably. The FC programme has helped to reduce the loss of oral contraceptives from 15% to 5% (as in the ESPs in general). Altogether, the inputs of the consultant in the FC programme are gauged as satisfactory; they have in part been adopted by the executing agency. However, the government has still not found a permanent remedy for the structural deficits in the warehouses and operational staff shortage.
- In general economic terms and for the end user, pills are relatively expensive products in comparison with longer-term contraceptives. For a couple of years of protection (CYP) oral contraceptive costs in Bangladesh are low at EUR 4-7 by worldwide standards of EUR 14-24. For the end-users, the oral contraceptive CYP in fact amounts to 40 to 80 taka (EUR 0.5-1) when pills are distributed by the government (incl. an unofficial charge of 5-20 taka (EUR 0.1-0.5) per visit to a health station at 4 visits a year)<sup>1</sup> and via social marketing at 60-234 taka (EUR 0.8-3), depending on the type of pill.
- The introduction of user fees for public family planning services as advocated by the FC programme did not succeed under the HPSP, but cost recovery has improved due to the growing market share of social-marketing contraceptives. The share of government finance in the HPSP has remained the same at approx. 65% but has not risen, contrary to expectations. Under the sequel HNPSP, the share of donor finance will increase somewhat (with 50% higher total volume, however). The government has raised the percentage budget expenditure for health finance by approx. 12% in real terms from 6% (1996) to 7.5% (2005). The increase per capita is only minimal, though; at US\$ 4 in annual state expenditure, Bangladesh ranges in the lower bracket worldwide. It must therefore raise efficiency by a considerable margin to ensure sustainable self-finance.

Weighing up the above points, we assess the **efficiency** of the programme overall as sufficient (subrating 3).

We judge the overall developmental efficacy of the programme to be sufficient (Rating 3).

Due to the significance of supplying contraceptives for reducing population growth, the programme has also made a substantial contribution to poverty reduction. The rationale for assigning the programme in the appraisal report to the category of contributing directly to poverty eradication (SUA category) was only very general in scope, citing an unspecified improvement in the conditions of life of the poor population and a contribution to economic growth. The Implementation Completion Report of

<sup>1</sup> In practice, user fees are already charged in the state sector in the form of illicit payments. In 1996, about 40% of all women said that they made unofficial payments to government service providers. This has improved a lot under the HPSP: At the end of 2003, about 23% of all interviewees paid an average of 10 taka in illicit contributions for ESPs. In family planning activities and above all for oral contraceptives, the number (up to 70%) and price (5-20 taka) of informal payments are much higher. This affects poor women in particular, who are often unaware that these payments are illegal and cannot assert their rights in dealings with health personnel. Several studies have shown that formal charges of 10 taka for contraceptives are accepted by and affordable even for the poor end-users. At 0.4% of annual expenditure, the effective 'costs' for pills distributed by the state are still under the Chapman Index (1%). Only the poorest 10% of women, also including very young women, would have problems paying informal fees in addition to formal charges for contraceptives, which exceed 5 taka per visit to a health station (that is 20 taka a year).

the World Bank also criticizes that the public health services provided have not helped the very poor. A detailed target-group analysis or poverty targeting was not carried out by gender, region or affordability. Forty-seven per cent of those using pills distributed free of charge by the government come from the topmost three income brackets. This population group is already quite capable of paying its own contribution for receiving contraceptives, while 53% are poor women. The programme is therefore assigned to other direct poverty eradication.

The programme aimed at easing access to modern family planning methods to improve the conditions of life for women by affording them choices in planning their personal life and reducing the health risks entailed in high numbers of births and short intervals between births. Owing to its conceptual design the FC programme is classified as also impacting gender (category G1). However, the programme has taken too few measures to put these generally sound arguments into practice. Young women in particular (with large unmet needs) would have had a keen interest in widening their options for planning their personal life with children.

The programme did not have any environmental objectives (E0) and its design had little bearing on decentralization and good governance (PD/GG0).

### General Conclusions and Recommendations (*Lessons Learnt*)

- Family planning is a priority area for poverty reduction in many countries. Development cooperation should therefore make a significant contribution to this sector in selected countries like Bangladesh. It must, however, provide a much sounder poverty rationale for its future involvement – both in programme and project finance. It should also better address poverty reduction in programme design through geographical poverty targeting, including mother and child as well as in early childhood (including nutrition) dimensions in family planning policy, and through ex-ante impact analyses and poverty monitoring, for example.
- Family planning must place much more emphasis on gender-sensitive measures in programme design. This includes more focus on young women in underprivileged regions in the country, involving men in family planning activities and awareness raising, addressing social and income security for women, and fighting domestic and social (sexual) violence against women. This may include facilitating outreach workers for especially underprivileged women and young girls, educational campaigns through media and schools, further training for pharmacists and outreach workers.
- To improve financial sustainability and promote user equity, user charges shall be (gradually) introduced for family planning services. The current practice of charging informal fees should be done away with and replaced by official and transparent pricing systems. Special support measures shall be introduced for very poor target groups that would be deprived of family planning services through the introduction of fees.
- In sector-wide programmes where FC can make significant contributions to improving health care, FC should engage more in sector dialogue where it has core competencies such as family planning. FC may also opt for taking the thematic lead role in broader policy issues, such as more equitable finance and the introduction of user fees to strengthen sustainability, and target-group issues and distribution channels. Support to the sector should also be designed more systematically as part of donor harmonization.

### Assessment Criteria

<b>Developmentally successful: Ratings 1 to 3</b>	
Rating 1	Very high or high degree of developmental efficacy
Rating 2	Satisfactory developmental efficacy
Rating 3	Overall sufficient degree of developmental efficacy
<b>Developmental failures: Ratings 4 to 6</b>	
Rating 4	Overall slightly insufficient degree of developmental efficacy
Rating 5	Clearly insufficient degree of developmental efficacy
Rating 6	The project is a total failure

### Criteria for the Evaluation of Project Success

The evaluation of the developmental efficacy of a project and its classification during the ex-post evaluation into one of the various levels of success described in more detail below concentrate on the following fundamental questions:

- Are the project objectives reached to a sufficient degree (aspect of project effectiveness)?
- Does the project generate sufficient significant developmental effects (project relevance and significance measured by the achievement of the overall development-policy objective defined beforehand and its effects in political, institutional, socio-economic and socio-cultural as well as ecological terms)?
- Are the funds/expenses that were and are being employed/incurred to reach the objectives appropriate and how can the project's microeconomic and macroeconomic impact be measured (aspect of efficiency of the project conception)?
- To the extent that undesired (side) effects occur, are these tolerable?

We do not treat sustainability, a key aspect to consider for project evaluation, as a separate category of evaluation but instead as a cross-cutting element of all four fundamental questions on project success. A project is sustainable if the project-executing agency and/or the target group are able to continue to use the project facilities that have been built for a period of time that is, overall, adequate in economic terms, or to carry on with the project activities on their own and generate positive results after the financial, organisational and/or technical support has come to an end.