Document of
The World Bank

Report No.: 36564

PROJECT PERFORMANCE ASSESSMENT REPORT

BANGLADESH

FOURTH POPULATION AND HEALTH PROJECT (CREDIT 2259-BD) AND

HEALTH AND POPULATION PROGRAM PROJECT (CREDIT 3101-BD)

June 23, 2006

Sector, Thematic and Global Evaluation Division
Independent Evaluation Group

Currency Equivalents (annual averages)

Currency Unit = Bangladesh Taka

1990	US$1.00	Tk. 35.79
	Tk. 1	US$0.02794
1998	US$1.00	Tk. 46.55
	Tk. 1	US$0.0225
2005	US$1.00	Tk. 64.33
	Tk. 1	US$0.01555

Abbreviations and Acronyms

AOP	Annual Operational Plan
BNP	Bangladesh National Party
CAO	Central Accounts Office
CBNC	Community-Based Nutrition Component
DP	Development Partner
EOC	Emergency Obstetric Care
ESP	Essential Service Package
GOB	Government of Bangladesh
FEPS	Final Executive Project Summary
FP	Family Planning
FPHP	Fourth Population and Health Project
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
FWVTI	Family Welfare Visitor Training Institute
FY	Fiscal Year
HAPP	Health and Population Project
HNP	Health, Nutrition and Population
HNPSP	Health, Nutrition and Population Sector Program
HPPP	Health and Population Program Project
HPSO	Health and Population Sector Office
HPSP	Health and Population Sector Program
HPSS	Health and Population Sector Strategy
ICMH	Institute of Child and Maternal Health
ICB	International Competitive Bidding
ICR	Implementation Completion Report
IEG	Independent Evaluation Group
IEPS	Initial Executive Project Summary
IMED	Implementation, Monitoring and Evaluation Division
MCH	Maternal and child health
MCWC	Maternal and Child Welfare Center
MIS	Management Information System
MTR	Midterm Review
MOHFW	Ministry of Health and Family Welfare
NGO	Nongovernmental Organization

NIPORT	National Institute of Population Research and Training
NIPSOM	National Institute of Preventive and Social Medicine
OED	Operations Evaluation Department (now IEG)
OPCS	Operations Policy and Country Services
PCD	Project Concept Document
PPAR	Project Performance Assessment Report
PSR	Project Status Report
RD	Rural Dispensary
RTC	Rural Training Center
RPA	Retroactive Project Aid
SAR	Staff Appraisal Report
SD	standard deviation
SWAP	Sector Wide Approach
TA	Technical assistance
TFR	Total fertility rate
VAT	Value added tax
UHC	Upazilla Health Complex
UNICEF	United Nations' Children's Fund
UNFPA	United Nations Fund for Population

Fiscal Year

Government: July 1 – June 30

Director-General, Evaluation	:	Mr.Vinod Thomas
Director, Independent Evaluation Group, World Bank	:	Mr. Ajay Chhibber
Manager, Sector, Thematic and Global Evaluation Division	:	Mr. Alain Barbu
Task Manager	:	Mr. Howard Nial White

IEG Mission: Enhancing development effectiveness through excellence and independence in evaluation.

About this Report

The Independent Evaluation Group assesses the programs and activities of the World Bank for two purposes: first, to ensure the integrity of the Bank's self-evaluation process and to verify that the Bank's work is producing the expected results, and second, to help develop improved directions, policies, and procedures through the dissemination of lessons drawn from experience. As part of this work, IEG annually assesses about 25 percent of the Bank's lending operations. In selecting operations for assessment, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming studies or country evaluations; those for which Executive Directors or Bank management have requested assessments; and those that are likely to generate important lessons. The projects, topics, and analytical approaches selected for assessment support larger evaluation studies.

A Project Performance Assessment Report (PPAR) is based on a review of the Implementation Completion Report (a self-evaluation by the responsible Bank department) and fieldwork conducted by OED. To prepare PPARs, IEG staff examine project files and other documents, interview operational staff, and in most cases visit the borrowing country for onsite discussions with project staff and beneficiaries. The PPAR thereby seeks to validate and augment the information provided in the ICR, as well as examine issues of special interest to broader IEG studies.

Each PPAR is subject to a peer review process and IEG management approval. Once cleared internally, the PPAR is reviewed by the responsible Bank department and amended as necessary. The completed PPAR is then sent to the borrower for review; the borrowers' comments are attached to the document that is sent to the Bank's Board of Executive Directors. After an assessment report has been sent to the Board, it is disclosed to the public.

About the IEG Rating System

The time-tested evaluation methods used by IEG are suited to the broad range of the World Bank's work. The methods offer both rigor and a necessary level of flexibility to adapt to lending instrument, project design, or sectoral approach. IEG evaluators all apply the same basic method to arrive at their project ratings. Following is the definition and rating scale used for each evaluation criterion (more information is available on the IEG website: http://worldbank.org/oed/eta-mainpage.html).

Relevance of Objectives: The extent to which the project's objectives are consistent with the country's current development priorities and with current Bank country and sectoral assistance strategies and corporate goals (expressed in Poverty Reduction Strategy Papers, Country Assistance Strategies, Sector Strategy Papers, Operational Policies). *Possible ratings:* High, Substantial, Modest, Negligible.

Efficacy: The extent to which the project's objectives were achieved, or expected to be achieved, taking into account their relative importance. *Possible ratings:* High, Substantial, Modest, Negligible.

Efficiency: The extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared to alternatives. *Possible ratings:* High, Substantial, Modest, Negligible. This rating is not generally applied to adjustment operations.

Sustainability: The resilience to risk of net benefits flows over time. *Possible ratings:* Highly Likely, Likely, Unlikely, Highly Unlikely, Not Evaluable.

Institutional Development Impact: The extent to which a project improves the ability of a country or region to make more efficient, equitable and sustainable use of its human, financial, and natural resources through: (a) better definition, stability, transparency, enforceability, and predictability of institutional arrangements and/or (b) better alignment of the mission and capacity of an organization with its mandate, which derives from these institutional arrangements. Institutional Development Impact includes both intended and unintended effects of a project. *Possible ratings:* High, Substantial, Modest, Negligible.

Outcome: The extent to which the project's major relevant objectives were achieved, or are expected to be achieved, efficiently. *Possible ratings:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Bank Performance: The extent to which services provided by the Bank ensured quality at entry and supported implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of the project). *Possible ratings:* Highly Satisfactory, Satisfactory, Unsatisfactory, Highly Unsatisfactory.

Borrower Performance: The extent to which the borrower assumed ownership and responsibility to ensure quality of preparation and implementation, and complied with covenants and agreements, towards the achievement of development objectives and sustainability. Possible ratings: Highly Satisfactory, Satisfactory, Unsatisfactory, Highly Unsatisfactory.

Contents

This report was prepared by Howard Nial White, who assessed the projects in March, 2006. Ms. Soon-Won Pak provided administrative support.

Principal Ratings

	*ICR**	*ICR Review***	*PPAR*
Fourth Population and Health Project			
Outcome	Satisfactory	Satisfactory	Satisfactory
Sustainability	Likely	Likely	Likely
Institutional Development Impact	Modest	Modest	Modest
Bank Performance	Satisfactory	Satisfactory	Satisfactory
Borrower Performance	Satisfactory	Satisfactory	Satisfactory
Health and Population Program Project			
Outcome	Unsatisfactory	Unsatisfactory	Unsatisfactory
Sustainability	Likely	Likely	Likely
Institutional Development Impact	Substantial	Modest	Modest
Bank Performance	Satisfactory	Satisfactory	Unsatisfactory
Borrower Performance	Unsatisfactory	Unsatisfactory	Unsatisfactory

* The Implementation Completion Report (ICR) is a self-evaluation by the responsible operational division of the Bank.
**The ICR Review is an intermediate Independent Evaluation Group (IEG) product that seeks to independently verify the findings of the ICR.

Key Staff Responsible

Project	*Task Manager/Leader*	*Division Chief/ Sector Director*	*Country Director*
Fourth Population and Health Project			
Appraisal	C.O. Panneborg	W. Kacher	S. Asanuma
Completion	Jagmohan Kang	Richard Skolnick	Pierre Landell-Mills
Health and Population Program Project			
Appraisal	Philip Gowers	Richard Skolnick	Pierre Landell-Mills
Completion	Sandra Rosenhouse	Anabela Abreu	Christine Wallich

Preface

This project performance audit report (PPAR) covers two projects: the Fourth Population and Health Project (FPHP, Credit 2259-BD for US$ 180 million) and the Health and Population Program Project (HPPP, Credit 3101-BD for US$ 250 million). These projects closed in June 1998 and June 2005, respectively.

The PPAR was prepared by the Independent Evaluation Group (IEG, formerly OED), based upon the Implementation Completion Reports (ICR), project documents, and interviews with government officials and Bank staff with experience of the projects. The report also draws on the OED impact study *Maintaining Momentum? An impact evaluation of interventions to improve Maternal and Child Health and Nutrition Outcomes in Bangladesh.* Fieldwork was undertaken in March 2006, which benefited from the support of Ms. Shirin Jahangeer, who also assisted in the preparation of the report. The mission is grateful to the many people who spared their time to share their views, and for the cooperation of the Government of Bangladesh in undertaking this study.

These projects were selected for review for several reasons. Bangladesh has a good track record in improving health outcomes, a success which has been achieved with the help of a succession of Bank-led, donor-supported projects, culminating in the largest externally-funded health project in the world (HPPP). As an early example of the sector wide approach (SWAP), valuable lessons can be learned about this instrument. The study will also inform the health sector review to be undertaken by IEG.

Following standard IEG procedures, the draft of this PPAR was sent to the borrower for comments before finalization, but none were received.

Summary

The Fourth Population and Health Project (FPHP) and the Health and Population Program Project (HPPP) were the latest in a series of World Bank projects supporting the creation of a health and family planning service in Bangladesh, starting with the First Population Project in 1975. These Bank-led projects, with substantial cofinancing, have made a clear and demonstrable contribution to the country's remarkable success in reducing fertility and under-five mortality.

FPHP, continuing this pattern, expanded project coverage to have a stronger focus on health services. Like earlier projects, funding was provided to construct and renovate facilities, train staff and pay a share of their salaries. There were also interventions for specific health issues, such as the successful TB program, which once again demonstrated the country's ability to deliver health services through government channels, though in this case through a partnership with a number of NGOs. These project outputs are linked to the continued rise in contraceptive prevalence and consequent decline in fertility. Health outcomes, notably under-five mortality, also continued to improve. **The outcome of FPHP is rated satisfactory overall, as are both Bank and borrower performance**. Given commitment to the program by both government and development partners (DPs) **sustainability is rated as likely**. However, whilst successful in service delivery, the project approach of FPHP, which was treated by government as 66 separate projects, was seen as time consuming and inefficient. The project did little to address these issues, so that **institutional development is rated as modest**. In order to address this issue, the follow on project was designed as a sector wide approach (SWAP): the Health and Population Sector Program (HPSP).

HPSP is the largest health sector program in the world, and is often held up as a model of a successful SWAP in practice. Yet, whilst the SWAP has been successfully established, there were many unsatisfactory aspects in the implementation of HPSP. The program included the controversial reform to unify health and family planning directorates. Although designed with high-level support, and popular amongst workers at the field level, the policy was strongly opposed by a vocal minority of family planning employees and eventually reversed by government. The Bank suspended loan disbursements in May 2003; the resulting tensions tainted many other aspects of HPSP by association, set back government-donor relations and disrupted service delivery. Very many activities which were planned under HPSP did not take place at all or were only partially implemented. The major program of civil works was the creation of a new tier of service provision through the construction of community clinics. But this program was abandoned after fewer than 10,000 of the planned 16,000 clinics had been constructed, and the vast majority are unutilized. Access rates to public clinics declined during the project, and doorstep delivery of contraceptives, the cornerstone of the country's success in family planning, also suffered a setback. Although there were some areas of success, such as expanding immunization coverage and continuation of the TB program, most areas of the project were not satisfactorily implemented. It is therefore not plausible to attribute continued improvements in the health outcomes to the project. Indeed, the decline in infant mortality stalled during the project, and that fact may well be a result of the problems resulting from the project. On account of these factors, **the outcomes of**

HPSP and both Bank and borrower performance are all rated as unsatisfactory. Given the failure of reforms, **institutional development impact was modest**. However, **sustainability is likely** since commitment to service delivery remains high.

A number of lessons follow from the analysis contained in this report:

- ***Aid-financed health infrastructure can work in improving health outcomes… provided other conditions are in place***: the creation of an extensive health and family planning system, with considerable assistance from external finance, has made a demonstrable improvement to the health outcomes of Bangladeshis. However, this success was achieved through the balanced growth of infrastructure and trained staff.

- ***Public and private provision are complements not substitutes***: The health demands of Bangladeshis are met by both public and private providers. These suppliers do not work in parallel, but co-exist through various symbiotic relationships.

- ***A SWAP takes time to implement and is an evolutionary process***. In Bangladesh it took 20 years of donor coordination to begin the process of implementing a SWAP. It is not feasible to jump from a project approach to fully-fledged SWAP overnight: institutions need to evolve though a series of interim institutional arrangements.

- ***Wide stakeholder participation in preparation helps ownership but can weaken design***. The broad participatory process made it difficult to prioritize. A compromise need be sought between participation and technical guidance.

- ***Think through the implications of the new system***. A SWAP implies a change in how things are done in ways which are often not well understood. It is imperative to think through how systems will actually work, and make sure that all involved understand this. This process will necessarily take time.

- ***Draw on the appropriate skills mix.*** Many aspects of the design and implementation of a SWAP do not fall within the competence of health specialists. Thus, the need for appropriate expertise should be recognized and drawn on. Bank staff should seek to draw on the Bank's experience with similar issues in other countries, making sure that local staff, DPs and government can all benefit from this experience.

- ***Failure to assess fully the political economy of reform and to prepare both a proactive plan for addressing/mitigating risks and a contingency plan will considerably diminish prospects for successful reform.*** In a politicised environment policy reversals are the norm not the exception. Donor agencies should be prepared to adapt their approach: maybe renaming institutions will suffice, but it may not be so.

- ***Too much donor/Bank intervention can undermine government capacity and ownership of a SWAP approach.*** Preparation of the SWAP started with a high degree of local ownership. But the extensive role played by donors in the review process, and the importance of the tasks which eventually fell to Health Program Support Office (located in the World Bank office), but would have been better carried out by government, reduced local ownership.

- ***Be realistic in tackling major reform objectives.*** HPSP combined the move to a SWAP with two major sets of reforms: unification and decentralisation, as well as the introduction of a new tier of service delivery at community level. This was rather a lot to hope to achieve in a single project. A more focused approach may have achieved some of the goals HPSP failed to reach.

Vinod Thomas
Director-General
Evaluation

1. WORLD BANK SUPPORT TO THE HNP SECTOR

Family Planning and Health in Bangladesh before the 1990s

1.1 At Independence in 1971 Bangladesh had amongst both the highest fertility rate and the highest population density in the world. The newly independent government recognized population as one of the country's most pressing problems. The First Five Year Plan proposed a health and family planning system comprising a hospital in each district, which in some cases was supplemented by a Maternal and Child Welfare Center (MCWC) at sub-district level. Each upazilla was to have an Upazilla Health Complex (UHC), and then each union a Family Welfare Center (FWC); see Box 1.

Box 1. A note on Terminology

Bangladesh has six divisions, which are divided in 64 districts. Each district is sub-divided into a number of upazillas (called at various times thanas), of which there are currently 490. An upazilla is further sub-divided into a small number (five or six) unions, each consisting of a number of villages.

All health and family planning facilities (except primary care in urban areas) fall under the Ministry of Health and Family Welfare. For most of the time since independence health and family planning have been functionally separate with a directorate for each, and each having their own facilities at the different administrative levels. Whilst, there have been various name changes at various times, especially during the period of unification when facilities were merged. This report, however, uses the nomenclature outlined below.

	Health	Family Planning
Tertiary		
National	Medical Colleges (including specialized hospitals)	None
Secondary		
District	District Hospital	Maternal and Child Welfare Center (MCWC), 1 or 2 per district FP staff in District Hospital
Upazilla (thana)	Upazilla Health Center (UHC)	FP staff in UHC
Primary		
Union	Rural Dispensaries	Family Welfare Centers (FWCs)
Village	Community clinics*	
Training	NIPSOM Medical Assistant Training Schools Rural Training Centers (RTCs)	NIPORT Family Welfare Visitor Training Institutes (FWVTIs) Rural Training Centers (RTCs)

Note: * Community clinics were a jointly-operated facility introduced under HPSP. The vast majority are not functioning.

1.2 Government's efforts to reduce population growth cannot be separated from the role of external agencies, since these agencies were central from the outset, paying the majority of program costs, including salaries. The Bank was invited to participate in implementation of the plan and first fielded a mission in May 1973. Donor coordination was envisaged from the outset. However, disagreement arose over whether family planning should fall under a separate organization or be integrated with health services.

Somewhat ironically, given events 25 years later, the Bank led the group which successfully urged a separate program for family planning, on the grounds that a vertical program was required to attain the necessary focus.[1] Six bilateral agencies cofinanced the First Population Project (1975-84, Table 1), with the objective of assisting the development of a comprehensive fertility-control program. This project was the first cofinanced social sector project undertaken by the World Bank anywhere in the world. Already in 1970s elements of a sector wide approach (SWAP)[2] were in place: donor activities were coordinated in the context of a government-led strategy (the First Five Year Plan), with a large part of support to the sector under a single project.

Table 1. World Bank Credits for Health, Population and Nutrition

Project	***Years (FYs)***	***Project costs (US$ mill.)[1]***	***Loan amount (US$ mill.)[1]***	***Cofinanciers***
First Population Project	1975-82	45.7	15.0	Australia, Canada, Germany, Norway, Sweden, United Kingdom
Second Population and Family Health Project	1979-85	89.9	30.8	Canada, Germany, Norway, Sweden[2]
Third Population and Family Health Project	1986-92	246.4	100.9	Australia, Canada, Germany, Netherlands, Norway, United Kingdom
Fourth Population and Health Project (FPHP)	1992-98	756.3	188.4	Australia, Canada, EU, Germany, Netherlands, Norway, Sweden, United Kingdom[3]
Bangladesh Integrated Nutrition Project (BINP)	1996-02	65.74	58.6	None
Health and Population Sector Program (HPSP)	1998-05	2815.9	224.0	Canada, EU, Netherlands, Sweden, United Kingdom
National Nutrition Project (NNP)	2000-05	124.5	92.0	Canada, Netherlands
HIV/AIDS Prevention Project	2001-06	52.6	40.0[4]	United Kingdom

Notes: 1/ Actual amounts other than NNP and HIV/AIDS, which are appraisal estimates; 2/ UK was to cofinance but decided to not participate; 3/ Belgium was to cofinance but decided to not participate and a component to be financed by Japan was dropped by the Government; 4/ US$ 22 million of this amount has been cancelled.

1.3 The First Population Project set about creating the infrastructure needed for service delivery by the Ministry of Health and Family Welfare (MOHFW): both hard and soft. Sixty-nine percent of project costs were for civil works, half of that amount being for the construction of upazilla health complexes (UHCs) and the bulk of the remainder for Family Welfare Visitor (FWV) training institutes (FWVTIs). On the software side, most of the funds were used for the training and salaries of fieldworkers (Family Welfare Assistants, FWAs). By 1978 16,700 FWAs had been posted, with UNFPA paying salaries for most of those not supported with Bank finance.

1. The debate over vertical versus integrated services continues, for example regarding HIV/AIDS. In many countries immunization has been a vertical service, though Bangladesh is an example of how it can be successfully integrated into service delivery.

2. In Bangladesh the SWAP is most usually referred to as a sector program or programmatic approach. This report uses the expression SWAP throughout unless as part of a name or direct quote.

1.4 During preparations for the Second Five Year Plan, the government invited all donors to participate as technical advisors in drawing up the family planning strategy, alongside a request for preparations for a follow-on population project, subsequently named the Second Population and Family Health Project. Once again, about half of project costs went on civil works, mainly UHCs and Family Welfare Centers. The third project continued this pattern. Although the projects paid the salaries of field staff, government was assuming a larger share. Under the first two projects government had paid only 10 percent of project costs, but this share rose to 17 percent by the third project and was planned for 28 percent in the fourth project, but in fact reached 40 percent. Under HPSP government financed the majority share of program costs.

Success in Family Planning

1.5 By the late eighties there was firm evidence that the massive expansion in service delivery supported by the first three projects was having an impact. The Bangladesh Fertility Survey (BFS) of 1989 showed a steep decline in the total fertility rate (TFR) from 6.8 in 1979 to 4.6 in 1988. Other surveys revealed a similar trend. An OED report from 1991 said there was incontrovertible evidence of fertility decline and that Bank-financed projects had contributed to that trend. The project completion report (PCR) for the third project said that the progress was remarkable and the contribution of the Bank's projects both substantial and undeniable. OED's recent impact evaluation confirmed that family planning provision has indeed been a major factor behind fertility reduction.[3]

Health Services

1.6 With the emphasis on family planning, health services were relatively neglected, though with important exceptions. One is the National Drug Policy of 1982, which helped develop a national pharmaceutical industry making low-cost medicines widely available. The other exception was the immunization program of the 1980s: the Expanded Program of Immunization (EPI), launched in 1985 with financial support from several donors increased immunization from less than 5 percent to over 50 percent in its first five years. The following two projects, which are the subject of this report, substantially expanded the focus on health.

The Fourth Population and Health Project (1992-1998)

Preparation

1.7 The Fourth Population and Health Project (FPHP) followed on logically from the previous three projects, with project preparation missions being combined with supervision of the Third Population and Health Project. The project concept document (PCD) was prepared in October of 1988, with identification the following March. Pre-appraisal was in February 1990, followed by the appraisal mission in October of that year. Things then moved quickly to get the project to the Board by June (i.e. the same

3. *Maintaining Momentum: An impact evaluation of interventions to improve maternal and child health and nutrition in Bangladesh*, OED (now IEG), World Bank, 2005.

fiscal year) since other major projects in the country's pipeline, notably Jamuna Bridge, were lagging. The conditions for effectiveness were reached by March 1992.

1.8 The project continued support to family planning activities, though with a greater emphasis on health than had been the case in previous projects. There was also less emphasis on civil works, though they were present, and more focus on improving service delivery through both supplies, specific health components (e.g. TB, ARI and support to EPI), and quality-enhancing activities. Government was actively involved in project preparation, with the lead taken by the Planning Cell of MOHFW. Government's Fourth Five Year Plan provided the overall context for the project, though a gap emerged between the government and donor planning cycle.[4] Project proposals were put to the planning cell through a series of working groups involving government staff, consortium members, and NGOs. The SAR was based on the approved project proposals.

1.9 Internal Bank discussions during preparation raised two concerns related to the size of the project. One issue was that the project was very complex, combining a program approach, in which the Bank and other donors were paying a share of recurrent expenses, with a more traditional project approach. Concerns were also raised about the large number of cofinanciers and whether Bank supervision structures could manage such a large program with so many partners. To cater for these concerns it was proposed that the project be split into a sector adjustment program and two or three stand alone investment projects. The argument against these points, which eventually prevailed, was that the project followed on from three previous projects which had also successfully contained these features, including Bank management of a large consortium.

Objectives

1.10 The objectives of FPHP were to: (a) reduce fertility by increasing the CPR to 45-50%; (b) lower morbidity and mortality in children under five; (c) improve maternal care and ensure safer deliveries thereby reducing maternal mortality from the current 6-8 to 4-5 per 1,000 live births; (d) reduce disability, morbidity and mortality from common poverty-related diseases; (e) enhance the nutritional status of women and children; and (f) improve effectiveness and efficiency in the planning and delivery of FP and health services to accelerate the achievement of the above objectives.

Project Components

1.11 The project had four main components, most of which had many sub-components, so that there were 66 sub-components under the project as a whole (Table 1; the sub sub-component budgets are in Annex B). The first component, to strengthen family planning and MCH services, was the largest, accounting for 60 percent of the planned project cost, over half of which (56 percent) was to improve access to FP services by recruitment, training, contraceptive supplies, and renovation and construction of facilities.

4. The Five Year Plan covered the period 1990-95, whereas FPHP was set to run from 1991-96, and in the event was effectively 1993-98.

1.12 The component to strengthen health service delivery (26 percent of costs) included substantial elements of training, but also supported several health programs - including TB and leprosy, the Vitamin A and Iodine Deficiencies and ARI Programs, and the Intestinal Parasite Control Project - as well as construction and rehabilitation of health facilities. The third component (12 percent of base costs) supported institutional activities for service delivery.

Table 2. FPHP Components

Strengthening FP/MCH Services Delivery (US$321.7 million)	(1) Improving Access to FP Services (US$180.1 million) (2) Strengthening MCH Services (US$38.6 million) (3) Enhancing Clinical Service Delivery and FP/MCH Quality Assurance (US$31.5 million) (4) Imparting In-service to FP/MCH staff and TBAs (US$17.3 million) (5) Construction and Renovation of FP/MCH Facilities (US$41.6 million): (i) Construction and Upgrading of FWCs and RDs; (ii) Upgrading the Maternal and Child Health Training Institute (US$8.3 million); (iii) Strengthening the FP/MCH Logistics and Supply System (6) Private Sector Contraceptive Marketing (US$12.6 million)
Strengthening Health Service Delivery (US$144.2 million)	(1) Comprehensive Maternal and Neonatal Health Care Pilot Project (US$2.1 million) (2) Strengthening Nursing and Medical Education (US$41.8 million): (i) Nursing Education; (ii) Medical Education; (iii) Medical Quality Assurance; (iv) Community-based Medical Education; (v) Institute for Mother and Child Health; (vi) NIPSOM. (3) Supporting Medical Research (US$1.5 million) (4) Strengthening Disease Prevention and Control (US$52.5 million): (i) Reorganizing Programs for Tuberculosis and Leprosy; (ii) Continuing the EPI and CDD Programs; (iii) Supporting the Vitamin A and Iodine Deficiencies and ARI Programs; (iv) Developing Control of Vector-Borne Diseases; (v) Assisting the Intestinal Parasite Control Project; (vi) Expanding the Institute of Public Health; (vii) Modernizing the Drug Testing Laboratory (5) Developing Urban PHC (US$2.2 million) (6) Continuing and Expanding School Health Programs (US$1.1 million) (7) Improving Health Facilities (US$21.8 million): (i) Renovating District Hospitals and UHCs; (ii) Constructing UHCs (8) Improving Utilization of UHCs and FWCs (US$21.2 million)
Improving Supportive Activities to the Delivery of FP and Health Services (US$66.2 million)	(1) Strengthening Information Systems (US$5.4 million): (i) MIS for FP/MCH; (ii) MIS for Health; (iii) Health and Demographic Survey; (iv) Epidemiological Surveillance System (2) Improving FP and Health Organization, Management and Financing (US$ 22.8 million): (i) MDU Support to FP and Health Services; (ii) Reorganization of Health and FP programs; (iii) Strengthening the PDEU; (iv) Establishment of the MCH Coordination Cell; (v) Establishment of the Health Economics Project; (vi) Restructuring of the Project Finance Cell; (vii) Project Management Support; (viii) Construction of a FP and Health Building; (ix) Establishment of the Maintenance and Construction Management Unit (3) Communications Programs (US$15.3 million): (i) Functional integration of IEM and HEB Units; (ii) Support for Mass Media Activities; (iii) Promotion of Community Participation (4) Supporting NGOs (US$7.8 million) (5) Developing Innovative Projects (US$4.9 million) (6) Supporting Technical Assistance Projects (US$10.0 million)
Women's and Nutrition Programs (US$11.6 million)	(1) Continuing the Three Women's Projects (US$9.2 million) (2) Coordinated Nutrition Program of the National Nutrition Council (US$2.4 million)

Financing

1.13 In the Final Executive Project Summary (FEPS), the proposed IDA contribution to FPHP was US$ 85 million. Since the project could absorb more, this figure was taken as a 'low scenario', with a 'high scenario' figure of US$ 150 million. However, the SAR put the Bank's credit at US$ 180 million. This figure was stated as being derived from the gap between the budget for agreed project activities and contributions from government and other donors. While the gap could have been reduced by cutting activities, the country team was keen to have the larger amount approved since other projects due to go the Board in that fiscal year were lagging in preparation, so a larger credit to FPHP would help maintain the volume of the country program.

1.14 In the budget given in the SAR FPHP was to be co-financed by 10 bilateral agencies, though in the event only 8 took part. IDA and the Government of Bangladesh (GoB) were to meet around 30 percent of project costs each, and the bilaterals the balance of 43 percent.

Table 3. Financing for FPHP

	US$ millions		***Percent***	
	Appraisal estimate	***Actual***	***Appraisal estimate***	***Actual***
IDA	180.0	188.4	30.6	25.1
Canada	40.3	35.8	6.8	4.8
EU	47.8	40.4	8.1	5.4
Germany	51.6	89.6	8.8	11.9
Other bilaterals[1]	104.2	94.3	17.7	12.5
Government of Bangladesh	165.1	303.2	28.0	40.3
Total	589.0	751.7	100.0	100.0

Note: 1/ Australia, Netherlands, Norway, Sweden, and United Kingdom

The Health and Population Program (1998-2005)

Preparation

1.15 Preparation for HPPP began under FPHP, with the project concept document being issued in February 1996. Originally called the Fifth Population and Health Program, and then the Health and Population Project V (HAPP V), it was finally named the Health and Population Sector Program (HPSP, see Box 2) in recognition of the move to a SWAP. The name also reflects the fact that, unlike earlier programs, prominence was to be given to health rather than family planning. The project was appraised in February 1998, going to the Board just four months later (June) as there was pressure to have the project approved that fiscal year; effectiveness was reached two months later.

Box 2. A Note on Terminology 2: HPSS, HPSP, HPPP and HNPSP

The government's strategy during the SWAP was the Health and Population Sector Strategy (HPSS). Activities carried out in support of this strategy were financed under the Health and Population Sector Program (HPSP). The support of the Bank and cofinanciers to HPSP were provided through the Health and Population Program Project (HPPP). The follow on project and program are called the Health, Nutrition and Population Sector Program (HNPSP).

1.16 Preparation of HPSP was a highly participatory process with a large degree of stakeholder consultation, but also more missions than the norm to support the in-country preparation activities. The Health and Population Sector Strategy (HPSS) was prepared by a GoB team (the Project Preparation Cell, supported by bilateral agencies) based on inputs by seventeen working groups, which had a tripartite structure of GoB-Development Partners (DPs)-NGOs. Technical missions were fielded by the Bank to support these working groups. Consultations were held with government workers, civil society and other stakeholders at both local and national level as the strategy developed. There were, however, clear lines for donor influence. Most notably, the broad thrust of the strategy towards basic services was set in the framework of the 1993 *World Development Report* on health. The decision that these ideas – and the notion of prioritising services based on a cost effectiveness assessed against the burden of disease – should form the basis of the strategy was taken at a Consultative Group meeting in Paris in 1995. Indeed, the idea of creating a prioritised Essential Service Package, was already being discussed in the context of FPHP by 1996. Aspects of the HPSP design, notably the community clinics, appear to have been introduced rather late in the day, and it is not clear where the initiative came from.[5]

1.17 Given that HPSP was later to become highly politicized, with the name "HPSP" being equated by many with the destruction of the country's family planning services, it is worth remembering that (1) HPSP was initiated under one party and introduced by another,[6] and that the change in government mid-way during the program marked the start of serious implementation problems (2) there was a very broad consultation process, and (3) the proposals were owned at the highest levels of government, not just in the MOHFW but also by Finance and the Prime Minister's Office.

1.18 As mentioned above, the ESP approach was agreed in the donor-GoB consultative meeting in Paris to discuss next phase of consortium support in 1995.[7] The basis for the package was that identified in *WDR 93*, though that package cost US$12 per person whereas Bangladesh had a budget of US$3.50 per person. A technical working group was formed to develop the package, which formed four subgroups, which grew in size and spawned subgroups of their own. Each group developed a wish list with little thought for prioritization. These lists were not informed by a burden of disease (BOD) analysis or

5. Some respondents believe this was a World Bank idea introduced at the last minute; others suggest it was included to sell the program to the prime minister.

6. The Bangladesh National Party (BNP) was in power when the basic approach to HPSP was agreed, although most of the design and initial implementation fell to the Awami League administration. Implementation problems came to the fore once BNP came back to power.

7. This paragraph is mainly based on Abdo Yazbeck, 'How to Buy a $12 Package at $3.50, a Bangladesh case study', September 1999, World Bank, mimeo.

calculation of the relative cost-effectiveness of different interventions, which is the basis of the approach advocated in the Bank's *WDR*. Data to inform such an analysis were not available and no attempt was made to compile them at the time. The resulting sub-group proposals totalled greatly in excess of the available funds. A ranking exercise was undertaken to refine the proposals into a package within the budget envelope, but it proved difficult to drop any of the programs identified. Whilst BOD analysis may not always be cost effective in resource poor environments, the lack of systematic application of Bangladesh-specific data in the exercise resulted in considerable inertia in the types of service being provided, but did provide a platform to attempt to shift the focus from costly curative care.

1.19 The experience of ESP supports the view, stated in the ICR, that wide consultation resulted in a diffuse program, whereas one drawn up by a narrower technical group may have been more focused. An alternative point of view is that leaving design in the hands of the medical profession would not have achieved a reorientation of health strategy toward primary care. The ICR also claims that consultation prolonged the preparation process. However, the time taken between the PCD and appraisal (25 months) was the same as that for FPHP. A perhaps more serious point is that the strategy made little difference to the pattern of service provision in practice.

Objectives

1.20 The objectives are not clearly stated in the Project Appraisal Document (PAD), but the following can be extracted, although the specific objectives are a mixture of inputs, outputs and outcomes.[8] As the project was part of a SWAP, the objectives of HPPP were the same as those stated for HPSP, which were based on the government's strategy, HPSS.

1.21 Overall objective: To assist the Government of Bangladesh to improve the health, nutrition and family welfare status of the population of Bangladesh, particularly vulnerable women, children and the poor, and to reduce mortality and slow population growth. In the PAD the overall objective is given more concretely as "better access to essential services for the poor, lower maternal mortality and morbidity, and continued improvements in child health and family planning".

1.22 Specific objectives:

- Objective 1: technical support and funding to improve coverage and quality of essential health and family planning services for vulnerable groups, particularly poor women and children, through the delivery of the Essential Service Package. ESP was targeted to receive 60-65 percent of government expenditure in the sector and 50 percent of donor assistance.

8. The objectives vary between the DCA and PAD. The overall objective given here is from the DCA. However, the DCA does not include any specific objectives, which are derived from the PAD. The specific objectives as stated in the PAD do not, however, state certain aspects of these objectives very clearly, so that additional text from the PAD is used to elaborate the objectives.

- Objective 2: support public sector reorganization and reform efforts to achieve more cost-effective service delivery, elimination of duplication, improved quality, and better utilization. Two key aspects of this objective were (1) unification of the health and family planning directorates and (2) sector-wide approach established and operational.

- Objective 3: laying the groundwork for broader health reform, including greater involvement of NGOs and the private-for-profit sector in service delivery, decentralization (including hospital autonomy), cost recovery and new approaches to financing.

Project Components

1.23 Though HPSP had a complex design there were essentially three areas: (1) provision of an integrated Essential Services Package (ESP); (2) re-organization of MOHFW; and (3) implementing a sector-based approach toward aid management. The full list of activities is given in Table 4. The largest share of the project budget (56 percent) was the Essential Services Package (ESP), planned as an integrated health service program including reproductive health. Other services under the first component included hospital services, public health and support services such as behaviour change communication (BCC) and the merger of the four management information systems into a single MIS. There was also a sub-component for expanded service delivery through NGOs and to develop a regulatory framework for the for-profit sector.

Table 4. HPSP Components

Delivery of essential services package and other services (US$ 2,872 million)	(1) Essential services package (US$ 1,624 million)	(i) reproductive health care; (ii) child health care; (iii) communicable disease control; (iv) limited curative care
	(2) Hospital services (US$ 348 million)	(i) district hospitals; (ii) medical college hospitals
	(3) Other public health services (US$ 10 million)	(i) environmental and industrial occupational health; (ii) health emergency preparedness and response; (iii) emerging and re-emerging diseases; (iv) school health services; (v) intra-sectoral approach
	(4) Other health and nutrition services (US$ 254 million)	(i) other health services; (ii) nutrition services
	(5) Support services (US$ 629 million)	(i) behaviour change communication; (ii) human resources development; (iii) management information systems; (iv) logistics and procurement; (v) quality assurance; (vi) facility construction and maintenance; (vii) research
	(6) Private sector	
Program organization and management /sector reform (US$ 23.5 million)	Reorganization and rationalization of MOHFW (US$ 4 million)	(i) Unification of service delivery at thana level and below; (ii) reorganization of MOHFW; (iii) rationalization of directorates; (iv) RIBEC initiative for rationalization of budgeting and expenditure; (v) decentralization
	Sector program management (US$ 20 million)	(i) Overview; (ii) annual operational plans; (iii) annual performance reviews; (iv) management capacity development
	Policy reform (US$ 7 million)	(i) National Drugs Policy; (ii) sustainability; (iiii) gender issues; (iv) participation issues; (v) environmental issues

1.24 The second component covered program management and sector reorganization and reform. Central to this component was the unification of the Health and Family Planning directorates and integration of service delivery at thana level and below. Also included under this component was implementation of Annual Operational Plans (AOPs) and Annual Performance Reviews (APRs), intended to change the nature of sector management and the government-donor relationship.

Financing

1.25 The Netherlands, Sweden and DFID agreed to pay funds into a Pooled Funds Account, which together with the IDA contribution totaled US$ 250 million. These funds were not allocated to specific activities, but were disbursed against agreed categories of goods and services.[9] Just over US$ 50 million was pre-allocated between the five categories in the appraisal document, but the bulk of funds were unallocated. The allocation was to be made on an annual basis based on the work program agreed with the development partners.

1.26 So of the $2,895 million, US$ 705 million was to come from the donors, of which US$ 522 million were disbursed through the pool, which MOHFW could use to meet expenses incurred in execution of the Annual Operational Plans. The remaining US$183 million were linked to specific components. Many DPs also continued support health activities outside of HPSP.

Nutrition

1.27 Nutrition was not a major focus of either project. In addition to vitamin A and iodine supplements, FPHP provided institutional support to the National Nutrition Council in readiness for a larger scale nutrition intervention. By the time of HPPP, a separate nutrition project, the Bangladesh Integrated Nutrition Project (BINP),[10] was underway, with discussions already taking place for a follow-on National Nutrition Project (NNP). Hence nutrition did not fall under HPSP.[11]

9. Category 1: Goods, other than those under 2 and 3, works and operating costs; Category 2: drugs, vaccines and contraceptives; Category 3: diagnostic and surgical goods, and ambulance; Category 4: technical assistance, training and fellowships, and survey and research; Category 5: NGO support. Category 1 was called ‘time-slice financing’ since it covered all sector expenses not under the other four categories.

10. BINP is discussed extensively in IEG’s impact evaluation and subject to its own PPAR (Report No. 32563).

11. The inclusion of nutrition as an activity under HPSP in the PAD is an example of why the intended activities in a sector program document can be unclear, since the project description includes activities to be implemented under entirely different projects.

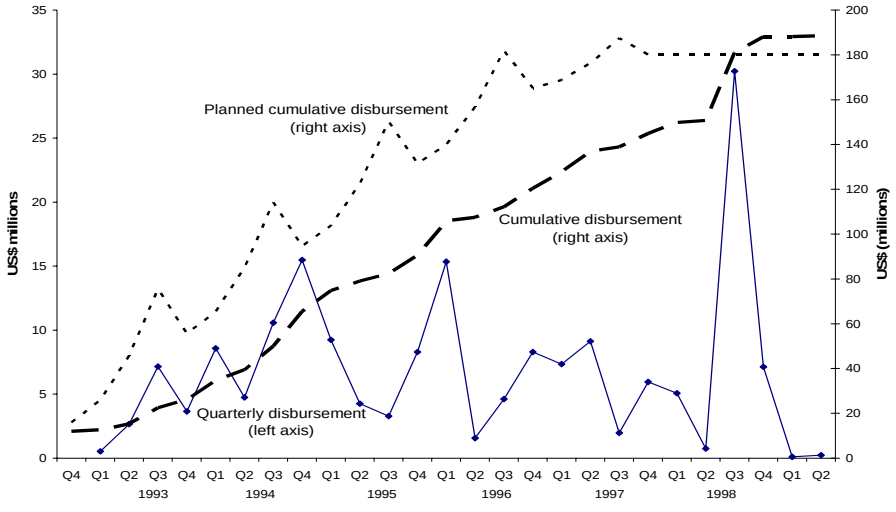
2. IMPLEMENTATION ISSUES

2.1 This section begins by briefly reviewing progress in implementation of the two projects. The main focus is, however, on HPPP in order to learn the lessons of the SWAP experience, including the transition from a project approach under FPHP to a SWAP under HPPP. The SWAP is meant to address a number of problems in the project approach. The way in which these problems manifested themselves under FPHP is discussed in the presentation of FPHP implementation. Turning to the SWAP, the following issues are discussed: (1) the transition to the SWAP approach; (2) supervision under the SWAP; (3) procurement and disbursement; and (4) governance issues. A final section reviews the performance of the Bangladesh SWAP.

Implementation of FPHP

2.2 Dates and financing. The start up of FPHP was delayed by two factors. First, the bilateral financing agreements were not in place at the time of effectiveness, and were not until late 1992 or early the next year. Hence many project activities could not begin until one year after effectiveness. Once they began, those in family planning proceeded without much difficulty, as there was a well-established track record. By contrast, many health projects experienced serious implementation delays, so that actual spending continued to lag behind planned (Figure 1).

Figure 1. FPHP IDA Disbursement Profile



2.3 As the project neared the closing date of June 1996 there remained a large balance of unspent funds. However, there was resistance from region management to the "culture of extension" and a "no extension of any project" rule was in place in 1996. Nonetheless, Bank staff mounted a case for extending FPHP based on both mitigating circumstances and need. The mitigating circumstances were that the project had gone to the Board in June 1991 since other major projects for Bangladesh were lagging in preparation, but did not really get going until early 1993 because of the time needed to put the bilateral cofinancing agreements in place. The need-based argument was to avoid a disruption to service delivery between project close and the follow on HPPP. Given these arguments, a single 18 month extension, until June 1998, was allowed.

2.4 Use of funds. In 1995 the government requested that SDR 17.4 million (13 percent the IDA total) be re-allocated to medical supplies on account of increases in the price of these supplies, notably contraceptive products. The funds would be taken out of the unallocated budget line and that for consultant services. The Bank approved a SDR 9 million reallocation from the unallocated budget line. The following year government again requested the balance, which this time the Bank agreed to, taking the money mainly in equal part from consultant services and equipment, and lesser amounts from other budget lines. In addition, seven sub-projects were cancelled as a result of either implementation problems or a view that they were of low priority.

Problems in the Project Approach

2.5 FPHP presents many of the problems of a project-based approach. The sixty-six sub-components (and the other 60 odd donor projects outside of FPHP) were each treated as a separate project within MOHFW, each requiring separate approval, appointment of a project manager, preparation of an annual audit report and so on. Donor agencies fielded supervision and evaluation missions for each project separately;[12] as one senior MOHFW official put it "every day there were people from one donor agency or another in the corridors". Managing such a large number of projects, and almost an equal number outside of FPHP, was clearly a very time consuming activity for ministry officials, taking time away from the task of managing the sector. Government's completion report for FPHP stated that: "IDA fielded supervision missions too frequently… Too many visits by the IDA Missions kept most of the best officers busy preparing background materials and position papers, causing at times disruption in the normal project implementation works" (FPHP ICR:49).

2.6 At a systemic level, reliance on external finance meant that MOHFW focused on attracting donor resources rather than setting policy and making choices about resource allocation. To the extent that these things were considered it was so as to increase the chance of external finance. Since such finance paid the bulk of health expenditure the government's health budget bore little relation to what was happening in the sector. These tendencies undermine normal processes of accountability.[13] These shortcomings were present despite the coordinated approach taken by donors to the country's health sector since the First Health Project. The problems were well-recognized by MOHFW officials, who bemoan the lack of accountability of projects, the difficulty of coordination, and the lack of autonomy from the Ministry of Planning.

Implementation of HPPP

2.7 Under a SWAP there are no development projects, rather aid finances the government execution of sector activities by the line Ministry. The position of Project Director disappeared, being replaced with that of Line Director. This was not a mere

12. This is true for projects outside FPHP. The situation for projects under FPHP was a bit more complicated, and is discussed in the sub-section on monitoring and evaluation.

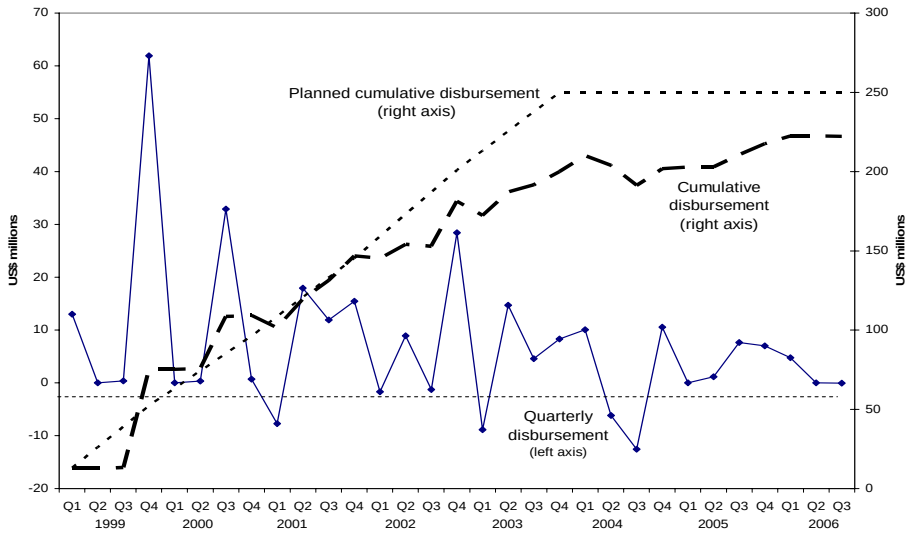
13. These arguments became a standard critique against the projectized approach by the late nineties. For a statement in the context of the health sector (specifically FPHP) see "Evaluation of the European Commission's Country Strategy for Bangladesh", November 2003.

semantic change, there were two important changes. Line Directors fall under their relevant Director General, whereas Project Directors reported directly to the Minister, undermining the accountability structure. The Line Directors prepare Annual Operational Plans (AOPs) which outline their activities for the year and the proposed budget. These plans are approved by within MOHFW. By contrast, projects had to be individually approved by the Ministry of Planning. Under the new system just one project was approved (HPSP) which encompassed all donor activities falling under the sector wide approach, including the Bank's HPPP, thus giving MOHFW discretion on the use of the US$ 2.8 billion without further recourse to Planning. The importance of these system reforms should not be under-estimated and are a significant achievement of the SWAP.

2.8 Although the SWAP was executed through MOHFW, program units (equivalent to the old project cells) were created. These were the Change Management Unit (CMU) and the Program Coordination Cell (PCC). On the donor side the Health and Population Support Office (HPSO) acted as a secretariat for the project.

2.9 As discussed in detail below, unfamiliarity with Bank procurement procedures and rapid turnover of government procurement staff resulted in substantial delays, which were still being identified as a problem at the time of the mid-term review, despite the training in these matters. The disbursement profile (Figure 2) does not, however, show any serious lags in the early years of the project. Indeed, actual disbursements exceeded planned for a while. This occurred since pool finance was partly used to finance a "time slice" of government expenditures in the sector, from both the recurrent and development budgets, and so including local expenditures (notably salaries), for which procurement was not required.

Figure 2. HPPP IDA Disbursement



2.10 But where pool finance was used to procure goods and services which had to be contracted then Bank guidelines had to be followed, as they did for all other project activities. The delays in these activities created a drag on disbursements, negative disbursements taking place when GoB had to repay funds in cases of declared misprocurement. The suspension from May-July 2003, although a very important symbolic event, had little impact on disbursements.

2.11 As the project close date drew near a larger disbursement lag had opened up and, more importantly, many project activities were at best partially implemented. And, once again, preparation of the follow on project would not be completed in time to avoid a gap between projects. Hence two project extensions were granted, totalling 18 months. Whilst the extensions avoided the gap, they did not contribute that much to the completion of uncompleted activities for reasons that are explored below. They also did not help expend the IDA credit since the government chose to spend grant funds from other donors first, so that only US$ 224 million of the planned US$ 250 million from IDA were disbursed, though of course the extension did enable the bilateral cofinanciers spend their remaining balances.

The Transition from Project to SWAP

2.12 Government's own evaluation of HPSP states that the 128 donor projects "were declared officially non existent from July 1, 1998… without allowing a time frame for transition from a projectized approach to programmatic approach" (IMED, 2003: 24). This claim appears to be an overstatement, although similar sentiments were echoed in both donor and government communities. A more balanced picture has to take account of the fact that many projects did indeed continue under HPSP, although their *modus operandi* changed, and that both the Program Coordination Cell and the Change Management Unit in MOHFW had responsibilities for overseeing and supporting the transition. So there were transition arrangements, but they turned out to be insufficient.

2.13 Many of the personnel involved, from both GoB and DPs, had little understanding of what a SWAP was. A note on an early meeting to discuss HPSP mentions that there was no agreement on adopting a SWAP as no one present knew what it was. The change from project to program has far reaching implications. There was little appreciation of the extent of these changes, and far too little attention to thinking through their implications. Changes were required at many levels reflecting both new institutional arrangements, including unification, new responsibilities (procurement, preparing annual operational plans etc.) and the reorientation of service delivery in line with the introduction of ESP and the shift toward facility-based services. Such wide-ranging changes need to be supported by a concerted effort to win staff over to the new arrangements and to make sure they fully understand the new structure and their responsibilities within it. There were also losers from the transition amongst project employees and reduced power for the Ministry of Planning, but no effort was made to accommodate their resistance to the changes.

2.14 Lengthy documents were prepared on the SWAP by the DPs, which were transmitted to government. But it cannot be assumed that the mere transmission of documents means they have been absorbed. Many commentators believe that government (and possibly DPs) did not realize what they were signing off to in terms of changes in administrative responsibilities (a euphemism for power) under HPSP. The example of procurement is discussed below. It is one thing to design a new procurement system in accordance with the new structure. It is quite another to ensure that it will be able to function efficiently once the program starts.

Supervising the SWAP

2.15 A large number of planned activities under HPSP did not take place. Foremost amongst these was the unification of health and family planning. But there was much else, some of which, but not all, were directly linked to the failure of unification: the unification of Management Information Systems, implementation of a BCC program, hospital reforms (no delegation of authority or local accountability took place, a new system was developed for fee management and retention but not implemented)[14], agreeing an allocation formula to redress the fact that better off districts received more resources, and the proposed quality assurance mechanisms were not acted upon. Several reports or other documents were prepared but not acted upon, such as the "Strategy for Change" drafted for HPSP, engagement with NGOs, and the output of the Health Economics Unit (although the latter had a greatly increased budget from that originally planned). Other areas were subject to long delay, such as the construction of community clinics. The question which arises is whether the move to a SWAP approach, in which funds are no longer linked to the implementation of specific activities, allows planned activities to slip. If so, is this because supervision no longer pays adequate attention to such matters, or because there is no leverage over government?

2.16 The system designed in Bangladesh should have safeguarded against such problems. There were two channels for supervision. At a macro level is the Annual Performance Review, which reviews progress on a range of process, output and outcome indicators and presents a qualitative analysis of progress. The APR consisted of (i) a review of performance indicators, (ii) joint GoB-DP field visits, (iii) review of progress toward HPSP goals, and (iv) dialog to address problems.

2.17 The APR was initially managed by MOHFW, but once the program units in the ministry were closed responsibility shifted to HPSO. The APR process can be regarded as a good model of donor involvement in a SWAP. Rather than being involved in day-to-day micro-management, the APR provides a means of regular, less frequent, interactions with arm's length inputs. However, over time it has become an exercise for the benefit of donors rather than a management tool for senior officials in the health sector. This problem partly reflects the lack of a results-focus in MOHFW. But it also resulted from the way in which the APR was carried out, especially after the PCC was disbanded in 2003 so that HPSO became responsible for the management of the APR. The benefits of the APR have become diluted and were, anyhow, offset by the second channel for supervision through the AOPs.

2.18 The 22 line directors prepared Annual Operational Plans (AOPs) against which they were provided an annual budget. DPs were part of the AOP approval process. It is not clear that there was a precise mapping made of the AOPs onto HPSP, but the allocation of line director responsibilities follows the strategy's main areas of focus, so that all activities should be covered. Donors became heavily involved in this review process, partly in response to requests from government to do so (especially once the PCC was disbanded), to the extent that micro-management of the sector by DPs has not

14. A few hospitals received autonomy on a pilot basis.

been removed by the shift from projects to programs. The review of progress on AOPs resulted in action plans, though the proposed actions were often not undertaken.

2.19 Supervision failure is not, then, the reason that many of the activities under HPSP were not implemented. Rather, each case of non-implementation has its own specific factors. But for many of these cases the politicisation of HPSP around unification is a critical factor. The MIS and BCC components were not implemented because they were based on unification and so foundered on the non-cooperation of health and family planning staff. On the reform front, decentralisation was also a political challenge. But the donors, the Bank in particular, exhausted all their political capital in the unsuccessful fight over unification. There was none left to pursue decentralisation, which probably matters far more for service delivery. Post-reunification "HPSP" was virtually a curse word, and nothing associated with it could expect support.

Procurement and Disbursement

Procurement

2.20 Three issues are discussed relating to procurement: (1) MOHFW capacity in managing procurement, (2) the use of UN agencies for procurement, and (3) local versus international procurement.

2.21 MOHFW Capacity: Under FPHP most procurement was carried out by the specialized UN agencies, such as UNFPA and UNICEF. In line with the SWAP philosophy of a government-led program and merging government and donor finances, HPSP envisaged responsibility for procurement shifting to MOHFW following the Bank's procurement guidelines. However, there was inadequate planning at the design stage for this increase in responsibilities. There was no overall procurement plan in place at the time of approval, and insufficient attention to the need to build MOHFW capacity in this area. The result was that the process was lengthy and procedures were not followed correctly, so that Bank staff checking bidding documents frequently referred them back to government. On account of these problems it was nearly two years after project effectiveness that the first procurements were made under HPSP,[15] creating a widespread impression that the IDA procurement system is itself inherently slow.[16] The situation has improved substantially since then, with the majority of bids receiving at most minor modifications which do not delay the procurement process; fewer than five percent are referred back on more serious grounds such as too narrow a technical specification. In 2003 GoB issued new Public Procurement Regulations, which are very similar to the Bank's procedures, with standard bidding documents which are by and large the same as those of the Bank. However, high staff turn over amongst MOHFW procurement staff continues to be a problem, as it does in other units, with as much as 50

15. The result was that actual health spending fell below that budgeted in the early years of HPSP (whereas under FPHP it has typically been marginally higher than budgeted), because of under-utilization of aid resources (*Public Expenditure Review*, 2003: 68).

16. In fact a study done comparing Bank and government procurement procedures found the former to take a little less time.

percent staff turnover each year.[17] Nonetheless, the fact that under HPPP all procurement was being handled by government represented a considerable improvement in capacity.

2.22 MOHFW logistics staff still complain of the slowness of procurement, though they are very clear that it is to be preferred to UN procurement both because they are more in charge and because of the cost savings they can realise. This perceived problem is partly a PR failure by the Bank to have people understand that properly processed ICB can sometimes take 8-10 months, though there may be some limited scope for streamlining procedures,[18] or to keep MOHFW staff adequately informed when delays do arise. The fact that procurement takes this long should not be a problem provided there is adequate forward planning of supply needs.

2.23 UN Procurement: UN agencies state that they will act as procurement agents in the absence of government capacity to execute this function, though with an eye also to developing that capacity. The practice on the ground is somewhat different. Despite the presence of procurement capacity in MOHFW, agencies such as UNFPA continue to be involved in procurement. This involvement is not issue free. UN procurement is costly, with MOHFW procuring at a cost of up to 30 percent less than UNFPA. There are two reasons for such discrepancies. First, UNFPA procurement carries a service charge of 5 percent, reflecting in part the higher salaries of UN procurement staff compared to those of MOHFW staff, although they are doing the same job. Second, UNFPA does not award contracts on a competitive basis but selects from a list of eligible suppliers. There is also a conflict of interest between UNFPA's role as a donor and a supplier.[19]

2.24 Local procurement: Bangladesh has a world class pharmaceutical industry, meeting international standards in production. But pharmaceutical products for the health projects are procured internationally, not in Bangladesh, partly because oral contraceptives, which account for a large share of procurement, are not produced in country. But a second reason is that the move to the SWAP means very large orders, whereas individual projects meant smaller orders. Local firms do not have the scale of production to be eligible for these large orders. But in fact there was little local procurement under FPHP either, in that case on account of the reliance under that project on procurement by UN specialised agencies.

17. The PAD for HNPSP includes a condition that staff should remain in post for five years, but there is little scope for enforcing this. Training is given on a quarterly basis, which somewhat mitigates the problem, as shown by the fact that under HNPSP the first procurements were completed less than one year after effectiveness.

18. Ministry staff say that they have had to change all their procedures to meet IDA Guidelines, could not the Bank streamline its Guidelines to meet Bangladesh's needs.

19. During 2005 UNFPA was been arguing with GoB that there was a serious contraceptive shortage, which Bank staff were convinced was not the case (UNFPA's figures ignored supply already in the pipeline). With this apparently flawed argument, UNFPA urged government to use US$ 12 million of pool funds for UNFPA contraceptive supply, and that contracts in the pipeline under IDA rules be cancelled, even where bids had already been received. UNFPA stood to gain US$ 600,000 from such a move. Once UNFPA joined the pool under HNPSP created a clear organizational conflict of interest.

Disbursement Procedures

2.25 Although a SWAP, HPSP did *not* fund the government budget by mixing donor and government funds. Donor funds, including the pool, were still held in special accounts, as had been the case with projects but with the important difference that MOHFW could access the whole US$ 2.8 billion without having to seek Ministry of Planning and ECNEC approval on a project-by-project basis. Since HPSP used a familiar system of special accounts, no especial disbursement problems occurred. This is not so under HNPSP, where funding does now flow through government systems, the procedures involving Central Accounts Office (CAO). A tiny proportion (0.2 percent) of the money available has been disbursed, which staff of MOHFW's Financial Management Unit attribute to lack of familiarity with the required procedures on the part of CAO staff. This problem is similar to that encountered in procurement under HPSP, and might require gap filling TA whilst the gap is closed. Line Directors also complain of the system of RPA, by which they must first spend and then be reimbursed. But they do not have funds to spend, and the size of advance available is too low to allow any but marginal activities, so, they claim, the system prohibits spending.

Monitoring and Evaluation

2.26 Monitoring projects with many partners and very many activities is a major challenge. Was it feasible to monitor all 66 sub-components of FPHP? Given the size and complexity of the project, monitoring was built into the project using the MOHFW MIS systems. The Family Planning MIS was well established by the end of FPHP. Health is a more complex sector and less progress was made. Donor supervision mission thus had uneven data on which to draw. Supervision was coordinated amongst donors with two joint missions each year. These were large, multi-donor missions; the donor team for the mid-term review had 51 people. Having such large teams provided the possibility of covering the whole project; the report from each supervision mission included an annex with a table giving a row to each of the 66 sub-components stating implementation status and issues. However, the mission timetable shows that up to eight sub-components were reviewed in a single two hour meeting with the Project Directors (PDs). A 15 minute meeting with the PD is clearly very light supervision. Smaller specialized teams were occasionally fielded to monitor specific components, but these missions were not that frequent. At the end of FPHP the consortium commissioned an evaluation which reviewed progress on all 66 components. Overall the M&E system under FPHP was satisfactory, if illustrating the problems of monitoring a large program with many sub-components, and the M&E structure laid the basis for that adopted under HPSP.

2.27 Whilst not formally part of the supervision process, another important activity was that Bank staff were asked to review the government's Three Year Rolling Investment Plan, enabling staff to check consistency with planned project activities. Not only could it be checked that planned activities were reflected in the plan but also that government was committing the level of resources that had been agreed. The Bank also identified "low priority projects" which were dropped from the financing program.

2.28 HPSP had a sound model for monitoring, though there were drawbacks in implementation. Monitoring was based on an Annual Performance Review (see para.

2.16). The indicator review for the APR presented the most recent data available, data quality, measurement issues and matters arising from performance, utilizing indicators across the logframe. The design of the monitoring system for the Bangladesh health program can be held up as a best practice model for monitoring a SWAP. But there were problems in implementation. First, once the project cells in MOHFW were closed responsibility for managing the APR passed to HPSO, with a consequent loss of ownership in government. The APR is seen by many as an exercise for the benefit of donors, with scant evidence of an effective feedback loop into sector management by government. Second, whilst the APR itself stayed at the level of sectoral strategy, donors were also involved in the review of the AOPs, and through this mechanism became closely involved in day-to-day issues of sector management: one independent annual review accused donors or trying to "out micromanage" each other. Properly used, the APR system would have kept donor attention on matters of policy, but they have been drawn into detailed issues of process matters such as disbursement procedures. Third, there were significant problems in the health and family planning MIS for much of HPSP. Hence the Ministry's own data generation systems were not a significant source of data for the APR, driving a further wedge between government and the content of the reports. Finally, the system covered monitoring but not plans for evaluation. Despite the excellent design of the M&E system, and the commendable features that were put in place, the performance of M&E as a whole under HPSP must be considered only moderately satisfactory.

Governance Issues

2.29 Corruption is said to be endemic in Bangladesh, with the country appearing at the bottom of Transparency International's ranking of corruption in 159 countries.[20] The health sector is not exempt from these issues, the problem manifesting itself in the following ways: (1) charging of unofficial fees (i.e. bribes) to receive services in public facilities; (2) procurement malpractice; and (3) absenteeism. The extent to which these problems hinder performance is open to question, since the country is recognized as having one of the most successful family planning programs in the world, and the same is now said of the more recent TB program. Moreover, it is claimed that governance problems are not restricted to government, with allegations being heard regarding both NGOs and DPs.[21]

2.30 A 2005 household survey conducted by Transparency International found that: [22]

- Over a quarter (26.4 percent) of out-patients had to pay bribes to doctors for receiving medical treatment at the public hospital, averaging 60 taka per visit.[23]

20. In 2005 Bangladesh ranked equal bottom with Chad (http://ww1.transparency.org/cpi/2005/cpi2005_infocus.html#cpi).

21. The mission heard allegations of bribery by some NGOs to obtain contracts to be executing agencies for projects. Transparency International Bangladesh is currently conducting a review of governance issue in the NGO sector.

22. Transparency International "Corruption in Bangladesh: A Household Survey: Summary Findings" http://www.ti-bangladesh.org/documents/HouseholdSurvey200405-sum1.pdf.

- One-fifth of in-patients had to pay bribes for the same purpose at a much higher rate of an average of taka 478.
- In public hospitals over a third (37.5 percent) of patients requiring surgery in public hospital had to pay bribes at an average rate of 1,420 taka, over half (57 percent) had to pay an average of 516 taka for an X-ray, and 60 percent of patients who did pathological test had to pay 410 taka as bribes.

2.31 Fraudulent practices are proxied by audit observations, though of course mis-procurement also occurs from genuine errors arising from lack of familiarity with the Bank's requirements. The health projects have been subject to a large number of audit observations. At the time FPHP closed there were 7 outstanding observations from the Third Project and 45 from the Fourth. HPPP had incurred 50 audit observations by the end of 2003. The Central Medical Maintenance Unit (CMMU) and Central Medical Supplies Department (CMSD) are associated with an unusually high level of observations. The high level of audit observations for these projects cannot merely be the result of inexperience, but also likely reflects corrupt practices.[24] There are allegations of pay-offs along the supply chain from CMSD, through the civil surgeon down to upazilla stores. There is certainly a documented discrepancy between what is supplied at the top end of the system and what comes out in supplies to the public, which can be attributed to pilfering.

2.32 The lack of medical personnel in rural clinics is a product of two factors, high vacancy levels, as it is difficult to attract skilled personnel to positions away from major urban centers, and absenteeism amongst those who do accept such appointments. The overall vacancy rate is 26 percent, but 41 percent for doctors. Where there is an appointment, the overall rate of absenteeism is 35 percent, but again over 40 percent for doctors, being as high as 74 percent for doctors attached to Upgraded Family Welfare Centers.[25] Health workers were far more likely to be absent in the afternoon, since they carry out private practice at this time. One factor behind absenteeism is the common practice of doctors seeking posts in rural areas, collecting the resettlement allowance, but then not taking up their post and seeking another reassignment after some months.

2.33 Until recently, many of these issues were not openly addressed in a formal manner by the Bank or other DPs: neither the FPHP SAR nor the HPPP PAD use the term 'corruption', and the word 'governance' appears just three times in the over 100

---

23. This figure is higher than estimates from other sources. A more common practice appears to be that a brief free consultation has to be followed up with a later consultation with the same doctor in his or her private practice.

24. A review of audit observations in the early years of FPHP shows the following four problems to be the most common: funds collected from sale of tender documents not deposited with government, being unable to produce vouchers, funds paid to an agency but the planned activity had not taken place, and unauthorized expenditures. Each of these may be indicative of corrupt practices, but each may also reflect weaknesses in accounting systems and/or delays in implementation.

25. Nazmul Chaudhury and Jeffrey S. Hammer (2003) "Ghost Doctors: Absenteeism in Bangladeshi Health Facilities" *Policy Research Working Paper 3065*, Development Research Group, World Bank, Washington D.C. A more recent report, which distinguishes explained and unexplained absences, finds somewhat lower, but nonetheless significant, rates (FMRP, 2005).

page HPPP PAD, though not in any of the contexts mentioned here.[26] Nor is there any mention of the problems of bribery, mis-procurement or absenteeism.

2.34 The main donor response for most of the period covered by this assessment can be seen as side-stepping the issue by retaining parallel systems and trying to ensure that 'their activities' are not affected. Despite the SWAP ideal of financing government programs, HPSP created the PCC and CMU in MOHFW, used a Bank-managed pool rather than provide sector budget support, and HPSO was heavily involved in day-to-day monitoring of procurement (rather than relying on periodic audits) and other process issues. Donors became involved in discussing the details of AOPs (agreeing actions that were not acted on) rather than staying at the level of strategy, or developing strategy to address the corruption problems.

2.35 This situation has changed in recent years, with the Bank taking a more proactive position on governance issues, starting with raising governance during discussions around lifting the 2003 suspension. A first response was that government agreed to commission a public expenditure tracking study. A number of documents have been produced as a basis for policy dialogue, such as the reports on absenteeism and that on various aspects of governance, both cited above. Carrying out such analytic work is standard entry point on reform issues, but this process is still at the early stages. It can be expected to be carried forward given the prominence of governance issues in the Country Assistance Strategy. In the meantime formal measures have been instituted with respect to mis-procurement. There were a large number of unsettled audit observations from HPSP. Settlement of these was a matter for negotiation for HNPSP (50 percent of the value had to settled). The last observation was settled in December 2005 in response HNPSP disbursements being held up until this was done. Moreover, agreement has now been reached that government employees shall be subject to disciplinary action in proven cases of corrupt activities resulting in mis-procurement.[27] However, such cases are rare, since the standards of proof required by the Bank's legal department are very rigorous. Hence in the majority of cases mis-procurement can be observed, but the strong suspicion of corrupt practice not pursued. Nonetheless the Bank did cancel just over US$ 1 million from three projects, of which HPPP was one, in November 2005 as a result of evidence of collusive practices.[28]

26. The governance problems identified in the PAD are political resistance to reforms such as unification and hospital autonomy (HPPP PAD: 15).

27. Normal practice is for the government to have to repay the funds in cases of mis-procurement, but the Bank does not take a position on action against the responsible officials, so there is little incentive for such activities.

28. This case had been referred to the Bank's formal investigation department (INT). It was observed that this process was very lengthy and so not practical for the large number of observations in most projects.

Reflections on the SWAP Experience

A government owned strategy?

2.36 Today, health strategy in Bangladesh appears increasingly donor driven. The SIP for HNPSP was prepared by external consultants hired government for the purpose (with Japanese money), rather than being in the context of the plan or prepared by ministry working groups as had been done previously. The strategy for HPSS was a government document, but with considerable donor influence, the basic parameters having been set at a CG meeting in Paris in 1995. DPs currently express concerns over the quality of documents produced by MOHFW and so it might be concluded that lack of government capacity has required donors to assist in identifying strategy.

2.37 But the argument that government lacks capacity seems a bit odd when considering the historical experience. The earliest programs did take place within a government-defined framework, namely the Five Year Plans. The First Five Year plan was written by a small group of Bangladeshis called upon by government. For the Second Plan, the government took the lead in inviting donors to provide technical inputs in an exercise that led to the second project. Later, Bangladesh led the world in establishing an essential drugs policy in the early eighties (the National Drugs Policy of 1982), despite opposition from the United States and, later, the World Bank.[29] This policy helped both create the large pharmaceutical sector in the country and make essential medicines available at low-cost. Clearly at that time the Bangladeshi government had both the capacity and will to implement an imaginative and difficult health policy. So why is it that today external consultants are used to write the country's strategies?

2.38 There are a number of reasons, many to do with the changing role played by the DPs.[30] The nature of the aid relationship around the world changed in the 1980s with the advent of structural adjustment, with DPs increasingly seeing their role as influencing the policy environment. In Bangladesh this shift corresponded with the start of military rule. The end of elections meant that government was less not concerned with how its policies affected popularity at the polls: tax payers had no formal means of expressing their concerns. Anyhow, donors rather than taxpayers provided a large share of government revenue, so the voice of each individual donor carried considerable weight. Hence accountability was shifted away from the people toward the donors. Meanwhile the number of aid projects was growing rapidly, so that there were literally many hundreds of aid projects. The time of government officials was thus spent on project procedures and catering for visiting missions rather than the business of delivering government services. The incentive structure within government favored seeking project appointments, for their salary supplements and perks of transport and overseas travel. At the macro level,

---

29. In 1993 the head of the Bank's Industry and Energy Unit in Dhaka wrote to government stating that the protective measures under the Drug Policy should be liberalized. The Bank's health staff were not consulted, learning of the letter from the newspaper. A new letter was sent modifying the Bank's position. See Zafrullah Chowdhury (1996) *The Politics of Essential Drugs. The makings of a successful health strategy: lessons from Bangladesh.* Dhaka: University Press Limited for more discussion of the incident.

30. The arguments in this paragraph draw on responses from a number of sources. The first two points are directly attributable to Professor Rehman Sobhan.

the incentives are for the government to agree with the donors since this will secure the aid funds. The donors know exactly what they want, so why not let them write it? Any conditions won't be enforced, and government will carry on making genuine policy decisions without consultation, as was the case with the recent decision to undertake a major expansion of curative care.[31] Finally, it is generally conceded that the quality of senior public sector workers has declined as the more capable have been driven out by the increasingly politicized nature of government employment.

Coverage: what's in and what's out?

2.39 SWAPs are torn between the need to be all-inclusive and avoiding over-complexity. The need to avoid an over-complex project design is a perennial theme in IEG evaluations, but in attempting to cover the whole sector, SWAPs necessarily appear complex. This point remains an unresolved, and possibly irresolvable, dilemma. But there are also more practical points regarding HPSP as to what was in and what was out.

2.40 Though HPSP is complex it can still be seen as having left things out. The two most glaring omission are the urban and for-profit private sectors. MOHFW is responsible only for health services in rural areas, the Ministry of Local Government being responsible for primary health in urban areas. The SWAP covers the Ministry rather than the sector, so urban health is not part of the program. This is certainly a departure from the "SWAP ideal". More importantly, it may result in disparities in the level and quality of service provision, with the rapidly growing urban sector lagging given the high levels of funding available through the DP programs for rural health.[32] Whether this is or is not the case is not known since the issue has not been on the radar screen of the donors.

2.41 HPSP included a component for programs implemented by NGOs, and their other components which work with NGOs, notably TB activities. But the for-profit private sector, both traditional and modern, is ignored. Between them these account for over 60 percent of service provision in rural areas, so an inclusive approach can ill afford to ignore them. Some other parts of the health care system also fell outside the SWAP. WHO (2004) claims that the TB program has suffered from its lack of recognition in the HPSP logframe. UNFPA retained parallel financing in part because unmarried people have no access to the government reproductive health services supported by HPSP.[33]

2.42 Finally, two areas were "taken out" of the program: HIV/AIDS and nutrition. It was felt by the Bank that HIV/AIDS was inadequately reflected in the strategy and given insufficient attention by GoB. Hence a HIV/AIDs project was initiated which is a separate project with its own financing and project structure. There is a conflict between

31. District hospitals and upazilla health complexes are to be increased in size (from 50 to 100 beds, and 38 to 50 beds, respectively). This government decision was not discussed with the donors.

32. There is a division of labor amongst the DPs with ADB financing the mainly NGO-implemented Urban Health Project (which does not cover all urban areas) and the rest rural areas.

33. It is not being suggested that UNFPA should have abandoned its program so that all activities could fall under the SWAP. However this case highlights, as does the case of HIV/AIDS, the tension between the ownership ideal of the SWAP with the fact that donors may not agree with all government policies.

having an ESP-based SWAP which has prioritised services, and then introducing a separate program for something the DPs feel has not received sufficient priority. Government has maintained that HIV/AIDS can be handled within the context of the health sector, which is a plausible claim, given the low prevalence and likely transmission channels in Bangladesh. Nutrition was also removed, though has been reintroduced under HNPSP, though it is not yet clear how this will work.

Donor coordination: who's in and who's out?

2.43 The Bangladesh health program has a long history of donor coordination, a major part of which has been cofinancing of the Bank's projects, beginning with the First Population Project. This high degree of cooperation no doubt assisted the move to a SWAP. Some donors have historically remained outside of these arrangements, notably USAID and the major UN agencies (UNICEF, UNFPA and WHO, although these have been executing agencies or suppliers), but the SWAP has brought them closer. USAID was a member of the consortium, as were the UN agencies. Hence these donors have coordinated under the government's strategy, i.e. following under HPSP but not HPPP. Hence compared to many other countries there is a high degree of coordination, but this does not mean that it is problem free.

2.44 The major issues under HPSP have been the relative position of pool and non-pool donors and the role played by HPSO. Donors not contributing to the pool had a feeling of being "second rate partners". Indeed, this was more than a feeling, as they were openly told that they were observers at some meetings with GoB and should not speak, and many decisions were taken in the HPSO Steering Committee, consisting of pool donors only, rather than the wider consortium. Even as more responsibilities shifted to the consortium, smaller donors felt their voice was not being heard. Under HNPSP matters have been formalized with a voting scheme based on one member one vote, plus a share of votes weighted by contribution to the program, though in practice most decisions are made by consensus.

2.45 HPSO is situated in the Bank office, though actually in an annex to the main building, giving it some, though not much, separation.[34] Given the early problems with procurement and disbursement, HPSO became heavily engaged in these issues in the first two years of the program, increasing its identification as being a "Bank office". On the other hand, Bank staff felt that HPSO's structure allowed for donor "interference" in Bank affairs.[35] Whilst some DPs have criticized the closeness of HPSO to the Bank, the Bank was given this responsibility precisely so the consortium could draw on the Bank's strong technical expertise. Despite this, HPSO staff did not have a close relationship with the rest of the Dhaka office. For example, there were other skills needed at the time of suspension: these were available but not drawn upon. This problem was exacerbated by the fact that the Bank did not have a HNP specialist in Dhaka separate from HPSO, though of course this expertise was available in headquarters. Such a staff member,

34. The Bank office has moved to a new building since the end of HPSP.

35. The Bank staff stationed in HPSO were interviewed by a selection committee including the pool donors, so the line of authority appeared ambiguous.

situated in the main Bank office, rather than the HPSO annex, would have provided a link with other Bank staff, and a more strategic vision compared to the day-to-day management issues that HPSO got drawn into, and helped maintain a separation between the Bank and management of HPSO.[36]

2.46 Has the SWAP reduced transaction costs? There were 22 AOPs, compared to the 66 sub-components of FPHP. Hence it may be wondered if the transaction cost savings in terms of staff burden can be that great.[37] These savings are substantial for two reasons. First the 22 AOPs cover not just the 66 projects, but also the 60 odd previously outside of FPHP. More importantly, the move to a SWAP brought with it the important systemic change already mentioned of now being a single project.

2.47 Savings have also been realized from donor coordination and harmonization. Interactions with donors are now coordinated, and donors contributing to the pool have common reporting requirements. The supervision burden has been reduced by the introduction of a single APR involving all donors. The Bank's supervision costs for HPPP were a third those for FPHP, not because there were fewer supervision missions (in fact there were more), but because they had fewer staff since other DPs were formally integrated into the supervision structure. However, Bank staff also complained that the fixed supervision budget was too low for such a large, complex project.

2.48 On the other hand, transaction costs have not been reduced by as much as might have been the case because of continuing parallel structures, partly as donor financing continued to be separate. Bilateral donors continue to have separate agreements with government, though there is little alternative to this unless they were to channel funds exclusively through the Bank. And donor representatives continue to be heavily involved in day-to-day aspects of the health sector.

2.49 What should donor officials do? The SWAP philosophy is that donor officials shift their attention to issues of strategy and policy rather than day-to-day details of project management. This does not appear to have happened under HPSP, with donors becoming more involved in detailed discussion of the increasingly detailed AOPs. What were the reasons for this?

2.50 One simple reason is that agency staff located in Dhaka have to do something and their time would not be fully occupied by even monthly discussions on strategy and reading quarterly audit reports. Moreover, many of these staff have spent their careers overseeing project implementation, so the temptation to get drawn into these details will be strong. From a transaction costs point of view, simply having many parties involved in these discussions can hinder progress. As long as bilateral agencies continue to have projects outside the SWAP then these staff can continue in their traditional role. But for those whose aid starts to be almost exclusively in the SWAP, especially if through the poor, then remedies to this problem are required. A first possible remedy is a well-

36. There is some ambivalence in writing this. Had there been a HNP specialist separate from HPSO, there would no doubt be a comment that this arrangement did not make sense.

37. The ICR raises this same question saying there are 38 AOPs. But the increase from 22 to 38 was under HNPSP.

defined division of labor between donors within the sector. The second is for some agencies to be 'silent partners', providing resources but not taking an active part in sector management (though they receive reports for accountability purposes). Although there are no silent partners, Sida has reduced its involvement by no longer having a Health Advisor in Dhaka; there is one local staff with the title 'Program Manager'.

2.51 The irony is that donor officials spend a great deal of their time discussing matters they are not particularly qualified to discuss. As health specialists they should be focusing their skills on matters of health policy, rather than the design and implementation of disbursement procedures. In principle, these routine matters of program implementation should be left to the Bank. This does not happen, both for the reasons given above (donor officials have to do something), but also because the bilaterals apparently do not trust the Bank to manage these issues. This lack of trust may partly be continued fallout from the suspension episode, but also reflects that the Bank itself is also leaving too much responsibility for these matters in the hands of health specialists.[38]

Was pooled finance a successful financing approach?

2.52 Of the original budget of US$2,895 million, US$ 705 million was to come from the donors, of which US$ 522 million (74 percent the donor total) was to be pool finance (see paragraph 1.25 above on the workings of this fund). Of the funds for the pool US$ 250 million was to come from the Bank, which put all its funds in the pool, other donors putting 59 percent of their funds through this channel. Other donors providing parallel financing are not reflected in these figures, so the share of support through the pool is over-stated, but nevertheless still substantial. Of the US$390.3 million disbursed, the difference being accounted for by (1) EC cancellation of US$ 39 million following de-unification, (2) cancellations resulting for mis-procurement and, (3) exchange rate fluctuations at the time of disbursement.

2.53 This approach worked as planned. MOHFW was given flexibility in allocating the resources between activities on the basis of the agreed AOPs, and financing the full range of sector expenditures. Although there were a large number of audit observations, this had also been the case for the earlier PHP projects, and so cannot be said to be a result of pooled finance. The budget support approach to financing was a successful aspect of HPSP, but this success has been over-shadowed by unification episode.

3. ACTIVITIES AND OUTPUTS

3.1 Both FPHP and HPPP were large, complex project, so all components are not dealt with in detail. First, an overview is given of the continued, albeit uneven, progress in the expansion of facilities and service delivery under both projects. Data are then presented on selected specific activities: community clinics, the TB and leprosy program,

38. Procurement and disbursement specialists were included in some supervision missions, though not as many as might be expected given the problems being experience. But procurement and disbursement officers do not rank high in the Bank's hierarchy, and these issues are unlikely to be given a high priority.

training, MIS, and the Institute of Child and Maternal Health. HPSP outputs included a series of reforms, which are also discussed.

Continued Increases in Health Outputs: An Overview

3.2 The IEG impact evaluation showed how the externally-supported creation of a family planning infrastructure played a critical role in the reduction of fertility described above. EPI, provided through satellite clinics and national immunization days, played a similar role in reducing under-five mortality. Health outputs have continued to increase, and intermediate outcomes, such as contraceptive prevalence and use of antenatal care have continued their steady rise throughout the period of the two projects. There were, however, disruptions of service during HPSP and the creation of a new tier of service delivery was unsuccessful.

3.3 FPHP continued to support the expansion of the health and FP infrastructure created by the first three projects: 87 Family Welfare Centers were constructed, 429 Rural Dispensaries upgraded, and 10 new Upazilla Health Centers established. Many other facilities were upgraded (see Annex B for a complete overview). Civil works construction targets were mostly met or nearly met. Training was provided to, amongst others, female HAs (FHAs) and TBAs. Traditionally FWAs were female, but the health equivalent at community level, Health Assistants (HAs) had been male. With the increased emphasis on MCH this was not appropriate, so 4,500 female FHAs were recruited and trained under FPHP.

3.4 In addition to the number of facilities, the scale of services has also been expanded. For example, Mother and Child Welfare Centers (MCWCs) began to provide immunization services,[39] and the majority (67 out of 95) have been equipped to provide Emergency Obstetric Care, though this is through a UNFPA project started outside of FPHP. During FPHP C-sections at MCWCs increased by 273 percent, and those at district hospitals increased by 51 percent, the latter partly a result of FPHP's Thana Functional Improvement Pilot Project (TFIPP), though a separate UNICEF project also contributed at district level. From 2000/1-04/05 C-sections at MCWCs increased by a further 188 percent (FP MIS data).

3.5 Civil works were less satisfactory under HPPP. The main activity was the construction of 16,000 community clinics. The program was delayed and then abandoned before 10,000 had been completed. The clinics themselves are largely unused. HPSP's targets related to levels of access and customer satisfaction. Given the disruptions in service delivery caused by unification (see below), use of ESP curative services in public facilities actually fell from 13 to 10% between 1999 and 2003, although has since recovered.[40] Similarly the number of women receiving doorstep delivery of family planning declined, though has also recovered.

---

39. Operation of EPI through MCWCs is an example of the *de facto* collaboration between health and family planning at the field level, despite the failure of unification.

40. The former figures are from the Service Delivery Survey (SDS), the subsequent observed increase is based on the trend data from the facilities surveyed in the FMPR study.

3.6 Table 5 reports selected intermediate indicators related to the two projects' MCH-related objectives. As reported above, contraceptive prevalence continued to rise, with a corresponding fall in the unmet need for contraception. After a fall in the mid-90s, immunization rates have risen to new highs, and there has been an increase in the proportion of children with diarrhea treated with ORS, though with a very modest improvement in the most recent period. There has been slower progress with respect to maternal health, with steady but modest increases in attended births and those taking places in facilities, but a better record with respect to expanded coverage of antenatal care. The percentage of deliveries by C-section has risen from a negligible number to 3.5 percent.[41] In urban areas the target of 15 percent of deliveries being by C-section has practically been reached.[42]

Table 5. Selected MCH Output Indicators

	DHS 93/94	***DHS 96/97***	***DHS 99/00***	***DHS 04***
Percentage of married women currently using any method of family planning	44.9	49.8	54.3	58.5
Percentage of married women with an unmet need for family planning	18.1	15.8	15.3	11.2
Percentage of live births receiving antenatal care from a trained health professional		19.6	23.8	31.2
Percentage of live births delivered at a health facility		4.1	7.6	9.3
Percentage of live births receiving assistance at delivery from a trained health professional		5.2	7.1	7.5
Percentage of births delivered by C-section	<0.2%	..	2.5	3.5
Percentage of children fully immunized	58.9	54.2	60.4	73.1
Percentage of children with diarrhea who received either ORS or RHS		60.9	73.5	74.6

Source: http://www.measuredhs.com/countries/country.cfm. Accessed 2/20/06

41. DHS only collected data on C-sections in the last two rounds. The FPHP evaluation states that C-sections in the early 90s were less than 1 percent of the target of 15 percent of all deliveries, i.e. less than 0.15 percent.

42. Urban areas means the respondent resides in an urban area. Practically all, if not all, C-sections take place in urban areas regardless of the place of residence of the respondent. As incomes rise, it is likely that a proportion of C-sections are non-essential, but the data do not allow us to identify this proportion.

Selected Project Activities and Outputs

Training

3.7 FPHP included a large amount of training. On the family planning side, this training was carried out through the National Institute of Population Research and Training (NIPORT), the apex organization for the FWVTIs and RDCs around the country for training FWVs and FWAs respectively. There were difficulties in getting release of staff from government for training. Deeper problems began to emerge toward the end of the project. The target numbers of FWVs and FWAs were reached by the mid-90s, so these very sizeable training facilities began to operate at low capacity rates (at best 20 percent). Second, there were moves to make NIPORT an autonomous institution, which were resisted by staff, a conflict which undermined their productivity. On the health service side 27,000 staff were trained under FPHP's main training sub-component, and many others under other sub-components. A major initiative was training Female Health Assistants, as HAs had previously been male, which was inconsistent with the emphasis on MCH.

3.8 HPSP also included a great deal of training for both health and family planning, but NIPORT was not used as the agency for any of this training, being a major reason why FWVTIs and RDCs operated at very low capacity for nearly of a decade. NIPORT was by-passed as a result of both the internal problems mentioned above, and as another by-product of the tensions created by the merger, with health staff feeling that NIPORT's family planning focus made them ineligible for training in the unified program. The line director for training instead passed training to district and upazilla managers who either conducted training themselves or contracted it to NGOs, who often had no facilities, and certainly not the residential facilities required for multi-day programs. The quality of training is said to have suffered as a result. Under HNPSP, NIPORT has been made the line director for training. Although they are now undertaking midwifery and SBA training for FWVs, under-utilization of FWVTIs remains an issue.

3.9 Training Traditional Birth Attendants (TBAs): Training of TBAs, started under the Third PHP, was a major component of FPHP, although discontinued toward the end of the project with the shift of policy in favor of SBAs. DHS data show that the proportion of births attended by trained TBAs steadily increased throughout the period from 4.3 percent in 1993 to 13.8 percent in 2004. IEG's impact study showed that a birth being attended by a trained TBA reduces the probability of neo-natal death by around 7 per 1,000. Other evidence from Bangladesh shows that trained TBAs are more likely to adopt the 'four cleans' of safe delivery than are untrained ones. The IEG report acknowledged that the impact of maternal mortality will be limited in the absence of an EOC system to which trained TBAs can refer complicated deliveries. However, as the data presented in this report show, such a system of EOC *is* being put in place, reinforcing the message of the IEG impact study that abandoning the training of TBA was not necessarily the best policy decision: it was already having an impact on infant mortality, and the expansion of EOC creates the potential for an impact on maternal mortality.

Management Information System

3.10 By the time of FPHP, a good MIS system had been developed in family planning. A Logistics MIS (LMIS) was being developed which would have helped ensure the smooth supply of contraceptives. Built upon the records of the FWAs, the FP MIS had data collection built into their routine work, and a clear need for the information produced. FWAs had a strong incentive to record data, since there were performance targets. The situation in health was somewhat different, with the range of possible indicators more varied and complex, and a less clear use for these data from the point of view of the health professionals in the system.

3.11 Under HPSP the health and FP were to be unified. A unified reporting system was designed and the procurement process started. This process was subject to considerable delays owing to failures to meet the IDA Guidelines. Once over that hurdle, attempts to implement the system met with resistance from both health and family planning staff. However, the Unified MIS office initially published reports based on earlier data, and, prior to being disbanded, bought out the first annual report from the new geographical reconnaissance system which had been developed.[43]

3.12 The current situation is that there are separate MIS in health and family planning. So, for example, EOC is provided in both MCWCs, which are FP facilities, and UHCs, which are health facilities. Hence data on the number of C-sections in the former is collected by the FP MIS and those in the latter by the health MIS. But no one is adding up these two figures to report total C-sections in public facilities. There are two possible solutions to this situation. One is to situate the MIS at Ministry level rather than in the two directorates. If this cannot be done,[44] then a separate MIS coordination cell at Ministry level should be charged with this function. However, there appears little demand within government for MIS data, other than forecasts of contraceptive demand; it is undesirable that changes in the MIS should be donor driven. Creating data systems which are demand, not supply, driven requires time to build up awareness amongst users of the role data can play, and to be clear that systems can provide policy relevant information.[45]

Institute of Child and Maternal Health

3.13 The Institute of Child and Maternal Health has three areas of activity: training, patient care and research. The idea for ICMH dates from the early eighties. Japan had agreed to fund the project but withdrew after lengthy delays in the project approval process. In 1991 the Bank agreed to finance construction of the Institute under FPHP on

---

43. The geographical reconnaissance system was a detailed set of data collected at union level on health, family planning and aspects of living conditions (water and sanitation); see *Geographical Reconnaissance Data – 2002*, UMIS, MOHFW.

44. The fallout from HPSP means it is still not possible to propose any form of "unification". Both health and FP staff are adamant that health and FP MIS are necessarily separate activities, though the strongest reason given is that the former is supported by WHO and the latter by UNFPA.

45. A current example would the usefulness of a good manpower planning system, as the health workers trained during the initial establishment of the system are approaching retirement, so that replacement training programs need be planned for.

condition that it became an autonomous institute.[46] Construction of the campus was completed and the institute operational by 1998, with patient care provided through out-patient services at the nearby Jalkuri site since 1994.

3.14 The development of the institute was not trouble free. There were continuing court cases against ICMH from its acquisition of 12.6 acres of land to construct the campus.[47] ICMH employees resisted the establishment autonomous status. These disagreements lasted two years (1999-2001) ending with the removal of the Director, who had been the key mover in the founding of the Institute. It took some years for the Institute to regain its focus with a succession of Directors. These problems have subsided, with the current Executive Director in post since 2004, and all areas of activity – patient-care, training and research - now being successfully implemented (see Annex D for a brief overview).

3.15 The overall assessment is that ICMH was successfully constructed and has become operational. There is a problem of under-utilization which takes two forms. First, training facilities are not yet in full use, but there is a clear upward trend. Second, questions can be asked as to whether resources are appropriately applied. Given the high level of qualification of its staff, ICMH Hospital should act as a tertiary facility, but in the absence of a referral system patients from surrounding areas come with conditions that could be treated at upazilla level. Similarly, training should focus on senior medical professionals and training of trainers, rather than direct training of para-workers.

TB and Leprosy Programs

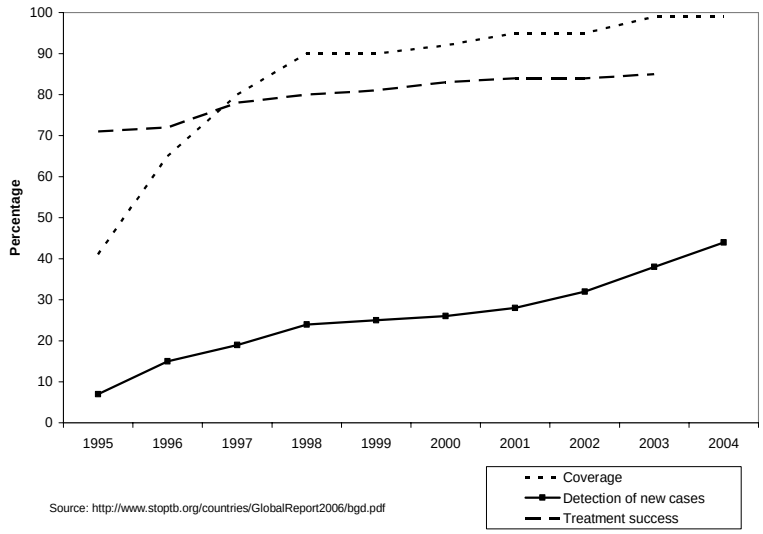
3.16 The ICR calls TB and Leprosy programs initiated under FPHP “amongst the most effective of their kind in the world” (ICR, 1999: iv). Though they accounted for just under 2 percent of the total project expenditure, these programs, implemented through a government-NGO partnership, made a major contribution to improved health outcomes.

46. The Bank met 58 percent of the costs and government the remaining 42 percent.

47. As the most densely populated country in the world, land is a contentious issue, and there is a high opportunity cost to constructing under-utilized facilities.

3.17 The National Tuberculosis Program (NTP) successfully developed essential service facilities for tuberculosis control through all 460 rural Upazila Health Complexes (UHC), raising case detection levels from almost zero to about 60,000 per year. Field level testing was conducted by NGO staff using supplies from government; lab analysis, monitoring and treatment of positive cases were carried out by government, who also participates in training and awareness raising activities.[48] The cure rate was increased from 71 percent in 1995 to 85 percent by 2003. However, challenges remain. First, despite the substantial rise the case detection rate was still only 30 percent at the end of the program; though it has continued to rise it is still well below the target of 70 percent. Second, NTP was a vertical program, a structure seen to be inconsistent with the integrated health service delivery envisaged under HPSP. However, the integration of vertical programs into general health services has not always been positive as specialized technical knowledge is lost (see Annex E).

Figure 5. TB Coverage, Detection and Success Rates, 1995-2004



3.18 The National Leprosy Elimination Program of Bangladesh was also supported under FPHP, aiming to detect over 85 per cent of the estimated cases within 5 years, to provide multi-drug treatment to all registered cases, to achieve a cure rate of 85 percent and to reduce deformity rate in newly detected cases from 21.4 per cent at the start of the project in 1993 to less than 5 per cent by the year 2000. The estimated prevalence of leprosy declined from 13.6 per 10,000 population in 1992 to less than 1 per 10,000 since December 1998, achieving effective elimination of the disease as a public health problem two years ahead of schedule. The deformity rate among newly detected cases declined from 21.4 per cent in 1993 to 7.9 per cent in 1999. As with TB a factor in the success of the project was a successful partnership between government and NGOs, with both sectors providing services in different areas.

48. At one UHC visited during the fieldwork, a one day TB awareness session was taking place in the hospital training building (constructed under FPHP) for village leaders, the course being delivered by one BRAC and one hospital staff member. BRAC is the main implementing NGO for the program, though a number of others are involved.

Community Clinics

3.19 Under HPSP primary care was to be provided through 16,000 static clinics, staffed by the FWA and the HA. Construction of these clinics was delayed, and less than 10,000 completed. More seriously, the utilization rate was very low. The IMED study reported that from 44 clinic visits only nine (20 per cent) were operational. Some clinics are now operated by NGOs through a DFID-implemented "Public-Private" scheme which provides matching grants to organizations taking on the running of clinics. But the majority remains non-operational.[49] Why did this happen?

3.20 There are a number of possible reasons given why the community clinics failed, and the truth is most likely a combination of these. The first is that they fell foul of being identified with HPSP. Rejection of unification meant that anything associated with HPSP also suffered. But it is also possible that the clinics were political victims in their own right: the new government was happy to have very visible signs of the "failure" of the previous government's efforts lying around the country. Second, it is widely argued that drugs were not available at the clinics, so people did not come and, consequently, health and FP workers stopped using the clinics as a basis for their operations. However, the clinics were providing free drugs at community level, so demand would be high and it is little wonder they rapidly ran out of stock. A final reason is that the quality of services was generally insufficient to attract patients, who went either to traditional healers or direct to secondary facilities if they felt the need. Health assistants received a negligible amount of training (three weeks) to enable them to deliver ESP, which was insufficient to provide proper services.[50]

Reforms under HPSP

Macroeconomic Stability and Budget Context

3.21 Macro stability was not included in the objectives of the projects under review. But the ideal for a SWAP is a stable macro environment ensured through a well-managed fiscal program, utilizing a Medium Term Expenditure Framework (MTEF) for consistency between sector spending plans and overall budget limits. The country lacked a MTEF during HPSP, though one is now being developed. In fact, the Third Year Rolling Investment Plans under FPHP played a similar role to that intended for the MTEF. The country has nonetheless preserved macro stability: since 1990 Bangladesh has achieved a reasonable growth performance combined with low inflation, the rate of price increase reaching a low of less than 2 percent in the early part of this decade.

49. The ICR states that 8,600 have been handed over to NGOs; but the general impression is that most are not operating. Even those selected by local MOHFW staff for the mission field visits were not operational.

50. This problem was identified in a memo included in the "HPSP preparation package", stating that the program was heavy on little trained field workers and short of better trained paramedics, but that the plans for HPSP would not redress this imbalance.

Unification and Suspension

3.22 Whether health and family planning should be combined or delivered separately has been a perennial issue in Bangladesh. The Bank led donors in urging the creation of a separate Family Planning service at the inception of the First Population Project, but later changed its position and urged re-unification, including under the Fourth Project. The original plan to have this structural reform as a part of FPHP was shelved when it was felt not possible given the political context of a new government in a new, but possibly unstable, democratic system. Instead a reorganization study was to be undertaken, but suffered serious delay and was finally made redundant by the development of HPSP. Two management units were established and FPHP, but neither functioned effectively and were closed prematurely.

3.23 In the run-up to HPSP the plan for unification was developed by a GoB High Level Committee. Under this proposal, services were first integrated at the field level (upazilla and below), proceeding next to district level and finally national level to achieve a fully unified service. In accordance with these plans, HPSP included specific activities such as a unified MIS and BCC.

3.24 Unification never got further than the upazilla, the new government 'de-unifying' the service. However, many aspects of service delivery continue to be integrated *de facto* at field level. For example, FP staff provide EPI services through MCWCs, and the FWA and HA hold joint sessions in the community clinic. A 2002 report from one upazilla states that whilst issues in the management structure remain to be resolved 'integration at the grassroots level happened, both psychologically and functionally'.[51] Supporters of the reform say that service provision was boosted by the reform, but there are no data to support this position, and so detractors are equally able to claim the opposite. For example, the HPSP evaluation report by IMED says that the rivalry created by unification was bad for service delivery.[52] In particular the move away from doorstep delivery to facility-based services was seen as very harmful, and called by one Bank respondent "a monumental mistake".[53] In principle, these two aspects of reform (unification, and one stop service) are separable, and this separation matters as the former is now a political non-starter, whereas the latter may be put back on the agenda. More convincing arguments against the success of reform related to the absence of a clear management structure once the reforms began.

3.25 Critics of unification say that it was a mistake to proceed bottom-up, since the bifurcated management structure complicated the command chain. Field-level staff confirm that there were difficulties in staff management and accountability at that time. But defenders of HPSP point out that alternative means of unification were discussed by

51. "Assessment of HPSP at upazilla level and below in Begumgonj, Noakhali", mimeo. This comprehensive report was prepared by the UHFPO apparently on his own initiative.

52. Earlier drafts of the IMED report came out in favor of unification, presenting evidence that it was working, but later versions of the report were substantially revised.

53. Defenders of reform say that there was never any order to stop doorstep services, but that FP staff were given this order unofficially to undermine the program. Data show that there was a dramatic reduction in these services, with a halving of the number of women receiving doorstep services from 1999 to 2003.

the committee. A bottom up approach was decided on precisely because it was recognized that it would take time to work with the Ministry of Establishment to merge the cadre at the upper levels. However, they argue that the whole process would have been completed within a reasonable time and that these problems would have been temporary ones had not unification been held up by court challenges by individual FP staff. The matter went from the High Court to the Supreme Court, who eventually ruled in favor of unification. But the change in government changed the situation, with the reforms becoming identified with the now opposition party.[54] Opponents of the reform mobilized support, allegedly raising substantial financial contributions from FP staff to support their position. With the politicization of the issue, the new secretary and minister also took a stand against reform, and the service was de-unified.

3.26 The bilateral agencies were divided on how to respond to this situation, but a hard line position emerged, identified with the Bank and the USAID the chair of the consortium at that time. The decision to suspend was taken, some bilateral agency staff feeling that there was inadequate discussion of possible alternatives or consultation over the final decision, though Bank staff recall that at the time bilaterals backed the decision. Bank-MOHFW relations became very sour with no dialogue taking place. The health specialists in the Bank possibly put too much pressure on the Minister of Health, rather than realizing that the blockage was also in the Ministry of Establishment.[55] High-level staff from three bilateral agencies (Dutch, Sida and DFID) came to help resolve the issue. This group enabled two key steps to be undertaken: MOHFW and the donors restarted a dialogue, and GoB was invited to join the consortium. Following these steps it was agreed that government could submit a revised strategy in the light of de-unification. The episode was concluded when the Bank's new country director lifted the suspension as one of her first acts on arriving in Dhaka. But the experience left a bitter aftertaste, with both continuing tension between the two directorates and a feeling that GoB-donor relations received a considerable set back.

3.27 It is easy with hindsight to say that things might have gone better. But Bank staff at the time had good reasons to be confident about the success of reform. It had clear ownership at the top, the specific proposal coming from a GoB High Level Committee, with support from the highest levels of government. Health staff were in a favor, as were the vast majority of the lower reaches the FP profession as they would be shifted from the development to the recurrent budget, giving them permanent government positions and the benefits that entails. Opposition came from a smaller, but nonetheless powerful, group of middle to high ranking FP staff. There were other losers from HPSP, who therefore had some interest in the reforms failing. These included in the Ministry of Planning, who lost power in the move from a project to a SWAP, and, it is claimed, some of the non-pool donors. It can be claimed with some fairness that more work could have been done to contain the discontent of these groups. A second shortcoming was the failure to work directly with the relevant government agency (the Ministry of

54. Identification of the reforms with the Awami League (AL) was reinforced by the Secretary responsible for the design of HPSP standing as an AL candidate in the 2001 elections.

55. The Ministry of Establishment had been earlier involved in the preparations for the SWAP, including unification, the Joint Secretary going on a study tour of African SWAPs. It was through MoE's involvement that some FP staff were switched from the development to recurrent budgets.

Establishment) in implementing the reform. This is of course not the area of expertise of health specialists, but they should have recognized this fact and incorporated appropriate skills if not at the Dhaka office, then at least into supervision missions. The decision to suspend can also be questioned: it created an apparent division amongst donors and non-pool donors continued to disburse, and did not produce the desired result. Instead it created an impression that the Bank was inflexible and confrontational. Whereas unification failed, normally divergent voices on the Bangladeshi side became unified in standing up to the Bank, creating fallout which has caused the unification question to be shelved for many years to come. Many other activities became tainted by association with HPSP and suffered as a result.

Decentralization and Hospital Autonomy

3.28 Hospital management was to be reformed in eleven pilot hospitals, including both new management systems and hospital autonomy, enabled in part by the retention of user fees. Although training took place, the new systems were not implemented. In particular, there has not been even a modest delegation of authority to hospital management or development of local accountability. The proposed Hospital Bill to allow autonomy has made little progress.

3.29 Hospital autonomy is an example of an activity which most likely suffered as part of the fall out from the unification experience. Like unification, this was a politically difficult policy. As already argued, the Bank spent all its political capital pushing for unification, leaving it unable to push for progress on hospital autonomy.

Introduction of a Sector Wide Approach

3.30 In contrast to the unsuccessful experience with unification and the lack of progress with respect to hospital autonomy, considerable progress was made in the development of a sector approach. The SWAP lacked some features of an ‘ideal SWAP’. Table 6 summarizes how HPSP fared against desired characteristics of a SWAP as stated by the Bank’s Operations Policy and Country Services (OPCS). However, the OPCS site also states that “there are no strict pre-requisites that must be met in order for an approach to be called a SWAP. Rather, the SWAP is characterized more importantly by the intention and the direction of intervention over time.” The experience in Bangladesh can indeed be seen as such an evolutionary progress, moving from high degrees of coordination under the earlier Population and Health Projects to creating a SWAP framework under HPSP, which is being further developed under HNPSP. Indeed, many now see HPSP as having been a pilot stage for HNPSP. The advantages of a SWAP over a project approach are clearly recognized amongst both government and DPs. Despite the bad name of HPSP, there is no talk at all of going back to a project approach; GoB discourages stand alone projects outside of the SWAP.

Table 6. HPSP Assessed against OPCS SWAP Characteristics

1.	Comprehensive sector policy and strategy	HPSP was under-pinned by a well developed sector strategy, HPSS. However, HPSS covers the activities of MOHFW, rather than the health sector, and so excludes primary health care in urban areas, which is the responsibility of the Ministry of Local Government. Although AIDS and nutrition are mentioned in the sector strategy the programs were not implemented under HPSP.
2.	Annual sector expenditure program and medium-term expenditure framework (MTEF)	No, a MTEF is currently being developed.
3.	Government-led donor coordination	There is effective donor co-ordination, but led by the donors (rotating chair of consortium and Steering Group for pool donors). In effect the Bank has played a lead role, partly on account of HPSO, which is jointly funded but Bank-run.
4.	Sound macroeconomic framework	Yes, Bangladesh has maintained low inflation.
5.	Consistency of sector expenditure program and macroeconomic framework	Yes, budget discipline is reasonable.
6.	Major donors provide support within the sector framework	Partially. Some major donors (notably USAID) are not part of the SWAP, but they are part of the consortium which allows for some coordination.
7.	Donors move towards greater reliance on government financial and accountability systems	Yes. HPSP used government procurement systems and all HPSP projects were on budget, though with a separate account. Under HNPSP funds now channelled using government's financial system.
8.	Significant donor movement towards the adoption of common approaches to implementation and management	Donors participating in pool have fully harmonized approach in all aspects. All donors participate in Annual Performance Review as main monitoring mechanism. However, donors maintain separate M&E procedures and non-pool donors have felt excluded from sector management.
9.	Participation of key stakeholders in sector policy	Yes, there were wide consultations in the development of HPSS.

4. OUTCOMES AND RATINGS

Relevance

4.1 The objectives of both projects are highly consistent with the overall strategies of government and the Bank. FPHP was aligned with the country's Fifth Five Year Plan, taking its quantitative targets from that document. The I-PRSP, issued in March 2003, includes as one of its goals to "ensure effective and equitable access to health services to all", stating that "the control of communicable diseases and improved maternal and child health to reduce high child and maternal mortality remains the highest public priorities". "Consolidating gains in human development" is the first "line of attack on poverty" in the Bank's 2003 Country Assistance Strategy (CAS).

4.2 Whilst, relevant at the overall level, some specific points about relevance can nonetheless be made. First, the objectives of FPHP were rather over-extended, including the reduction of maternal mortality and nutrition objectives which were not realistic as there were few activities related to achieving these objectives. Second, HPPP aimed to both improve service delivery whilst at the same time undertaking a substantial reorganization, which proved extremely disruptive. Tackling both at once was somewhat unrealistic. Whilst unification and decentralization and establishing the ESP were all desirable steps, the net result was that none of these were achieved. A phased approach giving greater chance of success to any one of them would therefore have been preferable. Third, the I-PRSP supports "health for all" and the project objectives and targets relate to health outcomes for Bangladesh as a whole. But, as noted above, MOHFW is responsible only for health in rural areas, and the projects only covered those areas. Moreover, public services account for a minority of service provision, with the private sector (NGOs, for profit, and traditional) being more important but which had limited engagement in the two projects. This is least so for NGOs, who were involved in both preparation and service delivery, though not on the scale envisaged. But the project withdrew from training traditional TBAs, and did little with the modern for-profit private sector.

Efficacy

Continuing Bangladesh's Successful Track Record

4.3 In the 25 years following independence, Bangladesh achieved rapid reductions in both fertility and under-five mortality. The decline in the TFR continued, albeit at a slower pace, during the 1990s,[56] as contraceptive prevalence continued to rise (Figure 3b). The decline in under-five mortality was most rapid in the 1980s, matching the period in which the immunization program became established (Figures 3c and 3d). The decline slowed in most recent years, progress in reducing infant mortality stalling altogether. Progress in immunization faltered in the mid-90s, but has since recovered. Continued expansion in immunization coverage is consistent with the fact that child mortality has continued to fall, whereas infant mortality, which is more dependent on other medical services, halted its decline.

56. It is commonly argued that fertility decline stalled (hit a plateau) in the mid-90s. However, as shown in IEG's study, this assessment is a mis-reading of the data, with several reasons to believe that the rate continued to decline.

Figure 3(a). Total Fertility Rate

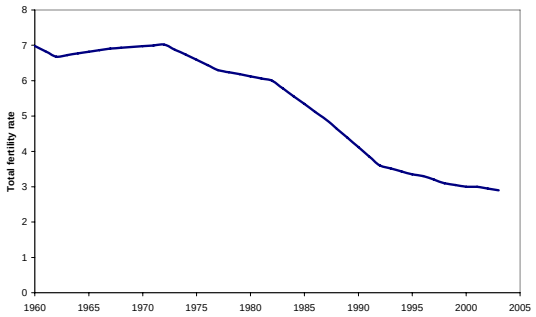


Figure 3(b). Contraceptive Knowledge and Prevalence

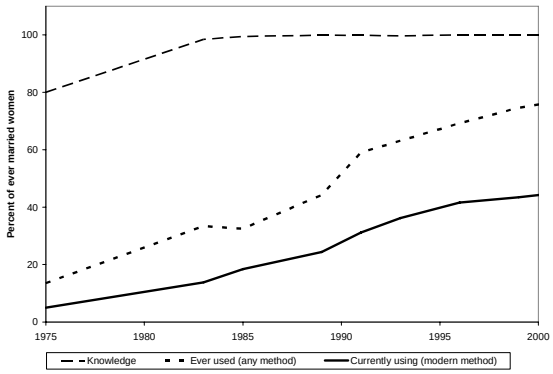


Figure 3(c). Under-five Mortality Rate (per 1,000 live births)

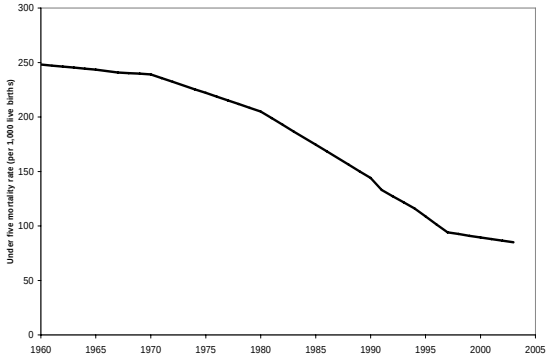
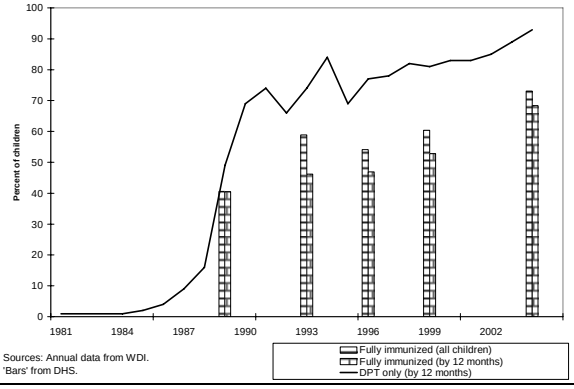


Figure 3(d). Immunization Coverage



Source: DHS. Note: DHS reports data for five year periods, e.g. fives years preceding the survey. These figures are taken to refer to the mid-point in the period and the series interpolated between surveys. The most recent years are an extrapolation of the most recently observed between-survey trend.

Objective-related Outcomes

4.4 Table 7 reports outcome indicators with respect to the main common areas in the objectives of the two projects. FPHP achieved lower fertility, higher contraceptive prevalence, lower infant and child mortality, a modest reduction in maternal mortality and increased access to services. The picture was more mixed under HPPP, service use fell, e.g. fewer children with ARI or fever were taken to clinics, and infant mortality stagnated. But immunization and antenatal care improved, as did fertility, child mortality, and maternal mortality.

Poverty Aspects

4.5 The project objectives targeted poor men and women. Whilst there have been no specific mechanisms for targeting the poor, the overall design of the projects did this in two ways: (1) focus on essential health services in rural areas, and (2) expanding public services at a time when the less poor increasingly relied on private providers. These factors mean that increases in service coverage will include the poor, often disproportionately so. Figure 4(a) shows that under-five mortality has fallen more rapidly

among the poor than the non-poor, so that the ratio of mortality rates between the two groups, shown by the dotted line, has declined. The proportion of children with no vaccination has declined dramatically from around one-third to less than 5 percent (Figure 4b). The increase in coverage has benefited all groups, far outweighing the remaining variations in coverage between wealth groups.

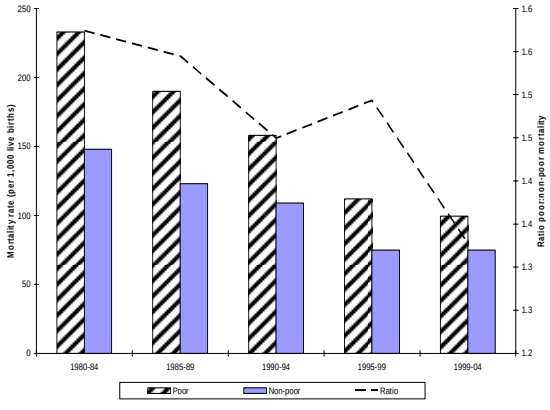
Table 7. Objective related Outcomes

Objective	*Indicator*	*FPHP*	*HPPP*
Reduce fertility/continued improvements in FP	Total fertility rate	1993/94: 3.91 1999/00: 3.3	2004: 3.0
Lower morbidity and mortality/continued improvements in child health	Infant mortality rate per 1,000 live births	1993/94: 87.6 1999/00: 66.3	2004: 65.2
	Child mortality rate	1993/94: 50.3 1999/00: 29.8	2004: 24.0
Lower maternal mortality and morbidity	Maternal mortality rate	Early 90s: 485 Late 90s: 449	Early 2000s: 400
Achieve better access to essential services for the poor	Percent bottom quintile with no vaccination	1993/94: 37.0 1999/00: 13.5	2004: 6.0
	Percent of children with ARI or fever taken to health facility	19967/97: 32.9	1999/00: 27.3 2004: 19.9

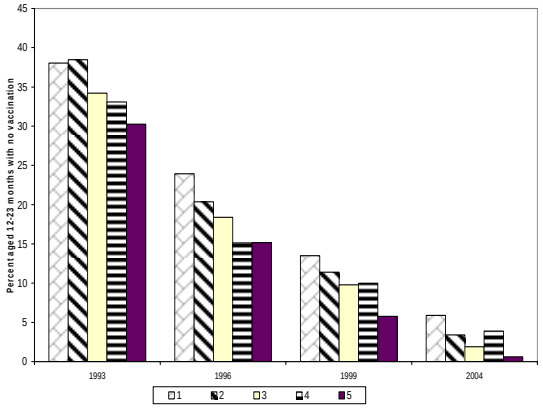
Note : Figures are direct estimates from DHS, but IEG's own analysis suggests the direct estimate from the first round is about 0.5 too low. Making this revision produces a trend consistent with the indirect estimates. Source: http://www.measuredhs.com/countries/country.cfm?ctry_id=1. Accessed 04/27/06.

Figure 4. The Poor have Benefited from Better Outputs and Outcomes

(a) Under-five mortality rates for poor and non-poor



(b) Percent of children aged 12-23 months with no vaccination by wealth quintile



Source: own analysis of DHS 1992/93, 967/97 and 99/00 data; 2004 data from DHS report.

Performance on Specific Objectives

4.6 Health and family planning outcomes continued to improve during the project, although falling short of the ambitious targets that were set, especially for nutrition where the project in the end did little as a new project was starting. The record on specific objectives was as follows:

- Reduce fertility by increasing the CPR to 45-50 percent: Achieved. The proportion of married women currently using contraception was 40 percent in 1991 and 50 percent in 1996/97.

- Lower morbidity and mortality in children under five: Achieved. In the five years preceding the 1992/93 DHS the under-five mortality rate was 134 and the infant mortality rate 88; in the five years before 1999/00 these figures had fallen to 94 and 66 respectively. Reliable morbidity data are difficult to obtain; the data from DHS (fever, cough and diarrhoea) show no clear trend.[57]

- Improve maternal care and ensure safer deliveries thereby reducing maternal mortality from the current 6-8 to 4-5 per 1,000 live births: Partially achieved. There has been a decline in maternal mortality, though not to the extent hoped for.[58] Since FPHP had little on maternal health this is not surprising. There has, however, been a rise in EOC.

- Reduce disability, morbidity and mortality from common poverty-related diseases: Achieved. The TB and leprosy programs are notable areas of success. More generally the project supported the continued expansion of public health services.

- Enhance the nutritional status of women and children: The project did too little in the nutritional field to achieve this outcome, these activities being picked up by the separate Bangladesh Integrated Nutrition Project. The main area of activity was Vitamin A supplementation, which was successful in raising coverage from less than 50 percent to 80 percent over the life of the project.

- Improve effectiveness and efficiency in the planning and delivery of FP and health services to accelerate the achievement of the above objectives: Not achieved. There were no significant institutional reforms during FPHP.

Health and Population Program Project

4.7 Whilst health outcomes continued to improve under HPPP, progress was not uniform, as infant mortality stagnated. To the extent that there were improvements, it is less plausible to claim such a clear link with the project as was the case with previous

57. DHS 92/93 to 96/97 show a reduction in ARI and diarrhoea prevalence, but this trend did not continue in the next two rounds.

58. Whilst the maternal mortality survey showed a MMR of 4 per 1,000 by the early part of this decade, it estimated it to have been 4.9 per 1,000 a decade earlier, rather than the 6-7 per 1,000 believed when the target was set. Hence the percentage reduction was less than planned.

projects. The continued provision of health and family planning services may have played a role: but many specific components of HPPP did not contribute to this. Construction efforts focused on community clinics which are not utilized. Attempts to reform health services failed, and indeed disrupted service delivery: use of government facilities fell and home visits dropped dramatically. Reductions in service use may have actually contributed to worsening health status, including the stagnation of infan mortality. However, services have since been restored – and some services, such as satellite clinics for immunization – continued throughout, as shown by the steady rise in immunization coverage. So some activities supported by the program did contribute to the continued improvement in outcomes, but those activities where the bulk of the money was spent did not.

4.8 Performance by specific objectives was as follows:

- Technical support and funding to improve coverage and quality of essential health and family planning services for vulnerable groups, particularly poor women and children: At best partially achieved. The community clinics failed and utilization of some public facilities declined in the unification period (though has since recovered). These shortcomings were not because government did not provide the agreed finance, which it did, but because of the problems in implementation.[59] The continued improvements in health outcomes and fertility reduction in Bangladesh may well have been in spite of HPSP not because of it.

- Support public sector reorganization and reform efforts: Partially achieved. Unification was unsuccessful. However, the SWAP was successfully established, as documented in section 2.

- Laying the groundwork for broader health reform: Not achieved. Although the SWAP was established, unification was reversed and decentralisation reforms were not implemented, and limited engagement with NGOs and, especially, the private sector.

4.9 In summary, FPHP continued that line of cofinanced Bank projects which successfully helped construct the country's health and family planning infrastructure. These **services supported by FPHP have directly contributed to the reduction in fertility and under-five mortality**. By contrast, **HPPP failed on many fronts**. Reforms were not implemented and the major infrastructure was not used. However, the SWAP was successfully established.

Efficiency

4.10 Whilst there is international agreement regarding the success of Bangladesh's family planning program, and the same is coming to be realized of much of its health

59. Under HPSP actual GoB spending was 99.7 percent of that planned, compared to 95.2 percent for the Bank and 79.1 percent for the cofinanciers. Government share of project financing has risen from just 10 percent during the first two projects to 50 percent under HPSP. The HPSP performance indicator that 65 percent of MOHFW spending should be for ESP delivery was surpassed, reaching approximately 70 percent.

program, questions might be raised about cost-effectiveness. However, what little evidence there is shows the country fares well on international comparisons. The FPHP Evaluation reported data on the cost per couple years of protection (CYP) by different means of contraceptive delivery. The CYP range of US$3-6 per year[60] compares favorably with the average of US$12-20 in other low and middle income countries. IEG's impact study estimated that the cost per life saved by immunization was in the range $80-300 per life saved. It is difficult to get comparable data (many studies consider vaccine costs only rather than the cost of vaccination), but estimates are usually in the thousands of dollars rather than hundreds. Finally, the FMRP study on the sector updates international comparisons made by HEU for the cost of inpatient admission and an outpatient visit as a percent of GNP: Bangladesh ranks third and second cheapest respectively (FMRP, 2005: 126-127). All available estimates are thus favorable, suggesting a good level of efficiency.[61] Since the project successfully supported the expansion of this service, **FPHP's efficiency is rated as substantial**. By contrast, HPPP supported creation of new infrastructure which is mostly unused and failed to bring about the intended efficiency-enhancing reforms (disrupting service delivery in the process), so **HPPP's efficiency is negligible**.

Sustainability

4.11 Both projects were part of a continuing partnership between government, the Bank and other DPs, which is now continuing under HNPSP. Government's share of program costs has increased over time, so that the projects have been resilient to the main risks such projects may suffer regarding financial support. In general they are also resilient to any risks associated with weak government ownership or institutional support, though HPPP suffered with respect to these on account of the unification episode. Nonetheless, **the sustainability of the services provided through the projects is likely**. There are two important caveats: (1) the community clinics are barely utilized, and (2) the reform agenda for decentralisation need be kept in focus. If formal decentralization proves impossible, other means for increasing local autonomy and accountability need be sought.

ID Impact

4.12 **Both projects had only a modest impact on institutional development**. Under FPHP there were few activities to improve institutional performance of MOHFW. During HPPP there were instances of successful institutional development, most notably

60. The cost differences between government and NGO delivery were not substantial, with NGOs cheaper in two of the three systems. As is to be expected facility-based delivery was cheapest, and home visit the most expensive.

61. However, to be sure of this conclusion, it is necessary to compare the design of the program with what could be achieved given the same resources taking into account the country's specific cost structure and burden of disease. Such an analysis is precisely what is intended to be carried out in developing an ESP, but, as discussed above, this was not done. In the absence of such analysis, a conclusion cannot be reached regarding cost-effectiveness of the program against its potential cost effectiveness. (A burden of disease analysis, including future projections, was produced by ICDDR-B in 2001 and a unit cost analysis in 2004, though these documents do not seem to have been used in planning HNPSP).

the move to a SWAP, but also the development of procurement capacity and the development of the Health Economics Unit. But there were also ambitious reforms for both unification and decentralization which were not realized, and areas of institutional deterioration such as MIS and BCC. Both projects had substantial amounts of training, but with limited impact on account of both implementation difficulties and the rapid turnover of staff on the government side. Turnover is less of a problem for field level staff who were also trained under both projects. FPHP trained female HAs and TBAs, though the latter was abandoned. HPSP envisaged development of substantial capacity to deliver primary services, but did not do so ineffectively on account of inadequate training.

Outcome

4.13 **FPHP is rated as satisfactory**. Contraceptive prevalence, and so fertility, continued to improve, as did under-five mortality. Whilst the other objectives related to maternal health and nutrition were not achieved, these were over-ambitious and fell beyond the scope of the activities supported by the project.

4.14 **HPSP is rated as unsatisfactory**, despite the continued improvement in outcomes during the period. It can plausibly be claimed that, as has been done in the HPSP indicator reviews, that other factors, such as continued economic growth, the rapid expansion of female education and earlier investments, account for these successes rather than then HPSP since service use actually fell during the course of the project. These falls were a result of the disruption caused by the unification episode, supported by evidence that there has been a recovery since then especially in the use of secondary facilities.

Borrower Performance

4.15 **Borrower performance was satisfactory during FPHP**, with the line staff of the two directorates executing their functions to deliver services. But **borrower performance was unsatisfactory under HPSP**. Government allowed reforms to be stalled and then reversed, despite the high level of commitment that had been there. Service delivery suffered as a result. The Change Management Unit and Project Coordination Cell were disbanded on political grounds. The community clinic concept was also abandoned, a waste of a sizeable investment. Other parts of the reform agenda were neglected.

Bank Performance

4.16 **Bank performance under FPHP was satisfactory**. The project continued a long line of successful projects in the country, contributing to improving welfare outcomes. The Bank continued its successful donor coordination role and oversaw the expansion of the scope of the project to have a stronger health focus.

4.17 Bank staff faced many challenges under HPPP in facilitating the transition of both GoB and other DPs to the SWAP, and there were many notable achievements in the face

of these challenges. But on balance **Bank performance during HPPP is judged as unsatisfactory** for a number of reasons.

4.18 On the design side, the community clinic concept can be seen as a seriously flawed, over-ambitious design, and one supported by insufficient logistical backup and inadequate training for the HAs intended to act as primary health care workers. It would have made sense to focus resources on the under-utilized union level facilities, upgrading their skills and trying to ensure provision of adequate health and family planning services at that level so that patients did not by-pass these centers, going directly to upazilla and district facilities.[62] There were also shortcomings in the design of ESP, which was allowed to become a weakly prioritized wish list. These shortcomings in design reflect poor performance on the part of both the Bank and the government.

4.19 The failure to properly think through the implications of the SWAP, to make sure that it was fully understood by all parties, and check capacity to utilize the new systems must also be laid at the door of the Bank as lead donor. By the time of preparation the Bank did have experience of health sector SWAPs in a number of African countries, but it does not seem that adequate efforts were made to draw on these resources in learning how to apply the approach.

4.20 The main supervision failure is the suspension episode, with a common perception amongst many that the Bank and other pool donors over-reacted and handled the matter in an inflexible manner.[63] These problems may stem from a number of issues in the Bank's management of its health portfolio in Bangladesh. First, there was inadequate separation between HPSO and Bank activities. The Bank should have maintained HNP expertise in the country independent of HPSO. Second, the senior Bank staff member at this time was new to the Bank, whereas responsibility for managing such a large program should ideally rest with someone with more experience in acting as the Bank's representative. Finally, HPSO does not have local staff in professional positions,[64] whereas such staff can play an important intermediary role, especially in difficult circumstances.

4.21 The ratings given in the Project Supervision Reports (PSRs) show some complacency. Financial management was rated satisfactory despite slow disbursement and the large number of audit observations. Second, the project was never rated unsatisfactory with respect to the overall project development objectives, despite the fact that the Bank felt it necessary to suspend the project.

---

62. As noted above, this is *not* just the benefit of hindsight. These same warnings were made during HPSP preparation.

63. This is not the view of Bank staff directly involved at the time who maintain that a stand had to be taken to demonstrate to government that they could not simply ignore all the commitments that had been made. But they concede that they under-estimated government's willingness to stick to its position in the face of donor pressure.

64. It does for nutrition, but this is a separate project.

5. LESSONS LEARNED

5.1 ***Aid-financed health infrastructure can work in improving health outcomes… provided other conditions are in place***: this PPAR has produced additional evidence in support of the main argument of IEG's impact evaluation that the creation of an extensive health and family planning system in Bangladesh, with considerable assistance from external finance, has made a demonstrable improvement to the health outcomes of Bangladeshis. However, this success was achieved through the balanced growth of infrastructure and appropriately trained staff. The experience of the community clinics shows that services will not be used if they lack resources or the skills of the staff are inadequate for what is expected of them.

5.2 ***Public and private provision are complements not substitutes***: The health demands of Bangladeshis are met by both public and private providers. These suppliers do not work in parallel, but co-exist through various symbiotic relationships.

5.3 ***A SWAP takes time to implement and is an evolutionary process***. In Bangladesh it can be said it took 20 years of donor coordination to begin the process of implementing a SWAP. It is not feasible to jump from a project approach to fully-fledged SWAP overnight. Rather institutions need to evolve from one to the other, though a series of interim institutional arrangements. The changing way in which donor funds have been handled under FPHP, HPSP and HNPSP is an example of this.

5.4 ***Wide stakeholder participation in preparation helps ownership but can weaken design***. The broad participatory process made it difficult to prioritize, notably with respect to ESP. A compromise need be sought between participation and technical guidance to working groups in order to maintain satisfactory quality at entry.

5.5 ***Think through the implications of the new system***. The move to a SWAP implies a change in how things are done for both DPs and government in ways which are often not well understood. It is imperative to think through how systems will actually work, and make sure that all involved understand this. This process will necessarily take time.

5.6 ***Draw on the appropriate skills mix.*** Many aspects of the design and implementation of a SWAP do not fall within the competence of health specialists. Thus, the need for appropriate expertise should be recognized and drawn on. Bank staff should seek to draw on the Bank's experience with similar issues in other countries, making sure that local staff, DPs and government can all benefit from this experience.

5.7 ***Failure to assess fully the political economy of reform and to prepare both a proactive plan for addressing/mitigating risks and a contingency plan will considerably diminish prospects for successful reform.*** In a politicised environment policy reversals are the norm not the exception. DPs should be prepared to adapt their approach: maybe renaming institutions will suffice, but it may not be so.

5.8 ***Too much donor/Bank intervention can undermine government capacity and ownership of a SWAP approach.*** Preparation of the SWAP started with a high degree of local ownership. But the extensive role played by donors in the review process, and the

importance of the tasks which eventually fell to HPSO, but would have been better carried out by government, reduced local ownership.

5.9 ***Be realistic in tackling major reform objectives.*** HPSP combined the move to a SWAP with two major sets of reforms: unification and decentralisation, as well as the introduction of a new tier of service delivery at community level. This was rather a lot to hope to achieve in a single project. A more phased approach may have yielded more lasting results in a less acrimonious manner.

Annex A. Basic Data Sheet

FOURTH POPULATION AND HEALTH PROJECT (CREDIT 2259-BD)

Key Project Data *(amounts in US$ million)*

	Appraisal estimate	*Actual or current estimate*	*Actual as % of appraisal estimate*
IDA Loan	180.0	188.4	105
Cofinancing	256.3	265.0	103
Government	165.1	303.2	184
Total project cost	601.4	756.6	126

Cumulative Estimated and Actual Disbursements *(US$ million)*

	FY92	FY93	FY94	FY95	FY96	FY97	FY98	FY99	Total
Appraisal estimate	16.0	39.6	39.0	37.0	33.5	14.9	0.0	0.0	180.0
Actual	12.1	14.0	39.4	25.1	29.9	24.4	42.1	1.4	188.4
Actual as % of estimate	76	35	101	68	110	78	-	-	105

Date of final disbursement: December 3, 1998

Project Dates

	Original	*Actual*
Departure of Appraisal Mission	04/90	10/29/90
Board approval	..	06/06/91
Signing	..	06/21/91
Effectiveness	09/91	03/17/92
Closing date	12/31/96	06/30/98

Staff Inputs (staff weeks)

	Actual/Latest Estimate	
	N° Staff weeks	*US$('000)*
Preappraisal	81.3	200.0
Appraisal	72.8	203.2
Negotiations	29.8	88.6
Supervision	1,186.3	3,151.5
Completion	4.0	17.0
Total	1,374.2	3,660.3

Mission Data

	Date (month/year)	*No. of persons*	*Specializations represented*	*Performance rating*	
				Implementation status	Development objectives
Identification/ Preparation	03/90	10	TM, SPS, PS, OA, P, PO, SHS, PHS		
Appraisal through Board Approval	6/91	9	TM, SPS, PS, OA, P. PO, SHS, PHS		
Board Approval through Effectiveness	03/92				
Supervision 1	11/91	10	TM, SPS, PS, OA, P, PO, SHS, PHS	1	1
Supervision 2	04/92	9	TM, PS, W, P, OA, P HS, SHS	1	1
Supervision 3	10/92	10	TM, PS, W, P, OA, PHS, SHS	1	1
Supervision 4	03/93	11	TM, PS, W, P, OA, PHS, SHS	1	1
Supervision 5	10/93	11	TM, PS, W, P, OA, PHS, SHS	2	1
Supervision 6	05/94	11	TM, PS, W, P, OA, PHS, SHS	S	S
Supervision 7	11/94	10	TM, PS, W, PHS, P, SHS	S	S
Supervision 8	05/95	11	TM, PS, W. P, OA, PHS, SHS, PE	S	S
Supervision 9	11/95	8	TM, PS, W. P, OA, P, HS, SHS, SPA, HE	HS	HS
Supervision 10	06/96	8	TM, PS, W, P, OA, PHS, SHS, SPA, HE	S	S
Supervision 11	12/96	8	TM, PS, W, P, OA, PHS, SHS, SPA, HE	S	S
Supervision 12	08/97	11	TM, PS, W, P, OA, PHS, SHS, SPA	S	S
Supervision 13	06/98	8	TM, PS, W, P, OA, PHS, LS, SS	S	S
ICR	12/98	1	PS		

Specializations Represented: TM=Task Manager; SS=Social Scientist; W=Women in Development; PHS=Public Health Specialist; PS=Population Specialist; P=Procurement Officer; OA=Operations Analyst; PO=Project Officer; SHS=Senior PHN Specialist; SPA=Senior Population Advisor; HS=Health Economist; PE=Principal Economist; LS=Lead Specialist

Performance Rating: 1: Improving; 2: Stationary; S: Satisfactory; HS: Highly Satisfactory

HEALTH AND POPULATION PROGRAM PROJECT (CREDIT 3101-BD)

Key Project Data *(amounts in US$ million)*

	Appraisal estimate	*Actual or current estimate*	*Actual as % of appraisal estimate*
IDA Loan	250.00	238.01	95.2
Cofinancing	192.44	152.28	79.1
Government	2453.45	2445.51	99.7
Total project cost	2895.89	2835.80	97.9

Cumulative Estimated and Actual Disbursements

	FY99	*FY00*	*FY01*	*FY02*	*FY03*	*FY04*	*FY05*	*FY06*
Appraisal estimate (US$M)	40.5	93.2	145.9	198.6	250.6	250.6	250.6	250.6
Actual (US$M)	75.3	109.3	146.9	181.2	199.9	201.8	217.6	222.3
Actual as % of appraisal	186	117	102	91	80	81	87	89
Date of final disbursement:	4/25/2006							

Project Dates

	Original	*Actual*
Project Concept Document		02/22/1996
Appraisal		11/061997
Board approval		06/30/1998
Effectiveness	08/30/1998	07/27/1998
Mid Term Review	03/15/2001	
Closing date	06/30/2003	06/30/2005

Staff Inputs (staff weeks)

	Actual/Latest Estimate	
	N° Staff weeks	*US$('000)*
Identification/Preparation	35.0	82.0
Appraisal/Negotiation	166.1	577.0
Supervision	447.19	1,048.0
ICR	20.0	41.0
Total	668.0	1,748.0

Mission Data

	Date (month/year)	*No. of persons*	*Specializations represented*	*Performance rating*	
				Implementation status	Development objectives
Identification/ Preparation	1/28/1996-2/11/1998 and 3/2/1996 – 3/18/1996	13	Including representatives of 5 consortium donors		
	8/29/1996 – 9/19/1999	12	Including 56 representatives of consortium of 15 donors		
	2/20/1997-3/6/1997	14	Including 70 representatives of consortium of 13 donors		
Appraisal	2/12/1998				

	Date (month/year)	*No. of persons*	*Specializations represented*	*Performance rating*	
				Implementation status	Development objectives
Negotiation	5/18/1998				
Supervision 1	03/23/1999	1	Task Team Leader	U	S
Supervision 2	04/18/1999	10	Sr. Population Specialist, Financial Analyst, Procurement Specialist, Disbursement Officer, Financial Management Specialist, Lead HD Specialist, Operations Officer, Sr. Population Adviser, Management Specialist	S	S
Supervision 3	6/24/1999	1	Task Team Leader	S	S
Supervision 4	11/18/1999	3	Sr. Population Specialist, Lead HD Specialist, Operations Officer	U	S
Supervision 5	1/13/2000	1	Task Team Leader	U	S
Supervision 6	3/4/2000	1	(size and professional composition of review team not available	U	S
Supervision 7	6/14/2000	1	Task Team Leader	S	S
Supervision 8	10/25/2000	1	Task Team Leader	S	S
Supervision 9	12/17/2000	1	Task Team Leader	S	S
Supervisión 10 – Technical Review	04/01/2001	4	Sr. Population Specialist, Sr. Institutional Development Specialist, Sr. Public Health Specialist, Sr. Operations Officer	S	S
Supervision 11	06/25/2001	1	Task Team Leader	S	S
Supervision 12	10/20/2001	12	Team covered Public Health Services, Logistics and Organization, Human Resources Development, Behavior Change, Communications, Monitoring Systems, Financial Management	S	S
Supervision 13	12/12/2001	1	Task Team Leader	S	S
Supervision 14	06/23/2002	1	Task Team Leader	S	S
Supervisión 15	12/23/2003	1	Task Team Leader	S	S
Supervisión 16	12/28/2004	1	Task Team Leader	S	S
Supervisión 17	04/03/2005	10	Sr. Health Economist, Lead Public Health Specialist, Sr. Counsel, Program Assistant, Consultants (procurement and disbursement), Sr. Financial Management Specialist, Senior Finance Officer, Health Specialist, Research Assistant	S	S
Supervisión 18	07/29/2005	1	Task Team Leader	S	S
ICR					
	09/26/2005	5	Sr. Public Health Specialist, Consultant (Project Adviser), Operations Officer, Public Health Specialist, Team Assistant	S	S

Performance Rating: S: Satisfactory; U: Unsatisfactory

Annex B. Selected tables

Table B.1 FPHP sub-components budget outturns

	Appraisal estimate	Actual	Actual as % appraisal	Share of actual
Family Planning/MCH Service Delivery	359.8	519.6	144	68.7
Access to FP services	200.9	361.2	180	47.8
Strengthening of MCH services	43.7	61.3	140	8.1
Clinical services development	34.7	25.8	74	3.4
In-service training				
NIPORT	13.5	14.2	105	1.9
TBA training	5.3	2.7	51	0.4
FP facilities				
Construction and upgrading of FWCs and RDs	36.0	36.9	103	4.9
Upgrading of MCH Training Institute	9.2	0.0	0	0.0
Strengthening of FP/MCH logistics supply system	2.2	3.6	164	0.5
Private sector contraceptive marketing	14.4	13.9	97	1.8
Health Service Delivery	157.2	176.7	112	23.4
Maternal and neonatal health care project	2.3	3.3	143	0.4
Strengthening nursing and medical education				
Nursing education	12.8	12.5	98	1.7
Medical education	15.1	11.6	77	1.5
Medical quality assurance	1.2	1.0	83	0.1
Institute of Child and Maternal Health	9.8	15.3	156	2.0
Expansion and development of NIPSOM	7.6	3.3	43	0.4
Development research in Bangladesh	1.6	1.5	94	0.2
Disease prevention and control				
TB and leprosy programs	30.4	14.3	47	1.9
EPI and CDD programs	7.1	54.2	763	7.2
Vitamin A and Iodine deficiencies and ARI	15.8	8.7	55	1.2
Control of vector-borne diseases	1.3	2.0	154	0.3
Intestinal parasite control	0.5	0.5	100	0.1
Expansion of Institute of Public Health	1.1	3.4	309	0.4
Modernization of drug testing labatorary	0.6	0.5	83	0.1
Development of Urban PHC	2.4	0.0	0	0.0
Expansion of school health program	1.2	0.6	50	0.1
Improvement of health facilities				
Development of District and Medical College Hospitals	11.5	15.6	136	2.1
Construction of UHCs	11.8	9.6	81	1.3
Improved utilization of UHCs and FWCs	23.0	18.8	82	2.5
Supporting Activities to Delivery of FP and Health Services	71.9	47.9	67	6.3
Strengthening of Information Systems				
MIS for FP/MCH	2.1	2.0	95	0.3
MIS for health	2.6	1.4	54	0.2
Health and Demographic Survey	0.6	0.2	33	0.0
Epidemiological surveillance system	0.5	0.5	100	0.1
Improving FP & health organization, management and financing				
MDU support to FP and health services	3.5	2.2	63	0.3

	Appraisal estimate	Actual	Actual as % appraisal	Share of actual
Reorganization of health and FP programs	1.6	0.8	50	0.1
Strengthening of PDEU	1.3	0.8	62	0.1
Establishment of MCH coordination cell	1.1	0.2	18	0.0
Establishment of Health Economic and Financing Project	0.4	4.7	1175	0.6
Restructuring of Project Finance Cell	0.4	0.4	100	0.1
Project management support	5.3	5.3	100	0.7
Construction of a FP and Health building	9.7	0.0	0	0.0
Establishment of the MCCU	1.7	2.3	135	0.3
Expansion of communication programs				
Functional integration of IEM and HEB units	7.6	2.2	29	0.3
Support for mass media activities	3.6	2.2	61	0.3
Promotion and community participation	5.4	2.9	54	0.4
Support of NGOs	8.5	13.9	164	1.8
Development of innovative project	5.3	1.7	32	0.2
Support for TA projects	10.8	4.7	44	0.6
Training health personnel				
Human resources development master plan				
Control and prevention of STDs				
Control and prevention of cancer				
Establishment of a pharmaceutical production unit				
Women's and nutrition programs	12.4	12.1	98	1.6
Continued support for three women's programs				
Women's cooperatives	3.7	3.7	100	0.5
Mothers' center	2.8	4.0	143	0.5
Women's vocational training	3.3	2.7	82	0.4
Coordinated nutrition program	2.6	1.2	46	0.2
Total project costs	601.4	756.3	126	100.0

Table B.2 FPHP outputs

	Target	Achieved	Percentage
Construction of Family Welfare Centers	100	87	87
Upgrading of Rural Dispensaries (RDs)	500	429	86
Improvement of infrastructure of Nursing Education Centers	7	7	100
Establishment of Nurses Training Centers	4	4	100
Renovation of Medical Colleges	8	8	100
Construction /repair of Medical College Hospitals for female students	5	5	100
Development of District Hospitals	10	10	100
Establishment of new UHCs	10	10	100
Improvement of infrastructure of Medical College Hospitals	4	4	100
Institute of Maternal and Child Health		Achieved	100
Construction of Leprosy Training Institute and Hospital		Achieved	100
Minor construction/repairs of UHCs (TFIP)		Achieved	100
Maternal and Child Health Training Institute		Cancelled	0
Population and Health Bhavan		Cancelled	0

Source: FPHP ICR p. 20

Table B.3 HPPP Actual and Appraisal Cost by Categories

	US$ millions		Percentage		Actual as percent of appraisal
	Appraisal	Actual	Appraisal	Actual	
Service delivery and policy reform					
Essential service package (ESP)	1,624.8	1,772.4	56.1	62.5	109.1
Hospital services	348.0	345.9	12.0	12.2	99.4
Other public health services	9.6	20.2	0.3	0.7	211.1
Other health and nutrition services	254.0	213.6	8.8	7.5	84.1
Integrated support services	629.0	467.4	21.7	16.5	74.3
Policy and regulations	7.0	1.1	0.2	0.0	15.4
Organization and management reform					
Reorganization of service delivery	3.6	1.9	0.1	0.1	53.0
Sector wide management	20.0	13.3	0.7	0.5	66.7
Total	2,895.9	2,835.8	100.0	100.0	97.9

Annex C. List of Persons Met

Meetings in Dhaka

Government of Bangladesh

Mr. M. Aminul Islam Bhuiyan, Additional Secretary, MOHFW
Mr. Shafiqul Islam, Joint Secretary, Financial Management, MOHFW
Prof. Dr. Md. Shahadat Hossain, Director General, DGHS
Mr. M. A. Akmall Hossain Azad, Director General, Directorate of Family Planning
Mr. Md. Mozzammel Hoque, Joint Chief (Planning), Ministry of Health and FW
Mr. Md. Tajul Islam, Line Director, Planning, Directorate of Health Services
Dr. Syeda Badrun Nahar, Line Director, Communicable Disease Control, DGHS
Prof. Dr. Mahbubur RAhman, Director, PHC, DGHS
Dr. Ahmed Al-Sabbir, Director (Research), NIPORT
Dr. Akhter Hussain Director Training NIPORT
Dr. Md. Abdul Jalil P.K Director,MIS, DGHS
Ms. Ummay Hasina Akhter, Director MIS, DGFP
Mr. A. Waheed Khan, Division Chief, SEI Division, Planning Commission
Mr. Md. Abdul Maleque, Director General, IMED
Mr. Najmus Sakib, Deputy Secretary, Ministry of Finance
Mr. Md. Morshed Alam, Deputy Secretary, PFO, Ministry of Health and FW
Mr. Md. Abdullah, Deputy Chief, Programming Division, Planning Commission
Mr. Muhammad Ali, Former Secretary, MOHFW
Mr. M.M. Reza, Former Secretary, MOHFW
Mr. Waliul Islam, Former Secretary and Team Leader PCC
Mr. M. Fazlur Rahman, Former Secretary, MOHFW
Mr. Md. Nurul Abedin, Former Additional Secretary MOHFW
Mr. Md. Azizul Karim, Former Joint Chief, MOHFW

NGOs/Development Partners

Dr. Jahir Uddin Ahmed, Additional Director General, FPAB
Mr. Iftekhar-uz-Zaman, Executive Director, Transparency International-Bangladesh
Dr. Md. Matiur Rahman, Thengamara Mohila Sabuj Shangha (TMSS)
Ms. Hosne Ara ABegum, TMSS
Md. H. Hasan Siddique, TMSS
Dr. A.J. Faisel, Engender Health
Dr. Ubaidur Rob, Population Council
Mr. Faruque Ahmed, BRAC
Dr. Munir Ahmed, CARE-Bangladesh
Mr. Shohid Hossain, Marie Stopes Clinic
Mr. Syed Khalid Ahsan, Program Officer SIDA
Mr. Peter Herzig, Health Officer, Delegation of EC
Dr. S.M. Asib Nasim, Program Officer, UNICEF
Dr. Enamul Karim, HLSP
Mr. George Komba Kano, Advisor, World Health Organization

Academic, think tank etc.

Prof. Rehman Sobhan, Chairman, Center for Policy Dialogue
Prof. Rounaq Jahan Subhan, Center for Policy Dialogue
Dr. Zafrullah Chowdhury, Chairman, Gono Shastho Kendro
Dr. Syed Jahangeer Haider, Executive Director, READ

World Bank

Ms. Christine Wallich, Country Director, World Bank
Mr. Qaiser Khan, Lead HD Specialist
Dr. Dinesh M. Nair, Health Specialist, World Bank
Dr. Farzana Ishrat, Nutrition Specialist, World Bank
Ms. Suraiya Zannath, Sr. Financial Management Specialist, World Bank
Ms. Nilufar Ahmed, Sr. Social Scientist, World Bank
Mr. Harvinder Singh Suri Consultant, Procurement
Mr. Sadeque Mohammad, Consultant Procurement

Field trip from March 17-19, 06 (on road from Dhaka to Comilla)

Friday, March 17, 06

Dhonarchar, Daudkandi upazila: new 20 bed hospital constructed as extension of UHC, replacing former RD. Met with Mr. Sifatullah, Medical Assistant (MA). (Abandoned RD building nearby).
Elam Private clinic, Daudkandi upazila. Met with doctor-in-charge/owner of clinic.
Chandina Upazila Health Complex (UHC). Dr. Mainuddin, UHFPO.

Saturday March 18, 06, visit to health facilities, Feni district

Feni district hospital (100 bedded): met Civil Surgeon and 10 Consultants, viz. opthalmology, surgery, Gynae, Othopaedics, radiology, pediatrics, etc.

Dagon Bhuyian Upazila Health Complex (UHC), constructed under FPHP. Met UHFPO and MOs.

Hasan Gauripur community clinic (CC), Dagon Bhuiyan upazila (union #3): met the Family Welfare Assistant and Female Health Assistant.

Marie Stopes Clinic, Feni

Dhania Union Family Welfare Center, accompanied by the Deputy Director Family Planning. Met the FWV, SACMO and the MO (MCH).

Sunday March 19, 06, Visit to facilities under Comilla district and the ICMH in Matuail.

Office of the Deputy Director Family Planning Comilla.

MCWC Comilla: met with MO and FWVs.

Family Welfare Visitor Training Institute (FWVTI), Comilla

TARC, Comilla of BRAC, discussed TB DOTS program.

Institute of Child and Mother Health, Matuail. Presentation by the Director and Q&A with Institute deputy directors and professors.

Note: the above list is from the March 2006 field trip undertaken for this PPAR. Other people were met in previous missions undertaken in the context of the IEG impact study, including during two field trips to other divisions.

Other Bank staff

Mr. J. Kang (TM FPHP)
Mr. K. Kostermans
Ms. B. Sorenson
Mr. R. Cortez

Annex D. Brief overview of ICMH activities

ICMH's activities can be summarized as follows:

- Patient care is now provided through the hospital building on the ICMH campus, the nearby ICMH Matuail Hospital, out patient services at Jalkuri and community based services. These services are fully utilized with bed occupancy rates exceeding 100 percent in both pediatrics, and obstetrics and gynecology departments.[1]

- Teaching and training has ranged from international conferences to training of paramedics in ESP. ICMH was a designated Lead Training Organization, providing substantial amounts of training financed by FPHP and HPSP, for both health and family planning staff. However, since the Institute was constructed with ample facilities, usage rate (including of residential accommodation) is currently around 50-60 percent.

- Staff have been carried out close to 100 research projects, some financed by HPSP, but also attracting funding from a range of organizations. About one-fifth of these projects have resulted in publications in internationally refereed publications. Policy has been informed by some of this research, most notably the UNICEF-funded survey of injuries which identified the importance of drowning as a cause of child death.

- ICMH became autonomous in 2002 and has been covering a growing share of its costs, achieving 37 percent in the last financial year. It is not, however, intended to achieve full cost recovery status (the target is 50 percent).

1. ICMH claims to be the busiest pediatric department in the country, with 300-500 cases a day. However, the mission visited Feni District Hospital, which handles 800 outpatients a day, and so is at least close to the same number of pediatric cases.

Annex E. Vertical Programs in a SWAP: the case of the National TB Program (NTP)

A WHO report (WHO, 2004) identifies difficulties faced in integrating NTP into HPSP, drawing parallels with the fate of the country's malaria program.

Bangladesh had a successful, vertically operated, Malaria Eradication Program, which begun to be integrated into the Integrated Upazilla Health Program from 1977 with the result that malaria control work at thana and district level started to be undertaken by staff without expertise in malaria; as one report put it, it was the malariologists who were being eradicated not malaria. Moreover, funding became available only for curative care rather than prevention. The resurgence of malaria in the Chittagong Hill Tracts and Cox's Bazaar area is linked to these weaknesses (WHO, 2004).

Turning to NTP the WHO report identifies several issues to be faced in integrating the program into the SWAP. First, the centralization of program management restricts the flexibility needed by individual programs such as NTP, and may cause them to lose momentum as focus shifts to management systems and away from service delivery. However, this argument does not appear valid in the light of recent events. There was a polio case in Comilla (the first in five years) immediately prior to the PPAR mission and a meeting of government and DPs quickly convened to agree a response. Respondents argued that the SWAP allowed such a rapid response, since under the old project approach approval would have had to be sought from the Ministry of Planning. Second, the WHO report points out that the overall objective of HPSP includes improving the health of vulnerable women, and TB is recognized as the major killer of women during their reproductive years. But NTP does not appear in the log frame, nor do any TB-related measures appear amongst the indicators. The report also argues that even in NTP achieves its objectives it will not reduce the number of active new cases emerging as there are already 60 million people infected, so a new, more comprehensive approach, is needed. HPSP potentially provides the opportunity for this more comprehensive approach, since integration means that, for example, TB-related messages can be incorporated into BCC, better coordination with other programs such as that for HIV/AIDS (e.g. joint training), and NTP can become involved in quality control of private sector treatment of TB. However, to date these remain largely potential advantages rather than actual ones.