Document of
The World Bank

Report No: 34755

IMPLEMENTATION COMPLETION REPORT
(IDA-31010 TF-21202 TF-21438 TF-22374 TF-22699 TF-23774)

ON A

CREDIT

IN THE AMOUNT OF SDR 185.5 MILLION (US$250 MILLION EQUIVALENT)

TO THE

GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH

FOR A

HEALTH AND POPULATION PROGRAM PROJECT

December 28, 2005

CURRENCY EQUIVALENTS

(Exchange Rate Effective November 15, 2005)

Currency Unit	=	Bangladeshi Takas
Takas. 65.735	=	US$ 1.00
US$ 1.00	=	Takas.0.015213

FISCAL YEAR

July 1 - June 30

ABBREVIATIONS AND ACRONYMS

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ADP	Annual Development Plan
ANC	Antenatal Care
AOP	Annual Operational Plan
APR	Annual Program Review
BCC	Behavior Change Communication
BINP	Bangladesh Integrated Nutrition Project
BMRC	Bangladesh Medical Research Council
BRAC	Bangladesh Rural Advancement Committee
CAS	Country Assistance Strategy
CIDA	Canadian International Development Association
CMMU	Construction and Maintenance Management Unit
CMU	Change Management Unit
DCA	Development Credit Agreement
DfID	Department for International Development (United Kingdom)
DGFP	Director General Family Planning
DGHS	Director General Health Services
DHS	Demographic and Health Survey
DMC	District Management Committee
DP	Development Partners
EC	European Commission
EOC	Essential Obstetric Care
ESP	Essential Services Package
EU	European Union
FP	Family Planning
FPHP	Fourth Population and Health Program
GoB	Government of Bangladesh
GTZ	Gesellschaft fler Technische Zusammenarbeit (Germany)
HFWC	Health and Welfare Family clinic
HPPP	Health and Population Program Project
HPSP	Health and Population Sector Program
HPSS	Health and Population Sector Strategy
HPSO	Health Program Support Office
HRD	Human Resource Development
ICB	International Competitive Bidding
ICPD	International Conference on Population and Development

IDA	International Development Association (World Bank)
ICDDR ,B	International Center for Diarrheal Disease Research, Bangladesh
IEPS	Initiating Executive Project Summary
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate
KfW	Kreditanstalt fuer Wiederaufbau (Gernany)
LD	Line Director
LMIS	Logistics Management Information System
MAU	Management Accounting Unit
MCH	Maternal & Child Health
MCU	Management Change Unit
MIS	Management Information System
MMR	Maternal Mortality Ratio
MOHFW	Ministry of Health and Family Welfare, Government of Bangladesh
NCB	National Competitive Bidding
NGO	Non-Government Organization
NIPORT	National Institute of Population Research & Training
NNP	National Nutrition Project
PAD	Project Appraisal Document
PCC	Program Coordination Cell, MOHFW
PHC	Primary Health Care
PHO	Population & Health Office
PIP	Program Implementation Plan
QAG	Quality Assurance Group
RIBEC	Reforms in Budgeting and Expenditure Control
SBD	Standard Bidding Documents
SDS	Service Delivery Surveys
SIDA	Swedish International Development Association
SOE	Statement of Expenditures
STD	Sexually Transmitted Diseases
TA	Technical Assistance
UHFWC	Union Health and Family Welfare Center
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD/US$	U.S. Dollar
WDR	World Development Report
WHO	World Health Organization

Vice President:	Praful C. Patel
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BANGLADESH
Health and Population Program Project

CONTENTS

Project ID: P037857	*Project Name:* Health and Population Program Project
Team Leader: Sandra Rosenhouse	*TL Unit:* SASHD
ICR Type: Core ICR	*Report Date: December 28, 2005*

1. Project Data

Name: Health and Population Program Project

L/C/TF Number: IDA-31010; TF-21202; TF-21438; TF-22374; TF-22699; TF-23774

Country/Department: BANGLADESH

Region: South Asia Regional Office

Sector/subsector: Health (97%); Central government administration (2%); General education sector (1%)

Theme: Population and reproductive health (P); Child health (P); Other communicable diseases (P); Participation and civic engagement (P); Administrative and civil service reform (P)

KEY DATES			*Original*	*Revised/Actual*
PCD:	02/22/1996	*Effective:*	08/30/1998	07/27/1998
Appraisal:	11/06/1997	*MTR:*	03/15/2001	
Approval:	06/30/1998	*Closing:*	06/30/2003	06/30/2005

Borrower/Implementing Agency: GOB/MOHFW

Other Partners: Development Partners include CIDA, DFID, EC, KFW, GTZ, SIDA and the Netherlands

STAFF	Current	At Appraisal
Vice President:	Praful C. Patel	Mieko Nishimizu
Country Director:	Christine I. Wallich	Pierre Landell-Mills
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2. Principal Performance Ratings

(HS=Highly Satisfactory, S=Satisfactory, U=Unsatisfactory, HL=Highly Likely, L=Likely, UN=Unlikely, HUN=Highly Unlikely, HU=Highly Unsatisfactory, H=High, SU=Substantial, M=Modest, N=Negligible)

Outcome:	U
Sustainability:	L
Institutional Development Impact:	SU
Bank Performance:	S
Borrower Performance:	U

	QAG (if available)	ICR
Quality at Entry:		S
Project at Risk at Any Time:	Yes	

3. Assessment of Development Objective and Design, and of Quality at Entry

3.1 Original Objective:

Background

By 1998, Bangladesh had succeeded in reducing population growth rates and total fertility dramatically (by 50%) compared to the mid 1970s along with a similar improvement in virtually all key indicators of maternal and child health over this period. Since 1975, as part of an informal donor consortium, IDA had participated in financing four population and health operations through successive structured investment projects, beginning with the First Population Project (financed as a consortium effort by IDA, Canada, Australia, Norway, Sweden, and the United Kingdom). Other donors participated in subsequent consortium-based programs (European Union, Germany, Netherlands). United Nations agencies (WHO, UNFPA, UNICEF), USAID and ADB also provided support for family planning and health programs, although frequently, outside the purview of the Ministry of Health, Population and Family Welfare (MOHFW). Donor assistance to the health sector has been continuous since 1975, and has been a major source of financing of investment and operating costs (including salaries) through the GoB's "development budget".

Initially, the focus of these operations was predominantly on family planning. However, in the early 1990s, this widened to include other elements of family health and ultimately all basic health services. The broadening of the focus of donor support reflected current international wisdom, which was expressed in the 1994 Cairo International Conference on Population and Development (ICPD). The thrust of ICPD was to improve women's health by adopting a focus on gender and rights, and as a result, countries began to move from a focus on family planning to "reproductive health". Concurrently, the World Bank had just completed the 1993 World Development Report (WDR) "Investing in Health", which assessed the cost-effectiveness of various interventions, and strongly recommended the adoption of an essential package of services as a cost-effective way to tackle some of the most common health problems affecting low income countries at the early stage of the epidemiological transition.

In addition, despite intense coordination efforts amongst Development Partners (DPs), operations had consisted of numerous and fragmented interventions, often running in parallel with separate managers, budgets and expectations. By the end of the Fourth Population and Health Project (FPHP 1998), the GoB investment budget presented the 66 "components" of the program as if they were individual projects. Without the benefit of an objective analysis of the situation, it was believed that the overall aggregate operational cost (both financial and in the effort applied) of these separate programs was higher and the effects less sustainable than if they were folded into a "coordinated program approach", where synergies and economies of scale might be realized.

Since at least 1975, family planning in the MOHFW had functioned as a vertical program within a separate "wing" of the Ministry, under a Director General. This was likely initially the result of donor-led initiatives (later adopted by governments) to give family planning programs the needed attention to bring fertility rates down. This "wing" delivered services primarily through a community-based network of outreach workers. The health "wing" of MOHFW, was also vertically organized, but its services were mainly provided through a clinic-based system,

including all levels of care. The issue of whether the structure of the MOHFW itself, organized with two major "wings", Health and Family Planning, constrained the generation of synergies between services, which had been under discussion since the 1979, had not been adequately resolved by the mid 1990s. There had been at least one attempt to merge the two wings under the FPHP, albeit an unsuccessful one.

Near the end of the FPHP, Bangladesh continued to face the challenge of improving health, as maternal and child health continued to be poor. Unlike the rapid improvements in health status and fertility declines experienced prior to the 1990s, these appeared to some, to be slowing down and reaching a "plateau" in the mid 1990s. Achievements on the ground were uneven. Improvements in family planning coverage and their resulting reductions in fertility were not matched with equally impressive improvements in other aspects of reproductive health nor child health. This would require increased financing for the sector, and the introduction in some reforms in both the practice of delivering health and family planning services, as well as the structures that support this delivery. The Bank, the donor community at large and a substantial number of national stakeholders felt that the new operation offered an opportunity to address these issues.

In what follows, the ICR uses the term "Program" for the overall Government of Bangladesh Health and Population Sector Program (HPSP), including government and Development Partner (DP) funding, and "Project" for the IDA-financed portion of this program, i.e. the Health and Population Program Project (HPPP). The primary focus of this ICR is to assess IDA's performance with respect to the design and implementation of HPSP. In order to harmonize project performance criteria between ICRs and OED evaluations, OPCS has updated ICR guidelines to include the same rating scale. However, the ICR template has not been updated. Thus, although harmonized criteria are used in the text, ICR tables continue to use the previous rating scale.

Objectives

The Credit was designed to assist the Government of Bangladesh (GoB) to implement its Health and Population Sector Strategy (HPSS) it prepared prior to project identification. The strategy was supported by the Development Partners (DPs), including IDA. IDA's contribution to the program was the Health and Population Program Project (HPPP, Credit 31010-BD). The HPPP development objectives were the same as the objectives of the HPSP. Although project development objectives were stated in slightly different ways in the DCA and PAD, essentially were to: *improve the health and nutrition and reduce fertility of vulnerable groups, particularly poor women and children.*

This would be achieved through three means:

(a) by increasing the coverage and quality of essential health and family planning services through the provision of a carefully designed "Essential Services Package" addressing the basic health needs of the population;

(b) by introducing public sector reorganization and reform efforts to increase efficiency and cost-effectiveness of services, and laying the groundwork for broader health reform;

(c) by enhancing sector-wide management capacity to increase effectiveness and efficiency of

implementation.

The two major strategies to achieve the development objective are thus: to focus public resources on the delivery of an Essential Services Package (ESP) that benefits vulnerable groups, and the introduction of sectoral reforms to ensure sustainability, efficiency and cost-effectiveness (including specifically, the unification at the upazila level and the reorganization of MOHFW at the district level and above, improved sector management and decentralization).

The project was fully in line with Country Assistance Strategy (CAS) objectives (CAS Report No. 14998-BD, discussed on 3/31/98) and with recommendations made in the recent WDR of 1993.

3.2 Revised Objective:

The development objectives were not revised during project implementation

3.3 Original Components:

The Bangladesh HPPP/HPSP was designed as a five-year specific investment operation, encompassing two broad sets of activities (Component 1: Service Delivery and Policy Reform and Component 2: Organizational and Management Reform) that included five and three subcomponents, respectively. Program components allowed for some flexibility with respect to the activities to be undertaken, consistent with good practice in social sector lending, allowing details to be presented in Annual Operational Plans (AOPs) of the line departments of the MOHFW. AOPs and their costs would be discussed and agreed each year with the DPs. Thus, program costs were defined as "budget provisions" rather than as a costing of pre-determined inputs for specific outputs. The detail with which each subcomponent was defined varies. Moreover, the number and order of components varies between that in Section C, at the beginning of the PAD, with the Detailed Description of the Project in Annex 2, and with the description in the Credit Agreement. The format followed here is that of the Detailed Description in the PAD. Total program cost over the five years was estimated at US$2.9 billion, out of which IDA and other DPs (CIDA, DfID, EU, GTZ, KfW, Netherlands and SIDA) were to provide US$532.5 million (US$250 million by IDA alone). Funds were actually pooled by IDA, DfID, EC, Netherlands and SIDA. Other DPs provided parallel financing.

Component A: Service Delivery and Policy Reform (US$2872.3 million, or 99 percent of total project costs).

Subcomponent A.1. Development and delivery of an "Essential Services Package" (ESP) containing reproductive and child health care, communicable diseases control and limited curative care (US$1624.8 million, or 56 percent of component costs). The program/project would strengthen the delivery and improve the effectiveness of an ESP, considered most critical to improving the long-term health status of the poor and rural populations. The contents of the package of services and the approach to delivery were very carefully defined. Besides fine-tuning/changing the services to be provided by agreeing to a package of services that addressed the most important health needs of the population, the manner in which services were to be delivered was also altered. Health and family planning services at the thana ("upazila") level and below were to be merged, and a shift from domiciliary services to fixed site services at community clinics for populations of 6000 was envisioned. However, domiciliary visits would be

continued to priority households as needed, complemented by monthly mobile services from Family Welfare Visitors. Thus, services would be integrated at the sub-district level, that is, in approximately 450-500 "upazilas", each with populations of between 50,000 to 300,000. GoB committed itself to devote up to 60 percent of the health sector budget to supporting the ESP (of which less than 50 percent would be for personnel). The subcomponent financed the operational costs of delivering the services, including salaries, medical supplies and equipment. Upgrading of infrastructure, construction of quarters for some medical officers as incentives to retain them in difficult areas was financed out of another subcomponent.

Subcomponent A.2. Improving the performance of public hospitals (US$348.0 million, 12 percent of program costs). This subcomponent sought to improve the management of public hospitals by providing them with greater autonomy combined with local accountability, thus improving the quality, efficiency and effectiveness of services. The latter would be done as a pilot in one Medical College Hospital and a District Hospital. Modern management methods to improve quality would be introduced, and health managers would be trained. Some pilot programs to introduce cost-recovery measures. District hospitals would be upgraded and equipped to support the delivery of the ESP. Interventions to improve the services of tertiary hospitals were limited. This was financed through parallel support from DfID.

Subcomponent A.3 Provision of other public health services (US$9.5 million, 0.3 percent of program costs). Improving a number of additional public health functions was also envisaged for inclusion of various annual operating programs of line departments. These included: Environmental and Industrial Occupational Health, Health Emergency Preparedness, Emerging and Re-emerging Diseases, School Health, Inter-sectoral Approach, and Prevention of STDs and HIV/AIDS. A separate project was prepared to handle Prevention and Control of STDs and HIV/AIDS in December of 2000.

Subcomponent A.4 Provision of other health services including nutrition (US$254 million, or 9 percent of program costs). This component was intended to strengthen secondary care facilities and nutrition services. The latter, however, were not incorporated, as a separate nutrition operation was prepared (the National Nutrition Project).

Subcomponent A.5. Improving general sector support services and functions (US$629 million, or 22 percent of program costs). The program provided resources to introduce and modernize additional key MOHFW services and functions considered critical in the effective provision of ESP, and facilitating the process of integration of the two wings of the Ministry. The main activities included:

(a) The development of a comprehensive behavior change communications (BCC) program to improve health seeking behavior, address knowledge gaps and misperceptions, and improve provider attitudes to generate a client-centered focus. The program would consolidate all existing, fragmented Information, Education and Communication (IEC) activities within the Ministry's separate programs.

(b) Integrate and strengthen Family Planning and Health Management Information Systems (MIS) by ensuring compatibility between the five existing MIS (management of facilities,

logistics, human resources, finance and procurement, and epidemiology) and improving data collection;
(c) unifying and modernizing MOHFW human resources management services;
(d) strengthening facilities construction planning and maintenance services;
(e) unifying and strengthening procurement and logistics management of the two "wings", including development and application of operating procedures, storage and handling facilities improvement, training for about 5,500 operating personnel;
(f) upgrading quality assurance of health care with community oversight;
(g) rationalizing and re-focusing research to support new approaches to delivering the ESP and quality management for both government and private providers;
(h) the expansion of the role of NGOs in the provision of health and family welfare services (to be initially carried out through a parallel project funded by USAID).

Component B: Organizational and Management Reform (US$30.6 million, or 1.0 percent of program costs)

Subcomponent B.1. Restructuring and Rationalization of MOHFW (US$3.6 million or 0.1 percent of program costs). This set of activities was intended to eliminate the bifurcation of the National Family Planning and Health directorates and achieve the integrated delivery of an effective ESP (see Component A.1) and increase access to low income women and children. Reorganization and integration that was to begin at the level of the "upazila" and district (typically containing 8-10 upazilas or a population of between 2-5 million people) would progress through to the unification of operational directorates in the Ministry itself. Restructuring was to begin at the upazila level, involving 50 upazilas initially. A new set of oversight and management arrangements would be created and applied at each level, including the participation of civil society. Job descriptions and assignations would be revised. To complement integration, the Secretariat of the Ministry would also be restructured to strengthen its own role in policy development, strategic planning, legislation, and evaluation of the execution of operational plans, strengthening functions to facilitate its stewardship of the sector, including the restructuring of central directorates and their roles, moving them to an oversight and stewardship function. At the same time, decentralization of management and finance would be sought through a pilot in one Upazila, including purchaser/provider agreements between MOHFW and districts (to be supported through EC parallel funding). Part of the restructuring effort would also include a phased decentralization of authority to hospitals and districts, building on pilot programs in these areas. Very little detail is provided as to how decentralization is to be implemented.

Subcomponent B.2 Sector Program Management (US$19.9 million, or 0.7 percent of program costs). The Ministry would introduce "sector based programming" (a sector wide approach) in an attempt to unify and reduce fragmentation of efforts and financing that had hitherto prevailed. The concept of the SWAp had been widely discussed and agreed among the GoB and DPs, and there was agreement on what constituted an "ideal state" of a SWAp operation. These included:

(a) existence of a clear sector policy and strategic framework;
(b) clear links between strategies and expenditure plans whereby allocation of resources reflects the strategy over the medium term (a Medium Term Expenditure Framework);

(c) annual operational plans specifying activities under each strategy with appropriate budgets;
(d) annual program reviews to assess progress and plan activities for the next year
(e) integrated management of activities under the responsibilities of line departments rather than as separate projects;
(f) performance monitoring and reporting for operational plans rather than separate projects;
(g) funding the operational plans from pooled funds of donors and government, without earmarks.

An additional feature would be that donor requirements for reporting, justification of disbursements, procurement regimes and financial management regimes would be harmonized and would use government systems to the extent possible for executing these functions.

GoB had already established some of the conditions deemed necessary prior to program launching, including the development of a new Health and Population Sector Strategy (HPSS) that had wide acceptance by DPs and a summary (5 page) Program Implementation Plan (PIP) that set an overall framework for operationalizing the strategy. The subcomponent would provide additional resources to support the development of the remaining elements: training for line directors (LDs) and the Ministry in general on the preparation of Annual Operational Plans (AOP)s; and preparation of Annual Performance Reviews (APRs) with DPs. The program would also reinforce the capacity of the Secretariat to manage the sector under the new regime by establishing or strengthening four new management units: a Planning and Monitoring Unit, a Policy and Research Unit, a Regulation Section, and a Finance and Administration Section. These would be supported by a donor assisted Program Coordination Cell (PCC) embedded in the Ministry, responsible for program coordination, mobilization of resources for the various activities to be undertaken, coordination of technical assistance and organizing and carrying out the APRs. Finally, the program would support a Change Management Unit (CMU), also embedded in the MOHFW, with responsibilities for the design and negotiation of regulatory changes required to carry out the restructuring of the Ministry and the transition to "sector management". As there were long-standing governance issues in Bangladesh, donors felt that they needed a separate support office outside the MOHFW was needed to assist the MOHFW in tracking and managing financial and procurement.

Subcomponent B.3 Health Policy Reform (US$7.0 million, or 0.2 percent of program costs). The program would support research, study and consultations aimed at addressing a number of pertinent health sector policy and regulatory issues covering the national drugs policy, selective cost recovery measures, public-private partnerships, health insurance schemes, adoption of a patient's charter of rights, assuring gender sensitivity in the provision of services; assuring adequate participation of stakeholders; and the management of medical wastes and other environmental impacts of providing medical services.

3.4 Revised Components:

There was no formal revision of project components. A reallocation of loan funds was approved in March 6, 2002, to reflect actual expenditure needs. The project closing date was extended

twice from December 31, 2003 to December 31, 2004 and to June 30, 2005. The latter was necessary because of implementation delays and to cover financing for the program while the follow-on program, HNPSP, was being prepared and approved.

3.5 Quality at Entry:

ICR Rating: Moderately Satisfactory. A formal quality at entry assessment was not carried out for this project. However, a Quality Supervision Assessment (QSA3) of the project was carried out by the Quality Assurance Group (QAG) just one year after effectiveness which comments on project design. The project was fully in line with Country Assistance Strategy (CAS) objectives (CAS Report No. 14998-BD, discussed on 3/31/98) and with a new Health and Population Sector Strategy (HPSS) produced by the GoB prior to program identification. Moreover, the design of the HPSP **contained many elements considered to be international "best practice" at the time.** This was evident in the adoption of an ESP to ensure access to basic care to low income Bangladeshis, and on the basis its contents, which included cost-effective interventions addressing epidemiological profile of the target population.

Moreover, the project/program design was bold in adopting **a program approach, simplifying GoB's transaction costs in dealing with all DPs, and incorporating management arrangements that permitted flexibility in implementation**. These included the use of annual work programming (APRs) and annually-determined costing and budgeting to allow flexibility in changing the work plans for line departments accounting for progress during execution. The large amount of unallocated funding set aside at the beginning of the program also provided donors with flexibility in determining disbursements, and created some incentives for effective implementation. To compensate for limited implementation capacity, the program provided for a PCC, which was staffed with Ministry staff and contractual personnel as a temporary measure, and a MCU (also staffed my MOHFW staff and consultants) to support implementation of the institutional reform components. While such arrangements would not normally be considered a "best practice", in a context where a SWAp was being developed, they could be considered acceptable risk mitigation measures.

However, the proposed overall program was **very complex and ambitious considering the limited managerial capacity of the MOHFW**, a point already flagged in the IEPS as a serious risk. In effect, the strategy called for the introduction of a new concept of service delivery (the adoption of the ESP approach), the introduction of significant organizational/institutional reforms (implying important changes in the approach to service delivery and in the functions of a large proportion of staff at all levels), all while simultaneously attempting to modify the traditional operating style of numerous partner donors (up to 16 separate agencies were involved in programs supporting maternal and child care, nutrition and population sectors). Moreover, several of the reforms implied changes in the regulations that governed civil service, which were under the jurisdiction of the Ministry of the Establishment, and not within the MOHFW's control. The QSA, which rated project supervision during the first year as highly satisfactory, also found project design too complex given limited implementation capacity. While it is clear that a large sector wide program would have greater complexity that an individual project, the absence of a conceptual framework to be able to prioritize and link interventions made this design appear more complex than it needed to be.

There appeared to be an **uneven development of components**, with service delivery aspects being very thoughtfully developed, and reform components lacking sufficient definition. The description of reform components such as decentralization, hospital autonomy, health insurance, for instance, did not give a sense of the complex legal, financial, administrative and behavioral aspects that their design and management would entail. Most importantly, the **reform components were not supported by a conceptual framework** to orient the implementation of reforms. There was no roadmap to guide the prioritization and phasing of the various activities and thus elements of key reforms seemed fragmented and unlinked, and were sometimes missing important elements that would facilitate their effectiveness. While the detail of reforms need not be specified a priori, as they can be developed during implementation, the lack of a framework in fact led to the development of fragmented initiatives that did not build on an overall system.

The complexity of the program proposed is in part the result of the highly participative preparation approach adopted. All key stakeholders, including government, NGOs, private sector and health users were organized into seventeen working groups to prepare different aspects of the program. A participative approach most certainly increased ownership amongst all, but on the downside, prolonged the period of project preparation (29 months from identification to board approval), and made for a complex design. It may be that an independent, highly specialized team could have revised the resulting proposal to make it more focused and internally linked, thus meeting the needs of stakeholders, but also ensuring greater ease of implementation.

The institutional restructuring of the MOHFW was seen as “long overdue” at project preparation. The topic had been under discussion since 1979, and the fusion of Family Planning and Health had been attempted before without much success. However, despite its long incubation period, **an adequate technical and political analysis of its feasibility was not carried out.** Proposals for the reorganization of the MOHFW had been developed by a High Level Committee on Organization and Management Restructuring of Health and Family Welfare Sector as a guide for the program, with technical assistance financed by DfID. While extensively discussed within Bangladesh, the recommendations and the means to implement them appear to have been made largely on the basis of intuition and consensus. While GoB showed clear signs of “ownership” of the proposed unification at the level of the cabinet and senior officials, there was limited buy-in for unification from senior officials at the district level even before the change in government. This "commitment" rapidly vanished with the change in government administration. While the rationale for the unification of the two wings of the Ministry seemed logical from a technical point of view, the powerful resistance to change within the upper levels of the MOHFW should have been foreseen. There might have been other alternatives to integrate service delivery at the point of service that implied a less threatening scenario for those affected.

Of the ten principal risks identified, eight were considered to be “high”. **While risk ratings were by and large appropriate, most mitigation measures were weak** and based principally on the expectation that the MOHFW would actually be able to act on its prior commitments. This unwarranted dependence on planning as a risk mitigating measure was most notable with respect to actions relating to launching the change management program. In fact, it was not recognized that most of the proposed mitigation measures would face their own risks of failure. As a case in

point, a proposal to mitigate the risk of failing to accomplish the planned reorganization by "implement[ing] the reform in a careful, phased manner, with high level political support and accommodation of vested interests" would face the risk that high level support might wane if confronted with objections and inertia emanating from the unionized and civil service staff of over 100,000 persons. No concrete steps had actually been taken to establish a roadmap for phasing the change process, for assessing such "vested interests", or for understanding whether and how they could in fact be accommodated. This left the change process open further risks of failure.

In sum, project/program design takes into account best practices of the day and structures program management so as to move closer to sector wide management, gradually strengthening GoB's ability to deal with numerous donors, and a more horizontal approach to health care delivery. However, the feasibility of the unification of the two wings of the MOHFW was not properly assessed, sector reforms were not linked to a framework to ensure the various pieces would build on each other thus increasing their sustainability, and the project was unnecessarily complex. In view of these issues, the project is rated as **moderately satisfactory**.

4. Achievement of Objective and Outputs

4.1 Outcome/achievement of objective:

The program/project development objective was: to *improve the health and nutrition and reduce fertility of vulnerable groups, particularly poor women and children.*

This would be achieved through three means:

(a) increasing the coverage and quality of essential health and family planning services through the provision of an "Essential Services Package" addressing the basic health needs of the population;

(b) introducing public sector reorganization and reform efforts to increase efficiency and cost-effectiveness of services, and laying the groundwork for broader health reform;

(c) enhancing sector-wide management capacity to increase effectiveness and efficiency of implementation.

While there are a number of household surveys that have measured health outcomes and some of the intermediate indicators related to improved health such as changes in utilization of specific maternal and child health services over the period covered by the HPSP, data on the extent to which quality, efficiency and effectiveness of service delivery was achieved is generally lacking. Thus, this ICR will rely on survey data to address the development objective of the program and the first of the specific objective, and on reports and interviews to assess the achievement of the second and third specific objectives. Survey data come from the series of Demographic and Health Surveys carried out in Bangladesh in 1997, 2000 and 2004, and data from Service Delivery Surveys financed by CIDA in 1999, 2000 and 2003. The latter included both household and service provider questionnaires, and focus more on public perceptions of health and family planning services, and their utilization, and not on measuring health outcomes. Because it is impossible to assess the contribution of IDA's support to program outcomes given the pooling of funds, this section will generally restrict itself to assessing program impact on health status and service utilization. Where possible, the impact and utilization of public health services will be assessed, as IDA funds contributed directly to MOHFW delivered services. While the HPSP had

national coverage, MOHFW services covered mainly rural areas while NGOs supported by DPs mainly worked in urban areas. Thus, outcomes in rural areas are more likely to be linked to HPPP financing.

Improving the health of poor women and children:

ICR Rating: Program/Project: Moderately Unsatisfactory. As DHS data will note, there have been improvements in child health as reflected in lower mortality rates, and a slight reduction in fertility. Nutritional status improvements are evident from 1997 to 2000, with minimal reduction in severe malnutrition, and none in moderate malnutrition thereafter. Data on maternal mortality are scarce. A survey was carried out in 2001 that gave estimates for 1999 of 320 per 100,000 live births but there are no subsequent surveys to use as comparisons (Bangladesh Maternal Mortality Survey). Access to antenatal care and professionally delivered births will be used as a proxy for maternal health. These data are assessed under "access to ESP".

Thus, overall, the program did improve maternal and child health, although not as much as it had originally expected (as the targeted values indicate). However, there were other concurrent social sector investments in Bangladesh that have likely also influenced health outcomes, including improved education for girls, greater access to safe water, improved agricultural production and rural electrification, as a recent OED *"Maintaining Momentum to 2015; An Impact Evaluation of Interventions to Improve Maternal and Child Health and Nutrition in Bangladesh"*, OED 2005. evaluation has shown. Thus, it is not possible to quantify the extent to which the program itself improved health outcomes.

Indicators	**1997**	**2000**	**2004**	**HPSP target**
Infant Mortality	89.6	79.7	72.4	50
Child Mortality	127.8	110.0	96.6	70
Fertility (wm.15-49)	3.3	3.3	3.0	2.5
Nutritional Status of children < 5:				
Wt./Age < 2 sd Mod. Underwgt	56.4	47.6	47.5	35
Wt./Age < 3 sd Severe Underwgt	20.7	12.9	12.8	8
Ht./Age < 2 sd Mod. Stunting	54.7	44.6	43.0	
Ht./Age < 3sd Severe Stunting	28.1	18.2	16.7	

Improved access to ESP:

DHS data on service utilization for Bangladesh as a whole show an increase in institutional births

and professionally assisted deliveries, and increased utilization of antenatal care (ANC) (see below). Child immunization against the basic childhood preventable diseases also increased gradually throughout the period.

Indicators	**1997**	**2000**	**2004**
% Use of Modern Contraception	42.1	44.0	47.6
% Delivery in Health Facility(last 5 years)	4.1	7.6	9.3
% Professionally Assisted Deliveries	8.0	12.1	13.2
% w/out any Antenatal Care	71.4	62.9	44.1
Vaccination:			
Measles	70.1	70.8	75.7
DPT 1	85.0	88.9	93.1
BCG	86.3	91.0	93.4

However, data from Service Delivery Surveys (SDS) note that there was a decline in the use of MOHFW health and family planning treatment services over the period of HPSP (13 to 10 percent from 1999 to 2003), and an increase in the use of private or NGO providers (from 30 to 49 percent for the same period). NGOs, with a long tradition of providing health services in Bangladesh, were financed under a separate project (ADB) through the Ministry of Local Government and Rural Development (MOLGRD), and by USAID, as part of HPSP. Utilization of preventive services, the focus of ESP, also declined from 2 percent of respondents in 2000, to less than one percent in 2003. Government services were also not the main choice for preventive services, with the exception of immunization, where utilization increased from 55 percent to 91 percent from 2000 to 2003. According to SDS, ANC coverage did not increase over the period, although the number of visits per user did increase slightly. Moreover, the proportion relying on government delivered ANC declined from 79 to 63 percent between 1999 and 2003. SDS data on place of delivery show virtually no change in the proportion delivering in a health facility (at 12 percent), although there was a decline in government-based deliveries, from 62 percent to 48 percent from 2000 to 2003.

Decline in utilization of government services is related to declining satisfaction with government-provided services, which declined between 1999 and 2000 and remained low in 2003 (38 percent rated government services as good in 1999 and only 10 percent after 2000). There was, however, no decline in satisfaction during that period for preventive publicly delivered services such as immunization, ANC, family planning and delivery, which form the core of ESP. But, as mentioned earlier, utilization overall is quite low. In sum, while overall there was an improvement in the health status of the population and in health care utilization, it appears that gains were made largely by non-government-provided services, with the exception of immunization. However, other factors such as access to safe water, likely also had a positive effect on child health.

Health Impact on the Poor:

Data on health status and health service utilization by income groups are available from the 2002 Status of Performance Indicators (Streatfield, et al. 2003) based on DHS data for 1996/97 (pre HPSP) and for 2000 (within HPSP). Income quintiles were constructed using household data on ownership of assets and home construction. Earlier Status of Performance Indicators utilized only mother's education as a proxy. Data indicate that infant mortality was 72 percent higher for the poorest households than for the richest in 1996/97. The gap is only slightly reduced to 68 percent in 2000. The declines between the periods, however, take place among the poor. Differentials between rich and poor with respect to under-five mortality are even larger, and increase over time from 83 percent in 1997 to 95 percent in 2000. However, these include deaths occurring during and pre-HPSP. Data also show considerable inequity with respect to under nutrition, with children from the poorest households being twice as likely to be moderately under nourished, and four times as likely to be severely under nourished, than children in the richest households. Despite the fact that under nutrition appears to have declined over time, the gap between the rich and poor widened. Data on service utilization regarding childbirth by trained personnel, and place of delivery, show wide disparities between rich and poor, but no increase in inequity over time. The 2004 DHS includes a similarly constructed wealth index which shows a decrease in inequity in infant mortality (38 percent higher for the poorest), and under five mortality (68 percent higher), and in the rate of severe malnutrition (down from 4 to 3 times higher in poor households) but remains the same for moderate malnutrition.

Although a similar index for the 2004 data is not available, rural-urban differentials can be used as a proxy, even if less sensitive. Moreover, MOHFW-delivered services covered primarily rural areas and thus may be more closely linked to HPPP effects. Given that the data are based on the five years prior to the survey, the changes between 2000 and 2004 are more relevant. The data show a similar trend, indicating marked differences in health status and in utilization of services between rural and urban populations. However, data show a decreasing gap between rural and urban values over time. Data indicate that declines in infant and child mortality, and fertility, are due primarily to changes in rural areas. Nutritional status (underweight and stunting) declined between 1997 and 2000, but remained unchanged from 2000 to 2004. Disaggregating by place of residence shows the change between 1997 and 2000 to be due to changes in rural areas as well and, and very minimal changes from 2000 to 2004. In the absence of a control group, one cannot say whether in the absence of HPPP under nutrition would have increase in rural areas as well. The data suggest, then, that program interventions (and other social investments) generally benefited rural populations more than the urban ones, with the exception of nutritional status, which showed limited effects. Service utilization data from the DHS confirm this pattern. Available published DHS data do not provide breakdowns of utilization of government services by rural/urban residence and thus GoB's role in effecting health status changes cannot be more closely pinned down. And unfortunately, SDS data do not disaggregate by place of residence. However, as indicated before, provision of ESP in rural areas was mainly in the hands of MOHFW, and in the hands of NGOs in urban areas. But it is also likely that investments in other sectors may have also had a greater effect on rural populations.

Indicators	1997		2000		2004	
	Urban	Rural	Urban	Rural	Urban	Rural
Infant Mortality	73.0	91.2	74.2	80.7	72.3	72.4
Child Mortality	96.4	130.9	96.5	112.7	92.2	97.7
Fertility (15-49)	2.1	3.4	2.5	3.5	2.5	3.2
Nutritional Status of children < 5 yrs						
Wt./Age < 2 sd Mod. Underwgt.	41.9	57.9	39.8	49.2	42.2	48.8
Wt./Age. < 3 sd Sev. Underwgt.	14.2	21.4	9.1	13.6	12.1	13.0
Ht./Age < 2 sd Mod. Stunting	34.9	56.3	35.0	46.5	37.7	44.3
Ht./Age < 3sd Sev. Stunting	17.0	29.2	13.0	19.3	13.5	17.4

Indicators	1997		2000		2004	
	Urban	Rural	Urban	Rural	Urban	Rural
% Use of Modern Contracep.	52.8	40.7	49.0	42.7	51.9	46.4
% Delivery in Health Facility	23.2	2.2	24.1	4.3	22.0	6.1
% Prof. Assisted Deliveries	35.0	5.5	33.0	8.0	29.6	9.1
% w/out any Antenatal Care	37.0	74.8	37.7	68.2	25.2	49.1
Vaccination:						
Measles	80.0	69.2	80.6	68.8	82.8	73.9
DPT 1	90.9	84.5	95.0	87.7	93.4	93.0
BCG	91.8	85.8	95.2	90.1	94.2	93.2

Service Delivery Surveys (SDS) show that both in 1999 and 2003, the poorest households were less likely to have used government or private services than less poor households. DHS data confirm this pattern. The poorest households were more likely to use unqualified practitioners. Focus group discussions noted that the poor felt they were discriminated against in government health facilities. Moreover, they could not afford unofficial payments demanded by service providers. Finally, analyses of improvements in equity in access to services and health outcomes were carried out as part of the 2005 Annual Program Review. They indicate that differences between rich and poor in infant and child mortality declined over time. However, differences between rich and poor increased over time with respect to under nutrition indicators, and access to immunization remained the same. Analyses carried out for the 2005 APR also found resource allocation to actually benefit regions and groups that were better off. The latter is not surprising given that the HPSP never introduced a targeting algorithm although it had intended to do so. The issue had been the focus of some analytical work and considerable discussion throughout implementation.

In sum, while overall the health status and overall health care utilization improved over the lifetime of the program, it seems that publicly provided ESP contributed little to these improvements, given low and decreasing utilization rates. It is also unclear that it had a pro-poor impact as the evidence is mixed. Generally, equity seems to have improved since 2000. However, in the absence of a counterfactual, it is difficult to discredit government efforts. Although utilization of government services was low, the program did introduce ESP as the basic services that needed to be provided nationwide, regardless of provider, standardizing service delivery and consolidating a patchwork of project-driven services into a coherent program. GoB also procured contraceptive supplies and vaccines delivered through NGOs. Finally GoB did maintain its share of financing of the sector at 60 to 65 percent over the lifetime of the project. GoB did not, however, increase the share government financing allocated to health as much as expected.

Impact of Institutional Reform on Efficiency and Effectiveness:

With respect to the outcome of the institutional reforms, there are no data to quantify improvements in efficiency and cost-effectiveness. SDS did collect data on service quality (both perceptions and some objective indicators) and in general, quality declined. The unification of family planning and health within MOHFW, which more than likely would have brought efficiencies in the delivery of reproductive and child health services and increased access for women by introducing one-stop services, was only temporarily carried out, and with very negative consequences due to the disruption it caused. The restructuring was carried out at the level of upazilas and below, but was never implemented at the higher levels of the MOHFW's administrative structure. While there was support at local levels, there was much resistance to the change at the district level and above and efforts were made to halt the unification even prior to the change in government in 2001. The measure was rolled back by the new government that assumed power in 2001, bringing about considerable disruption, causing considerable disorder and disaffection, leading to notable losses in productivity. The unification of support services with common functions which were to fall within the purview of the Secretariat also did not

materialize. Had preparation better analyzed the political economy of the unification of the two branches of the MOHFW, or had alternatives to unification been considered during implementation, the disruption could have been avoided.

With respect to the impact of all the other sector reforms, including decentralization, hospital autonomy, cost recovery, health insurance, etc, little was accomplished, as most remained as plans or small pilots. However, one can say that the investments prepared MOHFW to embark in the deepening some of the reforms that were initiated in HPSP as part of HNPSP.

Enhance sector-wide management capacity to increase effectiveness and efficiency

The program made satisfactory progress towards developing a sector wide approach to improving health, on both GoB and DP sides. The approach that GoB and DPs had developed over the years of working together was gradually evolving into sector wide management, and the HPSP served to solidify that progress and move it forward. HPSP fundamentally altered the nature of the relationship between MOHFW and the DPs. It transformed 126 donor-funded projects into a single program. Likewise, while the 1996-97 GoB Annual Development Plan (ADP) showed 93 separate investment and technical assistance "projects" under MOHFW management, the 1998-99 ADP showed one, the HPSP.

However, the concept of the "sector" to be brought under a SWAp itself remains unclear. At present the sector is being defined as activities that are being managed by the MOHFW, rather than the sector as a whole. While MOHFW has the most significant projects under the ADP within its management, the ADP for 2003-04 contained 34 "Health, Population and Family Welfare" projects, only 3 of which were under MOHFW. A vehicle for coordinating these actions into a broader "sector approach" has not been developed. Nevertheless, significant steps were made in moving towards sector-wide management.

Achievements by MOHFW

GoB had developed several of the basic elements of the SWAp prior to program inception, including a sector strategy that DPs accepted as the basis for support and ample experience with coordinated donor support. A large share of the financing of the MOHFW budget (between 35 and 40 percent) was derived from pooled donor sources, and devoted to programmatic purposes. MOHFW condensed 66 individually designated components of the Fourth Population and Health Project (FPHP) into compact budget lines ready for implementation through the regular operations of line directorates. During implementation of the HPSP, operational managers moved toward annual work planning (AOPs) as a line function of the Ministry, allowing the unit's work to be agreed at the beginning of the year rather than on a piece meal basis. These identified the activities and their corresponding budgets for the year, which were then consolidated into a single annual work plan for the MOHFW. The process not only reduced the bureaucratic costs of expenditure approval, but has given the MOHFW more control over budgetary resources. The approach to management also led to a change in Planning Commission-MOHFW operational and decision-making relationships, with the MOHFW being the only Ministry to have this relationship within GoB (APR, 2003).

The APR process was designed as a management instrument for both the MOHFW and DPs to monitor and evaluate the implementation of the HPSP. It was a joint review exercise to assess policy, operational and financial aspects of implementation. The process included: (a) an assessment of independently prepared "status of performance indicators" report; (b) joint GoB-DP field visits; (c) the preparation and review of an independently Technical Review of progress towards HPSP goals; and (d) policy dialogue with respect to the solution of identified problems and the way forward. In the early years it also included a "stakeholder participation meeting" which was later discontinued at the request of the Secretary of Health. The APR process was a joint exercise. The participation of Secretaries and high-level officials from other ministries in the policy dialogue enriched the discussion by allowing a better understanding of DP's concerns and how these could be addressed in a cohesive manner. Up until 2003, the APR was coordinated by the PCC under the chairmanship of the Joint Chief of Planning. A Lead Consultant would be in charge of APR preparation, defining the thematic areas for the TOR and the selection of consultants. HPSO drafted TOR for the APRs, and contracted and managed consultants for the independent reviews. The organization of the reviews was carried out by the PCC. With the elimination of the PCC in 2003, the bulk of coordination passed to the Health Program Support Office (HPSO) as the MOHFW lacked the necessary management and planning capacity to organize the process on its own. MOHFW line directors provided information towards the preparation of reports. While all was done with the final approval of the Secretary, MOHFW could have taken a more proactive role.

While many of the motions with respect to sector wide management appear to be made, there is evidence that although the process has in many ways been adopted, the objectives of it have not. A satisfactory medium term expenditure plan translating the strategy into a spending framework does not appear to have been fully completed, leaving AOPs less well anchored to the overall strategy. Moreover, there seemed to be an over-reliance on planning in the application of AOPs, to the detriment of implementation, supervision and monitoring , and were generally completed as a bureaucratic requirement rather than as a management tool. Part of the problem has to do with the civil service culture that permeates the MOHFW, having few incentives for good performers and no way to discourage bad performance. In part, an objective results-based focus to evaluate the performance of line directors has not materialized owing, perhaps, to the lack of progress in establishing the UMIS (see below). However, it appears that managers are not seriously engaged in the process, as there are no rewards for good planning and good performance. MOHFW has been slow to adopt an "evidence-based" approach to assess progress and steer the program despite the large program of research conducted by the Health Economics Unit, and independent analyses performed by DPs. Finally, although the relationship between MOHFW and DPs was altered, managers still see HPSP as a larger international project that is separate from their routine duties—the fact that MOHFW managers requested to have "assistant managers" to manage HPSP activities for them is an indicator of this perception. In fact, MOHFW has a separate budgeting and planning process for revenue and development (which finances HPSP) budgets, something DPs always disagreed with.

While a concerted effort was made to change the modus operandi to a sector wide approach, an assessment of the savings and efficiencies derived from the new form of management of the

individual projects/programs has not been carried out. Considering the large number of individual operations plans of line directors that are now involved (initially 22, but growing to 38 by the end of the program) the cost of coordination and oversight within the Ministry is growing again so that its comparative advantages are difficult to assess. In sum, there were some important achievements in reaching sector-wide management despite some important remaining challenges.

Achievements by Development Partners

Donors have also made progress in moving towards a SWAp methodology in Bangladesh. They made significant strides within the long standing consortium arrangement that had guided past operations in the sector. A considerable amount of financing was pooled, common management and supervision arrangements were adopted (including reporting, financial management and procurement), and views were coordinated and harmonized. The HPSP brought together 70 percent of the foreign contributions to the health sector. Of the eight DPs IDA, Canada, EC, KFW, GTZ, Netherlands, Sweden, UK providing the bulk of the financial support, five IDA, EC, Netherlands, Sweden, UK pooled their financing, accounting for about 91 percent of the HPSP foreign financing. However, funds were not pooled with GoB funds, but rather, through IDA managed trust funds.

DPs established the HPSO to provide coordination and reporting functions to the Health Donor Consortium. The HPSO was the Consortium's Secretariat. HPSO was managed by an HPSO Steering Committee made up of pool financiers, (in addition to CIDA and KfW who provided parallel support), under rotating chairmanship. HPSO was located in the World Bank and was managed by the World Bank, and financed through DP trust funds. Thus HPSO was to coordinate DP inputs and support MOHFW (jointly with MOHFW's PCC) in monitoring the progress and impact of the sector program, in addition to managing the trust funds through which donor support was being channeled to MOHFW. It was to be the source of financial and procurement information to report to their respective authorities. Of its six main functions originally envisioned for HPSO (forum role, provision of technical assistance, policy dialogue, program review, program progress and trust fund management), only two involved interface with GoB, and only one was specific to the World Bank's role as trust fund manager.

The role of HPSO was the subject of much controversy over the lifetime of the project. A review of HPSO commissioned by the Steering Committee in September of 2004 noted some of its strengths and weaknesses. The HPSO played a critical role in supporting the HPSP, both through ensuring smooth(er) procurement and financial management, as in delivering the necessary technical assistance. While the coordination of DP inputs to HPSP and the monitoring of those inputs were successfully carried out, the report sees HPSO as being less successful in working with the wider DP Consortium who were providing parallel financing and TA. This generated some aggravation between pooling DPs and the wider Consortium. The location of HPSO within the World Bank also generated some conflict, as HPSO came to be seen as a "World Bank" office. The use of World Bank Procurement guidelines for HPSP procurement led to considerable problems in the first two years, leading HPSO to focus much of its time on Bank processing (financial monitoring and procurement) only magnified the impression that HPSO worked for the Bank. With the change in government in 2001, perceptions of HPSO changed, as did its role, with

HPSO being seen more as representing the will of DPs. HPSO's role in coordinating dialogue improved after the lifting of the partial suspension. Moreover, it began to focus more on policy and advice, commissioning studies to inform program decisions. As the report notes, HPSO was understaffed until 2003. The period of suspension appears to have given all concerned time to assess their role and the need to work together.

In sum, considerable harmonization and coordination amongst DPs was achieved, although it was limited mainly to pooling members, leaving important partners outside the process. While there was harmonization of reporting and procurement and financial management, this was achieved by using World Bank approved standards and procedures, not government processes and procedures. This was understandable, however, given the weakness of government systems. Common appreciation of the progress in program implementation was also achieved. Further, a results-based approach to monitoring and evaluation was maintained even in the absence of reliable data from MOHFW, even though a culture of evaluation has yet to be adopted by MOHFW.

4.2 Outputs by components:

A. Service Delivery and Policy Reform

ICR Rating for the Component: Moderately Unsatisfactory.

Subcomponent A.1 Development and Delivery of an "Essential Services Package".
One of the achievements of HPSP was to consolidate a patchwork of project-driven services into a coherent and costed ESP. Moreover, it focused resources on the most cost-effective interventions and on public goods, therefore paving the way for a more efficient allocation of resources. It attempted to introduce a new service module, shifting from domiciliary services to fixed clinic based services at community clinics, supported with outreach visits for priority households. This was also intended to reduce costs and increase efficiency. However, GoB did not devote the needed resources, and, it is likely that the US$4.00 per capita that the PAD estimated as sufficient to provide ESP, was in fact not enough. GoB was to devote about 60-65 percent of the MOHFW Budget to the delivery of ESP of which less than half was spent on personnel, leaving a sizable residual to support implementation. However, during the first three years, less than 60 percent of its budget was allocated to ESP, and by 2002 it was only 57 percent. In fact, public expenditure on health fell in real per capita terms and as a share of total government expenditure during the first three years, rising only in the fourth year to pre-HPSP levels. It is not surprising, then that public health service utilization did not increase and apparently declined, and that quality of care also suffered. Service Delivery Surveys (2003) indicate that ESP utilization was lower at the end of HPSP, than pre-HPSP levels (from 13 to 10 percent). At the same time, use of NGO/private services increased from 30 to 49 percent. The same survey suggests that the client oriented focus in the delivery services did not meet expectations as perceptions of the quality of public services declined in spite of continued efforts to train upazila staff in client-centered approaches. An assessment of community clinics carried out in November 2002 found that not only was staffing below the planned levels, but the skills of staff in the new clinics were insufficient to provide the necessary quality of care, and the needed equipment and drugs were often lacking. The same analysis found them to be very under underutilized, with an average of 12 patients per day when they could easily handle a minimum of

60 (Normand, et al., 2002).

Other factors affecting quality, and thus utilization, have to do with the slowdown in service delivery that the reversal of the unification of family planning and health caused. A third factor had to do with the move away from domiciliary service delivery to clinic based services and the subsequent abandonment of the clinic system. The process of building 13,000 community clinics and making them operational was very delayed. By December 2002, 9413 had been constructed out of which 6707 were "functioning", but no upazilas had implemented the static clinic by then. (Mercer et al. 2005). The newly elected government abandoned the community clinic system in 2003 and domiciliary visits were reintroduced. While outreach work had been declining since before HPSP, these services were particularly affected during HPSP implementation. From 1997 to 2004, the percentage of married women who received a visit from a field worker in the six months prior to the survey declined from 35 percent to 18 percent (SDS, 2003). Thus, while outreach was discouraged, many clinics were not operational and when they were, often clinic-based services did not meet expectations.

In sum, insufficient allocation of funds, translating to poor quality of care, delays in the construction of clinics, and a lack government commitment to the clinic-based system after the change in administration reduced the effectiveness of this subcomponent, which represented 56 percent of HPSP costs. While program-wise, effectiveness was better as it included private/NGO services who were of better quality and whose utilization had been increasing, IDA financing went to government provided services, i.e. HPPP, and as such, this subcomponent met its objectives only partially.

A.2. Improving the performance of public hospitals

The GoB launched a Hospital Improvement Initiative (HII) which targeted eleven secondary and tertiary hospitals in a pilot program, aimed at testing new management systems and procedures, and arrangements which could lead to autonomous management of the facilities. The pilot was to cover training to improve managerial capacity, management of medical wastes, refinement of procurement systems, integration local oversight into management, and define the conditions to allow the retention of fees/payments from users to support operations. Under the auspices of a Hospital Management Committee, managers were trained in new management approaches and a system for the collection and retention of fees for services, was developed. This system was not implemented however, and little progress has been made in granting a meaningful degree of autonomy to pilot hospital managers. Legislation to grant autonomy to the pilot hospitals stalled. The absence of benchmarks or criteria for evaluating the pilot programs has made it difficult to assess progress or to inform a decision on rolling out the experience, even though limited in scope. Towards the end of the program, a further attempt to draft an Umbrella Hospital Bill was initiated but no meaningful action has been taken to press for its passage. Although, by the end of the program, some improvements may have been made in the management of the eleven pilot hospitals, even a modest degree of delegation of authority and local accountability had not been achieved.

Subcomponent A.3 Provision of other public health services

The only public health programs mentioned in documentation on HPSP are the TB program and the HIV/AIDS and STD program (HAPP). HAPP also had its own financing, and like BINP, shared procurement and financial management arrangements until 2003 after the mid-term review of HAPP concluded that it needed to set up its own procurement and financial management team. HAPP will be the subject of a separate ICR.

Subcomponent A.4 Provision of other health services including nutrition

Although the Bangladesh Integrated Nutrition Project had separate financing from HPSP, it did share procurement and financial arrangements with HPSP. The project closed in June 30, 2002 and a follow-on project (National Nutrition Project, NNP) was approved in May of 2000. NNP has separate financing and separate institutional arrangements. Because the Bank considers BINP and NNP separate projects from HPSP, they are not included here.

Subcomponent A.5. Improving general sector support services and functions

The improvement of general support services within MOHFW was uneven, with progress largely interrupted by the change in policy regarding unification of health and family planning wings. The principal results by sub-component include the following:

(i) A comprehensive behavior change communications (BCC) program, which was considered to be a key element in promoting family planning and maternal and child health objectives was not implemented during the life of the project..

(ii) MOHFW developed an excellent plan for a unified MIS (UMIS) and began to implement it. Early in the project, the existing MIS in each of the Family Planning and Health wings were suspended awaiting the development of the UMIS. However, the development of the UMIS itself was abandoned when the process of unifying the family planning and health wings was suspended, leaving the MOHFW “flying blind” for more than 4 years. The only data available were from periodic surveys supported by DPs and service statistics on immunization and contraception. The separated health and family planning MIS were restarted but without improvements relative to the pre-program situation.

(iii) MOHFW has made some progress in strengthening human resources development and management but considering its complexity, it remains very much “work in progress”. The project succeeded in establishing the concept of human resource management as including concerns for personnel development, career building and performance management, as an alternative to the traditional concept of “manpower posting”. Recognizing the constraints posed by existing civil service regulations, and other well-known informal arrangements governing recruitment and allocation of positions, this is a considerable achievement. However, there was no serious attempt to implement the "Strategy for Change" that was drafted for HPSP. Training was regularized as a line function with budgets and accountabilities assigned to line department managers, and a mechanism for promotion and performance based management was introduced in about 25

percent of the upazilas, although the practice remains to be rolled out to the rest. Some decentralization of responsibilities for recruitment and assignment of non-professional staff to District managers (next in line after the Ministry) was also achieved. And, the transfer of close to 70,000 field workers (mostly family planning) from Development (including DP funding) to Revenue budget was partially achieved. However, many issues remain to be resolved.

(iv) The construction and maintenance program was managed by the MOHFW Construction and Maintenance Management Unit. A total of 200 Health and Family Welfare Clinics (HFWC), and 13,000 Community Clinics were to be constructed. Altogether, a total of 152 HFW clinics and 9400 Community Clinics had been completed by December 2002 (Mercer et al, 2005). Besides new construction HFWCs, Upazila Health Complexes and District Hospitals were upgraded and remodeled. The up-gradation of hospitals was carried out through Public Works Department. Construction was suspended following the reversal of unification in 2003. While most of the clinics met location and space specifications (with the exception of provision of toilets and safe water) the quality of construction varied, with about one quarter considered as having insufficient quality (Normand, 2002). Part of the problem was the insufficient supervision of this sub component. There were considerable delays in execution of most of the works, with a lack of documentation regarding the underlying reasons for the delays. Reasons given for delays included floods, unavailability of land, lack of funds, and problems with contractors. Procurement processes sometimes lacked the necessary transparency, and resulted in some declarations of miss-procurement.

(v) Procurement performance has not met all of its expectations and has shown both strengths and weaknesses. The plan to integrate the procurement functions of Family Planning and Health wings was not completed. Building capacity within the two procurement agencies has been difficult and results uneven. Overall, the Family Planning Procurement Unit, which handled a more uniform set of items generally performed better than the Central Medical Stores Depot which handled a larger variety of supplies and equipment. Both units have adopted the use of World Bank procurement methods, although have required significant ongoing training, retraining, and hands-on support from the HPSO. Procurement has required a heavy degree of supervision during implementation to reduce delays and avoid mis-procurement. While there has been basic change in procurement practices in the MOHFW, it entailed considerable technical assistance and oversight. However, the team is now capable of handling considerably larger amounts of contracts than ever before.

(vi) The original intention plan to form a national quality assurance cell, and to establish national, divisional and other quality assurance teams appears not to have been systematically acted upon.

(vii) The program generated a large body of analytical work to support new approaches to delivery through the Health Economics Unit, which, although staffed largely by expatriates, carried out some important research. (DPs also conducted major self-financed studies on relevant sector issues). Unfortunately, much of this has not been used to inform decision-making by the GoB, and as a result, policy and management decisions of the Ministry remained largely driven by political or social concerns. Fortunately, much of the research has informed the development of

the follow-on HNPSP and has not been lost.

(vii) The program envisaged an expansion of the role of NGOs and for-profit providers in the delivery of the ESP, training, monitoring and evaluation of quality, advocacy for patients' rights, among others, and modified the practice of direct contracting with NGOs alone or through umbrella agencies (as practiced in the Fourth Health and Population Project) in favor of earmarking funds for contracting through line directorates of the MOHFW. Studies and discussions of an overall strategy and process of contracting required to engage NGOs were undertaken but not acted upon, although some ad hoc contracting did occur. As a result, in spite of the general recognition of the importance that the NGO and for profit sector as a partner in the sector, and specifically in improving access to services, little was effectively accomplished through the MOHFW. In fact, it wasn't until it was evident that improvements in the basic health indicators were slow to materialize, that it became clear that the role of NGOs and the for-profit sector needed to be strengthened. What was done relied essentially on the actions of three programs funded outside the pool including: the Bangladesh Population and Health Consortium (BPHC) financed by DFID, the National Integrated Health and Family Planning Project financed by USAID, and the Urban Health Project financed by ADB. and under a different Ministry. Only about 1.5 percent of the program's cost was assigned for NGOs or disbursed to them. Eventually, MOHFW ceded the management of selected community centers, numbering less than 100 and about 350 Union Health and Family Welfare Centers to NGOs participating in projects financed by other donors.

B. Organizational and Management Reform

B.1 Restructuring and Rationalization of the MOHFW:

ICR Rating for the Component: Moderately Unsatisfactory.

Restructuring of the MOHFW through the unification of family planning and health services at the upazila level and below was quickly accomplished at the inception of the HPSP through an administrative instruction, rather than in a phased manner as originally agreed. However, the merger of structures and procedures resulted in organizational chaos, creating considerable uncertainty for many staff, effectively paralyzing service delivery. As noted in the 2003 APR, the merger was not designed and implemented in a functional nor fair manner. With a change in government and senior Ministry staff in October 2001, GoB reversed the unification of the Health and Family Planning wings. With the reversal of the unification, the MOHFW's structure reverted to its pre-program position. These decisions had the effect of also suspending plans to unify various support services. There is little evidence that these decisions were based on objective analysis of the relative cost/effectiveness of alternative organizational structures, but, rather on strictly political grounds. There is little evidence that these decisions were based on objective analysis of the relative cost/effectiveness of alternative organizational structures, but, rather on strictly political grounds. Moreover, the restructuring received undue importance among DPs. As the 2003 APR notes, the failure of the unification came to be seen as "the single largest deterrent to MOHFW's organizational performance". The reversal of unification (and lack of progress on other issues) led to a suspension of disbursements in April 2003 that in retrospect could have been

avoided had different alternatives been considered once resistance was clearly evident, and the project had been restructured. This forestalled meaningful dialogue on the matter for some time and soured relationships between GoB and DPs. Most importantly, the objectives of this subcomponent were never achieved.

B.2 Sector Program Management:

There has been satisfactory progress in establishing the sector wide approach, although MOHFW's ownership of the process could have been deeper. Nevertheless it was a big step in the right direction for both sides, and the process dramatically changed the way in which DPs and MOHFW related to each other. Important formal steps in managing the development of a SWAp were taken, including the introduction of AOPs, and the use of APRs for evaluating progress and results, pooling of funds, unification of procurement procedures, financial management and reporting, and the establishment of a forum for the harmonization of consortium views. However, the AOP process has remained, in most cases, a formalistic budget allocation exercise, rather than a planning and management tool. This has resulted in part from the lack of regular MIS information, inadequate development of line managers' capacity, and an absence of a culture of evaluation and of focusing on results. The effectiveness of capacity building that was carried out was reduced by the high turnover of key staff within the MOHFW. The lack of focus on strategic outcomes came not only from the fact that AOPs become unnecessarily detailed, resulting in reduced flexibility and increased micro-management, but also from the expansion of the number of AOPs from about 22 to 38, split between two wings.

On the DP side, the process could have been deepened as well. The HPSO was expected to be primarily a forum to coordinate DP's views and harmonize their recommendations regarding program performance, and to provide financial management and procurement support to MOHFW to be able to provide information for DPs to report to their respective authorities. However, because of the need to tightly supervise transactions in the environment which had well-recognized governance issues, and substitute expertise in procurement and financial control which the Ministry lacked, HPSO activities became centered on process (financial monitoring and procurement), and DPs became overly focused on implementation details, agreeing to detailed "action plans" (often containing numerous points that were seldom followed up) instead of focusing on longer term strategic issues. HPSO began to focus on more strategic issues during and after the suspension. A functional analysis of HPSO functions carried out as part of management audit in 2004 indicated that trust fund management accounted for about 51 percent of the effort of the HPSO. The same management audit found that HPSO played a key role in areas where HPSP was successful, and was crucial in averting major problems, it never established itself as the overall DP coordinating unit for the SWAp. It often failed to represent the views of the non-pooling partners, and for many, it was over-identified with the World Bank. Thus, coordination amongst DPs could have been better, and the approach to MOHFW performance could have been a bit more hands off with respect to implementation details. Finally, despite the emphasis on working together and pooling funds, several of the "poolers" are also providing parallel support, weakening the benefits of a united approach.

B.3. Reform of health sector policies:

Progress with respect to this subcomponent was very uneven, and generally limited. Some studies and pilots were carried out but relatively little has been translated into concrete policy. Although the majority of these reform areas were under developed in the PAD, studies carried under the HEU were prepared in order to move these activities forward. However, the study results were never utilized by GoB. This includes pilot programs aimed at testing cost recovery mechanisms (fees for services) with retention of funds for local use in hospitals, and the testing voucher schemes to generate demand-driven services. A new ordinance covering drug importation (certification) has been prepared and still awaits implementation.

The focus on gender issues came during the second half of program implementation, particularly after it was clear that utilization of services was not increasing. GoB introduced a broad cross-sectoral program to improve the gender sensitivity. A Gender-Equity Strategy was approved and a Gender Issues Office was established in the MOHFW, supported by a multi-partner Gender, NGO and Stakeholder Participation Unit. An overall Gender Advisory committee was established to oversee activities. However, this has been a low priority for MOHFW. Activities were under-resourced, the Gender Equity Strategy was barely implemented, the Gender Issues Office was poorly staffed and not empowered, and a Gender Mainstreaming Project to incorporate gender issues into AOPs was never implemented (compliance was voluntary).

Good dialogue among stakeholders established during the preparation of the HPSP was not effectively translated into effective participation during implementation. Initially several (17) health watch groups were formed at the upazila level, mainly by local NGOs, some including poor persons and women, although an institutional framework for these organizations was not established. Despite assistance from DPs, an effective MOHFW communications strategy which could have informed stakeholders and built commitment to change, sought feedback and eventually solve problems of health care delivery, was not developed. A consultative process did emerge but was largely dominated by organizations of the professional health workers. Representatives of civil society did not actively participate. While GoB was committed to expanding participation of stakeholders, by the end of the program it had taken few concrete steps.

4.3 Net Present Value/Economic rate of return:
Not evaluated

4.4 Financial rate of return:
Not evaluated

4.5 Institutional development impact:
Although institutional restructuring under the HPSP did not meet expectations given the reversal of the unification of health and family planning, the reform of operational practices has been considerable. MOHFW has made considerable progress in institutionalizing the concept the sector wide approach (SWAp). It has instituted line department AOPs as a break from traditional program-based planning and financing of activities, although improvements in execution capacity,

supervision and management arrangements among other functions, are necessary before this can be considered "mainstreamed". Likewise, basic managerial functions including human resources management and procurement management have seen important improvements that will support future institutional development efforts. Finally, the process of APR was established as a "practice", although the organization of the exercise needs to be more fully managed by the MOHFW. Overall, therefore, the **institutional development impact of the program has been substantial**.

5. Major Factors Affecting Implementation and Outcome

5.1 Factors outside the control of government or implementing agency:

Limited in-house capacity for policy decision-making. Bangladesh has been dependent on donor support for many years, and has been the object of considerable analysis and study. This has produced a great deal of information on policy options for GoB on many fronts. However, with limits on GoB's in-house capacity for objective and independent analysis, and dependence on international assistance to meet budgetary obligations, GOB may have been less able and willing to develop an independent view of its options, and tools and capacity to implement them. Thus, during the development of its Health Sector Strategy prior to launching the HPSP, GoB was presented with detailed planning and implementation methodologies which the "international donor community" believed were sound, but which GoB may not have been in a position to assess for applicability in its own situation.

5.2 Factors generally subject to government control:

Limits imposed by cultural and legal framework. There were major influences within GoB's overall control that constrained program implementation which were outside MOHFW's ability, as implementing agency, to alter. Civil service culture and regulations were largely determined by the Ministry of the Establishment (MOE) setting a pattern of staff rotation, promotion, incentives and sanctions, and post assignments that severely complicated the introduction of reforms and the strengthening of management. The MOHFW was obliged to manage its re-organization within the legal and cultural framework that was set by the MOE with little room to re-negotiate these regulations or seek exceptions.

Poor Governance. The program operated in an environment of recognizably poor governance standards complicating the use of government systems for procurement and financial management normally associated with a sector wide approach. Instead, DPs were required to provide additional verification and on-the-job training in these areas, slowing procurement, financial reporting and disbursements.

Insufficient financial management and procurement capacity. The capacity of government institutions to manage finances and procurement was also chronically weak which deprived the MOHFW of a pool from which to upgrade staff. While GoB had launched a project to reform and modernize financial management systems, MOHFW was in the vanguard of applying the new methodologies and had few precedents to follow in doing so.

Insufficient share of government finance allocated to health. GoB was to increase its relative allocation to health from 6.0 percent to 7.5 percent of government spending. Up to 2003, it had

only increased to 7.1 percent.

5.3 Factors generally subject to implementing agency control:

Fragile commitment to reform across administrations. The reform components of the program made very little progress throughout implementation. Morever, those that did make some progress were reversed when there was a change in administration showing very fragile commitment to the reforms agreed to with the DP Health Consortium.

The high turnover of staff in the MOHFW has limited the impact of capacity building activities to strengthen in-house capacity.

Insufficient partnering with the private NGO sector: MOHFW was resistant to opening its operations to meaningful inclusion of the NGO and for-profit sectors as partners in providing health care services which could have leveraged its own actions to improve access and quality of services.

Insufficient supervision of field operations. Studies assessing the conditions and quality of services of community clinics found many deficiencies which could have been avoided with adequate supervision.

Insufficient use of data for decision-making and preparation of AOPs. The program produced considerable information for decision-making that was not utilized. Moreover, AOPs were prepared more for budgeting than for planning given the lack of focus on results.

Civil service culture provides no incentives for improved performance.

5.4 Costs and financing:

The cost of implementing the HPSP program was originally estimated at US$2,895 million, to which donors would contribute US$705 million. Of this contribution, the pooling DPs were expected to provide US$522 million equivalent. This cost was broken down by category of expenditure. However, financing was assigned to these categories only in the first program year and most of the financing left as “unallocated”, to be subsequently disbursed to meet the costs of AOPs as they were approved. The resource needs of individual components were not fully specified since these would be ultimately determined by the AOPs developed by line departments that were implementing the program.

As of November 23, 2005, following 2 extensions of the closing dates covering 18 months, the total realized cost of the program, estimated on the basis of costs considered eligible for reimbursements (SOEs) was US$2,835 million or 98 percent of the original estimate. Mapping the costs of completed AOPs against project components (Annex 2, Table 1) shows that the implementation of service-based components (ESP, other services such as HIV/AIDS prevention, facilities construction and upgrading) generally exceeded appraisal estimates, while realized costs of components devoted to restructuring and reform (policy development, re-organization, sector management, MIS development) were well below appraisal estimates.

Original commitments on the part of pooling partners (US$522 million) ultimately translated into

US$465.7 million, accounting for exchange rate variations during the period in which contributions were made to the "pool". Of this amount, about US$42.5 was cancelled during implementation, principally owing to the cancellation by the EU of about US$39 million equivalent (50 percent of its original commitment) in response to the GoB decision to reverse its policy on "unification". The remainder is accounted for by cancellations following proven mis-procurement. The "pool" has disbursed US$390.3 million of the remaining US$414.4 million of commitments (or 94 percent). Following the decision that grants should be disbursed before "credits", the full, undisbursed amount is of the IDA credit. At closing, 90 percent of the IDA credit has been disbursed.

Throughout program implementation period, annual audits of the project accounts revealed numerous discrepancies. By the end of 2003, there were 50 "observations" made in independent audits (observations identified by IDA as being critical), representing a value of about US$250 million. As a condition of negotiations of the HNPSP, government settled cases representing 50 percent of the observations in terms of value ($US130 million). The last observation was finally settled in December 2005 in response to IDA holding disbursements of HNPSP until all observations were settled.

6. Sustainability

6.1 Rationale for sustainability rating:

In spite of implementation problems, the program's modest results are **likely to be sustained**, albeit, with risks. Financing for the health sector is likely to continue to be available. GoB depends heavily on the donor community to support about 35 percent of the total health sector budget and this level of funding is expected to continue for the medium term. In addition, GoB has recently committed itself to increasing its own contributions to the sector by about 6 percent per year in real terms in order to at least maintain and possibly improve the per capita public expenditure on health services. Reforms that have been instituted in human resource management, procurement, annual operations planning and budgeting are also likely to be maintained and improved, considering that modernizing the management of the public sector is a shared concern of the donor community and much of the senior management of the Ministry. Moreover, unlike the HPSP, future actions to modernize the sector under the HNPSP are designed to be less prescriptive, leaving open a wider scope for a pragmatic and flexible approach to planning the ways and means of achieving program goals. Therefore a change process is more likely to be followed based on results, lessons and problem solving, building ownership, rather than by design.

Based on its progress to date, the sector wide approach is also likely to evolve further. GoB and DPs appear committed to pursue a policy driven results agenda, including, for example, meeting the Millennium Development Goals for health. The use of AOPs is likely to be maintained as it has been demonstrated as a sound vehicle to allocate untied financial support. However, it is also likely that an element of "project lending" will remain, driven in part by the legal requirements of certain donor governments and their commitment to projects outside the purview of the MOHFW. The Consortium is proving itself to be useful as a tool for ongoing coordination of assistance to the sector, and the APR a useful monitoring tool for both GoB and DPs. The focus, however, is likely to move more towards results and policy. Finally, the definition of the "sector"

is being expanded to bring in more of the institutions and agencies that affect health outcomes of the population. These factors are likely to lead to a "quasi-SWAp" which will be consistent with in-country realities, while being effective, and providing coherence between goals and financing.

6.2 Transition arrangement to regular operations:

GoB is now receiving support from the DPs who financed the HPSP, and from others for a new Health, Nutrition and Population Sector Program (HNPSP). GoB has mobilized resources of approximately US$4.3 billion, with donor contributions of about US$1.2 billion, of which the Bank has approved financing in the amount of US$300 million. The new program would have as its longer term health objectives, meeting the MDGs for health, as a minimum, with additional goals for reducing chronic infections, work related, and other life-style health threats and conditions. Implementation arrangements have been designed to increase the level of ownership of the GoB in implementation and its accountability for results. The SWAp would be further developed building on progress made to date, with improvements in the use of APRs, AOPs and harmonization of the requirements of DPs for financial management reporting, procurement administration, results-based reporting.

7. Bank and Borrower Performance

Bank

7.1 Lending:

During preparation, the Bank took a leadership role within the consortium, bringing together a very large number of stakeholders to work with the GoB in the definition of the program's design. This involved managing missions that frequently involved as many as 16 agencies and contained up to 70 individuals in addition to a large representation from the MOHFW. While inclusion is crucial to ensure ownership, it makes for difficult coordination, and can easily result in a complex project design as a result of trying to please many stakeholders. Managing such a large group requires clear rules of engagement in order to not lose sight of the overall objective, something that may have happened both during preparation as during implementation.

The preparation of the various components was very uneven. The ESP was very carefully worked out—it's the centerpiece of the PAD. But other aspects, like most of the reform areas, were only superficially addressed. This was surprising given the long preparation period. That the project was approved by the Board on the last day of the fiscal year suggests part of it may have been work in progress. Apparently there was management pressure to deliver the project that fiscal year.

The team failed to assess the political feasibility of the unification, with disastrous consequences. According to a review prepared by DfID, the team relied on the commitment of a small senior group within the Ministry and did not assess the extent to which the group's views represented those of the MOHFW as a whole. The "commitment" to reforms quickly disappeared when the group was replaced after a change in administration.

The Bank's appraisal of the program met most required standards satisfactorily. Again, the Bank assumed a leadership role on managing very large donor teams, organizing consultative workshops to address the key themes of the operation, and provided the majority of the analysis of the project's viability. However, as indicated above, deficiencies in three key areas lowered the

quality at entry. First, the appraisal team did not include a fully qualified and experienced institutional development expert, or expertise in managing institutional change. Second, as a result, the assessment of risks was ill informed and mitigation proposals inadequate. Third, being closely involved with senior and committed MOHFW staff in the preparation of policy, strategy and preparation of the operation, the Bank failed to appreciate that the level of commitment to the operation might not have been widely shared by those who would bare the full cost of the reorganization. Finally, it did not adequately account for the need for communications and consensus building on reform aspects at the time of appraisal.

While recognizing some shortcomings that lowered the quality at entry of the operation, other factors related to the Bank's providing focus and leadership to the operation would support rating the Bank's performance during the lending cycle as **moderately satisfactory**.

7.2 Supervision:

The HPSO, which represented the Consortium, but was financed by the pooling partners, was responsible for providing fiduciary supervision of the program and managing the trust funds (other functions were not World Bank related). Because much of the work of HPSO was with the management of the trust funds (and oversight of procurement and financial management), HPSO was often seen as being a World Bank Office when in fact it was to represent the Consortium. Staffing of the HPSO was insufficient. It wasn't until 2003, near the original closing date of the project, that the HPSO was fully staffed. On the side of the Bank, supervision resources assigned to supervise the HPSP were insufficient as it was treated as a single project. DPs complained that HPSO was carrying out the Bank's supervision responsibilities.

Formal supervision of HPSP was carried out through the APR process. The APRs typically established a strong factual basis, independent technical analysis and reporting. They also identified remedial measures, and enjoyed wide participation of all donors and officials of the MOHFW. APRs also tracked financial management and procurement issues using Bank norms and reporting. The inability of the MOHFW to organize the APR once the PCC was eliminated required that the HPSO assume a more direct role in managing the reviews. While this reduced MOHFW's ownership of the APR process, it did not compromise the Bank's ability to carry out supervision.

However, the APRs became increasingly focused on operational details, often leading to agreements to long lists of "action points" with tightly controlled timetables for completion which appear to have been poorly monitored and often ignored. In the process, strategically significant actions were often lost or underplayed. This affected the Bank's own focus on whether the program was meeting strategic objectives. On one hand, the close proximity of the Bank's supervising staff in the World Bank Office in Bangladesh to the MOHFW and its key staff, may well have re-enforced the tendency to track details, on the other, the Bank showed a commendable level of pro-activity in engaging the MOHFW in dialogue and supporting his implementation efforts. Throughout, the Bank supported its supervision effort with sector analyses conducted in collaboration with DPs and the MOHFW/HEU even though the results may not have influenced Ministry policy.

A QSA carried out one year after effectiveness rated supervision as highly satisfactory, and

commended the team for their proactiveness. Supervision provided was intensive, with heavy involvement from the resident mission, and a field-based task team leader. The APR process was carefully set up with GoB and the DPs, and fine-tuned by carrying out a "dry run" early on. The team focused on facilitating the process overall.

The monitoring and evaluation framework for the program, which included annual program expenditure reviews, national health accounts and service delivery surveys, was carried out as planned, bringing the necessary information to stakeholders to assess program progress. Given the absence of MIS data from the MOHFW, this proved to be even more important than originally expected. Organizing the numerous surveys was a complex task and the supervision team deserves some credit for ensuring they were carried out.

While the Bank and HPSO team was generally proactive in its approach to supervision, it failed to address the powerful resistance to the unification of the two wings of the Ministry in a timely manner, allowing dialogue with GoB to break, ending up in a partial suspension of disbursements by pooling financers. Consideration should have been given to restructure the project at the time of change in administration rather than waiting until a suspension seemed inevitable. The pooling financers were proactive in opening the door to dialogue and defining a new plan of action with GoB to lift the suspension.

The Bank was diligent in reporting through PSRs, but assessments and ratings were often unrealistic and not inconsistent with actual developments. As an example, at no time was the program development objectives rated unsatisfactory or the project considered to be a "problem project", even when Government failure to pursue a major program goal led to a partial suspension of disbursements. PSRs also rated financial management of the project satisfactory, even though the performance of the Financial Management and Audit Unit depended to a large extent of the contribution of donor financed consultants, and annual audits continuously drew "observations". Ultimately, the cumulative number of substantial observations reached some 50, with only about half of these being resolved by the time of negotiations of the follow-on HNPSP. By not having the audit situation flagging in PSRs, the Bank may have been deprived of an opportunity to apply sanctions earlier in the implementation period.

Considering its pro-activity, and role in providing leadership to the consortium during implementation, the Bank's supervision effort is considered **satisfactory**

7.3 Overall Bank performance:

Throughout program preparation and implementation, subject to some avoidable weaknesses, the Bank acted in a technically sound and goal-driven manner. It attempted to provide technical advice and implementation assistance to the borrower beyond the simple financing of the operation. As part of this effort it conducted complementary sector analyses in order to inform policy and program implementation, although it may have missed opportunities to broaden the consideration of alternatives within the range of international best practice that it advised during preparation. Its overall performance therefore is considered to have been **moderately satisfactory**.

Borrower

7.4 Preparation:

Throughout preparation, the Borrower was very committed to the objectives of the program. The GoB formulated a Health and Population Sector Strategy to guide preparation. The MOHFW took one of the lead roles in the preparation of the project, constituting 17 task forces and organizing numerous workshops with as many as 150 stakeholders. It also established a High Level Commission to address management reform issues in the health sector that was endorsed by the Cabinet. And, it increased health sector funding by 11 percent in real terms in the period preceding the project. However, GoB also did not entertain the political feasibility of some key reforms. As such, GoB/MOHFW's performance during preparation is assessed as **moderately satisfactory.**

7.5 Government implementation performance:

GoB's role in implementation could have been considerably more facilitating. Governance problems and government bureaucratic delays had a negative impact on program implementation. GoB was particularly slow in addressing financial irregularities uncovered in annual audits. Moreover, it did not sufficiently increase the share of spending allocated to health as had been agreed. GoB's performance in implementation is rated as **moderately unsatisfactory.**

7.6 Implementing Agency:

MOHFW's role in implementation changed over time. Overall, MOHFW seemed insufficiently engaged in the program, and overall progress was slow. It showed considerably more commitment to the program in the early beginning, hitting a low after the change in government in 2001. Performance improved a bit in the last year, but overall commitment was insufficient given the task at hand. While budgets were generally funded, plans generally followed, and disbursement rates were satisfactory overall, staff rotation of key positions was very high, as was absenteeism, the appointment of key staff was very slow, there were delays in launching studies, and much hesitation to proceed with increasingly difficult institutional changes and follow-up to remedial actions following APRs.

Some key decisions taken, like the reversal of the unification and the failure to engage NGOs, were based on political considerations rather than empirical information, and ended up limiting the impact of the program. MOHFW showed little enthusiasm for engaging NGOs and the for-profit sector despite evidence of their relevance highlighted in sector studies carried out for this purpose. Decentralization, another important reform agreed to during preparation, was never adopted. Much analytical work was carried out with DfID financing during the first two years to assist in the design of aspects of the reform components. However, GoB did not use the wealth of information available to inform their decisions.

The government was not forthcoming in offering alternatives to the unification, allowing a partial suspension to come into effect. An Action Plan Agreed Reform Agenda (APARA) and a contingency spending plan were subsequently agreed as the basis for lifting the partial suspension and extending the closing date of the credit to allow for continued financial support of health services, but GoB was also slow to follow through with these commitments.

The MOHFW's **unsatisfactory** performance in implementing this program has been partially mitigated by its decision to work with DPs to design a new sector program, taken soon after the

partial suspension was lifted. The HNPSP for which financing was approved by the Bank in April 2005, has placed a strong emphasis on achieving results, including meeting MDGs, without the level of prescribed institutional reform that characterized the HPSP. In implementing the HNPSP, there would be more choice in the ways and means of resolving questions, depending on analyses made at the time. This approach places its own demands on the performance of the GoB institutions and holds inherent risks, however, is less likely to lead to impasses that characterized the HPSP.

7.7 Overall Borrower performance:

Overall assessment of the GoB's/MPHFW performance is rated as **moderately unsatisfactory**.

8. Lessons Learned

The program offers insight into a number of important design and implementation issues with implications for other projects:

Sector Wide Management

Engaging in sector wide approaches to program management can be a challenge, given the number of stakeholders involved and the size of the programs. Amongst the key lessons regarding SWAps, we have learned that:

- SWAps cn be gradually adopted, yielding increasing improvements in sector management even when the change is incomplete.
- Mechanisms to facilitate implementation in the context of insufficient capacity or local governance deficiencies that prevent the exclusive use of "government systems" yield good results and allow the government to gradually take on the responsibility it should.
- It would also be important to establish performance indicators and progress benchmarks for establishing the SWAp as for any other set of project activities.
- SWAps need to clearly define the scope of the "sector" to be managed so that it includes all of the relevant parameters that affect the causal link between program activities and final results. Allowing key sector stakeholders to lie outside the influence of program interventions (such as NGO/for profit health care providers) or key donors to lie outside the donor partnership (such as the ADB), would structurally weaken the benefit of adopting a SWAp. Parallel funding, where possible, should be discouraged.
- DP coordination is a difficult and time consuming task, requiring negotiating skills, leadership and presence in the field. A Code of Conduct with clear rules of engagement for coordination and management of the SWAp needs to be defined upfront, to ensure decisions are taken swiftly, that time is not consumed by numerous meetings to reach consensus, and to maintain the focus of the program. Given the lack of experience with SWAps by both DPs and GoB, considerable time was spent on reaching agreements, as rules for engagement were not clear.
- SWAPs have to be carefully and diplomatically managed. Putting all "eggs in one basket" means that the program can easily be derailed if both sides do not handle issues in a constructive manner.
- The APR process needs to be carefully managed, to ensure it is maintained as a forum for

review and discussion. Including too many stakeholderslimits the discussion, making the discussion of solutions to problems identified less fruitful.

Managing Institutional Development

- Not carrying out the necessary analyses of the political economy of reforms can lead to failure. Opposition needs to be identified, whether within the MOH, physician's associations, other worker's associations, and users of the services themselves.
- Managing institutional change is a difficult process, and one that needs to take into account all stakeholders. Analyses should be made of what is at stake for everyone, and benefits for each need to be identified to bring them on board. They need to be consulted and convinced of the benefits of the process for them. Commitment to or at least understanding and agreement regarding the rationale for the institutional change sought could have been built among those most affected, and new elements could have been brought in as a result of negotiation with these stakeholders. An opportunity was therefore lost to identify incentives that could have bolstered institutional change.

Other Lessons

- It is often assumed that the poor always opt for public services as they cannot afford private services. However, some are too poor even to consume government services as the costs are not always financial and when they are, they are not evident. As Service Delivery Surveys indicated, the very poor did not benefit from MOHFW services, as informal fees charged made it costly for them.
- Participatory preparation, while enhancing ownership, can dilute the focus of a project design. A balance needs to be struck to ensure both goals are met. A review of the resulting proposal can be submitted to independent technical analysis for suggestions on how to improve the overall product without losing the key aspects of the design.
- It is important to measure not just long-term outcomes but also intermediate indicators that would lead to those outcomes to ensure program effects can be measured. Monitoring indicators for intermediate goals are crucial to be able to explain program effects. As such, it was difficult to link changes in health status to the program. For instance, there were many other factors that influenced the PDO that were not measured, such as girl's education and increased access to safe water.
- Project objectives need to be closely linked with program inputs and outputs, and the targets set need to be related to the capacity of the implementing entity. In this case, MOHFW services alone could not have improved maternal and child health.
- An adequate risk management strategy is needed. Management of risks must be an essential part of the APRs and routine project supervision.

9. Partner Comments

(a) Borrower/implementing agency:
No comments submitted.

(b) Cofinanciers:

Comments from CIDA:

1. One of the over-riding concerns about HPSP was that it was not a cohesive, conceptually coherent program. This was understandable given the multitude of challenges, and the size of the program. However, implementation and communication of the program would have benefited from a conceptually integrated approach. This is mentioned in this Report, but would have been useful advice during the design of the new HNPSP program. Unfortunately, HNPSP may be even more scattered than HPSP, in part due to the difficult environment in which it has evolved.

2. The allocation of effort to the ESP program was a key component of HPSP and has resulted in some notable progress in service delivery, although it is not consistent across the service network. Unfortunately, the reality, as noted, is the decline in clients using the ESP at GoB facilities to less than 10%. This represents a seriousl problem for the national health service of the GoB.

3. It is interesting to note that a feasibility study on the unification of the Directorates of Health Services and Family Welfare was not carried out. The importance of the lesson in capacity development strategies cannot be over emphasized. The feasibliiity study would have presumably made a comparison of alterative approaches to achieving efficiency gains within the GoB health and FP service areas but avoiding the politically volatile issue of wholesale unification.

4. A further important observation is this: HPSP and health SWAps everywhere are likely to be successful only if the recipient government is truly in the lead in setting priorities, especially involving structural, administrative and governance reforms. The lack of GoB ownership over the unification plan mitigated certain failure and disappointment on the part of donors. This lesson appears not to have been learned during the planning of HNPSP, where, once again, GoB has not been adequately involved in the planning and certainly has not taken any sort of leadership role on the planned components. Have feasibility studies been duly carried out for HNPSP components?

5. The harmonization gains among donors was an important achievement and still in progress with the present SWAp. However, further discussion of the impact of parallel programs on HPSP would be of considerable interest.

Comments from DFID:

(Note: Comments from DFID were mostly incorporated into the text. Included here are those remarks that were general in nature, and a summary of their contribution to HPSP)

Inevitably, perhaps, our comments focus on issues where our perceptions and/or memories differ from those stated in the draft ICR. The key issue of credit suspension is not covered sufficiently; this is (fortunately) a rare occurrence in WB lending and so we feel it merits fuller treatment to bring out the circumstances and the lessons. We also feel that there are places in the text where the balance of credit for success and blame for failure is a little too positive towards the World Bank and too negative towards the GOB. Some of our specific comments below relate to this

issue, and seek to correct this balance while not, of course, exonerating the GOB from all responsibility.

DFID Financial Contribution to HPSP

DFID approved a contribution to the HPSP of £55m. This contribution took two different forms. One was direct funding to WB of £25m, agreed under a MOU. The other was parallel funding of £30m for eight different components grouped together as "SHAPLA" (Special Health and Population Loan Assistance). These components were managed by four different agencies.

The final summary accounts of DFID disbursement to the HPSP are as follows:

Direct to WB under HPSP MOU	**-**	**£25m**
Parallel Funding as Technical assistance to SHAPLA:		
A) HLSP management costs	-	£2,014,352
1. Organisation and management	-	£5,170,768
2. Human Resource Development	-	£1,222,748
3. Hospital Management	-	£2,945,875
B) Maxwell Stamp		
4. Strategic Investment in Health Economic	-	£3,774,993
C) The British Council / NICARE (management costs)	-	£1,605,816
5. Medical Education	-	£1,938,818
6. Nursing	-	£1,897,480
7. Public Private Partnership	-	£2,061,480
D) BPHC		
8. Public NGO Partnership	-	£6,824,697
Total Technical Assistance	**-**	**£29.46m**
TOTAL SWAP	**-**	**£54.46m**

(c) Other partners (NGOs/private sector):

10. Additional Information

Annex 1. Key Performance Indicators/Log Frame Matrix

Part A Outcome/Impact Results

Indicator	Pre HPSP	HPSP Target (2003)	End HPSP Estimate (2005)*
Maternal mortality ratio	4.1/1000 (1998) to 3.1/1000(2001)	2.8/1000 live births	Estimated at <3.2
Infant mortality Ratio	57/1000 (1998) to 66.3/1000 (1999)	50/1000	60-65/1000
Mortality Under 5 years	94/1000 (1997) to 96/1000 (1999)	70/1000	85/1000 approx
Total fertility rate	3.3 (1999)	2.5	<3.0
Child Malnutrition, % , Moderate	35.7% (1996/97)	35%	33.5%
Child Malnutrition, % Sever	20.6% (1996/97)	8%	12.1%
Nutritional Status of Women (BMI < 18.5)	52%	60%	30-35% (2004)
STDs prevalence by group (syphilis)	CSW- 41% MSM- 12%	30% reductions in all groups	CSW 22.5-37.1 MSM- 5.8
Incidence of Polio	10 (1998) 29 (1999)	0 for 3 years	0 since 2000

*Source: APR 2005

Part B. Outputs/Inputs

Indicator	Pre HPSP	HPSP Target	End HPSP (2005)
1. ESP Services Use			
i)Curative Care	13% of cases (1999)	80%	10% (2003)
ii) EOC	5.1% (1994)	30%	8-18% (UNICEF)
iii)Client Satisfaction	unkn	80%	56% (SDS 3rd round, 2003)
iv) CCs fucntional	na	10,833	Unkn (8,600 turned over to NGOs
v) Unofficial payments paid	40% of public services users	0	Unkn; possibly 25%
vi) ANC	26.4-28.6% (1996/97)	65%	60% (2004) est.
vii) Assisted deliveries	8%	30%	13-14% (2004)
viii) Contraceptive prevalence rates	49.2% of couples (15-49) (1996/97	60%	60% est (2004)
viii)Budget allocation	60% of MOHFW budget allocated	65% of public expenditure on health	60-65% over 2003-2005
2. MOHFW Systems Integrated **			
i) Human Resources Development	Segregated HRD by wing	Unified HRD	Program designed to cover 6 essential areas with functions performed (see text)
ii)Sustainable BCC	Fragmented IEC	Unified and health	BCC not improved and

introduced	practices on small project scale	promotion BCC functioning	remains centralized, bifurcated and theme specific
iii) Facilities upgraded	Few ready to accommodate ESP and be gender responsive	Unspecified	Some facilities upgraded, with cost overruns and some mis-procurement; attractiveness and amenity not seen as improved by clients
iv) Unified sector-wide procurement, distribution and stocking system established,	Segregated services by wing	Unifies MOGFW services	Procurement services not unified; however, progress made separately in capacity development (see text)
v) Quality assurance bodies established, disseminating,	Not practiced	Regular practice	No substantial proigress
3. Other hospital level services focused and approved **			
i) Hospitals managed autonomously and accountable locally	Not begun	Lacked clarity	Suitable management systems prepared and training of hospital managers undertaken in 11 pilot cases; follow through not fully implemented (see text),
ii) Integrated referral system established for ESP involving public and private hospitals	Not begun	Lacked clarity	Not operational
iii) Private and NGO hospital focus on reproductive health and medical surgical emergency services meeting GoB standards	Autonomous and regulated operations	Regulated operations	Standards not set; leverage effect on NGO and private hospital/clinics performance not established
iv) Safe, autonomous, self sufficient blood bank and diagnostic laboratory	Risks to blood banks identified	Risks mitigated	Contract arrangements made with WHO to assume responsibility for safe blood supply work
4. Sector wide management system established and operational **			
i) Government to prepare/update long-term sector strategy, program plans and budgets based on ESP	De facto sector wide coverage by donors but through uncoordinated means, at high transaction costs leaving	Strategy and needs driven planning, programming and operations	Strategic approach slow to develop owing to lack of MIS, feedback systems. Process improved in context of

performance/impact	service gaps		HNPSP preparation
ii) Planning, monitoring and budgeting authority for annual ESP cycle devolved to local level and maintained by participant decision-makers	Centralized process	Nor clear	Not operational in a systematic manner; some localized
iii) Multi-level ESP-based M&E System established based on impact and output indicators and assumptions, and MIS adapted to support the system	Bifurcated system for MIS	Unified MIS	MIS for FP and Health were not unified. Interim project data gaps were partially covered by periodic surveys financed by DPs
iv) Financial, disbursement and expenditure control systems established and operational	Bifurcated systems	Unified systems; with good governance	Program re-enforced FMAU established but became disfunctional in 2003; . Numbers of annual audit observations abnormally high and GoB slow to resolve Program highly dependant on HPSO for financial controsl. However, disbursements usually met annual targets.
5. Policy and Regulatory Framework strengthened **			
i) GoB, private and NGO technical performance guidelines and standards policy established, enforced and monitored at all levels	Quality assurance issues identified; non supervised health care delivery; risks to efficacy and affordability by poor	Quality supervised in public, non governmental and for profit health sector for quality and efficiency	Performance standards, monitoring system and enforcement not developed (see text)
ii) Patient Charter of Rights adopted and disseminated	Issue identified	Charter issued and enforced	Not developed

** Indicators taken from PAD, Annex 1

Annex 2. Project Costs and Financing

Project Cost by Component (in US$ million equivalent)

Component	Appraisal Estimate US$ million	Actual/Latest Estimate US$ million	Percentage of Appraisal
A. SERVICES DELIVERY AND POLICY REFORM			
1. Essential Service Package (ESP)	1,624.76	1,772.41	109%
2. Hospital Severices	348.00	345.94	99%
3. Other Public Health Services	9.56	20.18	211%
4. Other Health and Nutrition Services	254.00	213.59	84%
5. Integrated Support Services	629.00	467.39	74%
Human Resources Development (HRD)	141.58	10.09	7%
Facilities	336.66	356.43	106%
Procurement and Logistics	109.63	75.32	69%
Quality Assurance	1.96	2.42	124%
Behaviour Change Communication (BCC)	19.10	8.07	42%
Management Information System (MIS)	10.58	5.92	56%
Researh and Development	9.49	9.15	96%
6. Policy and Regulations	7.00	1.08	15%
B. ORGANIZATION AND MANAGEMENT REFORM			
1. Reorganization of Service Delivery	3.55	1.88	53%
2. Sectorwide Management	19.98	13.32	67%
TOTAL	2,895.85	2,835.79	98%

Note: Actual/Lastest Estimates are estimated by aligning Line Directorate Operational Plans with project components, and aggregating realized costs as values of Statement of Expenditure (SoE)s for these Plans for last seven years of project implementation. Amounts converted to dollars at an exchange rate equal to the average rate of BDTaka.56.3415 = US$1.00.

Project Financing by Categories (in US$ million equivalent)

Categories	Appraisal Estimate			Actual/Latest Estimate			Percentage of Appraisal		
	IDA	Govt.	CoF.	IDA	Govt.	CoF.	IDA	Govt.	CoF.
Goods, Supplies, Civil Works and Operating Costs	64.50	2453.45	88.96	85.57	2445.51	52.90	132.7	99.7	59.5
Drugs, Vaccines and Contraceptives	145.20		58.33	101.41		69.50	69.8		119.1
Diagnostic and Surgical Goods, and Ambulance	23.50		26.46	22.85		9.85	97.2		37.2
Consultants' Services and Training	14.40		12.84	18.25		12.25	126.7		95.4
NGO Support	2.40		5.85	3.34		6.04	139.2		103.2
Goods/Civil Works of Part D.				6.59		1.74			
Total	250.00	2453.45	192.44	238.01	2445.51	152.28	95.2	99.7	79.1

November 23, 2005 Data

Note:

(1) “Appraisal Estimates” were given in the DCA only for the first project year : for the IDA portions were US$27.0 million for category 1; US$20.0 million for category 2; US$2.7 million for category 3; US$2.0 million for category 4; US$0.5 million for category 5; and US$197.8 million unallocated. The final estimate shown in the table represents the aggregate of allocations IDA and Trust Fund funds to cost categories made annually as part of the annual program review process. Data gathered from the World Bank *Client Connection* database. **All figures net of cancellations**

(2) Category 6: Goods/Civil Works of Part D. was created for the Post Flood Rehabilitation in 1999.

(3) The financing from Government sources at appraisal and actual estimates include the GoB Revenue and Development budgets, and financing fromUN agencies and additional non-pool donors.

(4) The actual/latest estimates were based on the MOHFW's Statement of Expenditure (SoE)s and Operational Plans for last seven years of project implementation.

Table 3: Disbursements by Year 1999-00 to 2004-05

IDA and Pooled Financiers; US$, millions

Fiscal Years	IDA	Other Pooled Financiers	Total
FY 1999-00**	109.4	26.7	136.1
FY 2000-01	37.6	17.6	55.2
FY 2001-02	34.4	8.5	42.9
FY 2002-03	18.8	36.4	55.2
FY 2003-04	1.8	37.4	39.2
FY 2004-05	22.0	11.1	33.1
Total Disbursed	224.0	137.7	361.7
Total Un-disbursed	26.0	0.2	26.2
Total Financing Available	250.0	137.9	387.9

Annex 3. Economic Costs and Benefits

Not applicable

Annex 4. Bank Inputs

(a) Missions:

Stage of Project Cycle	No. of Persons and Specialty (e.g. 2 Economists, 1 FMS, etc.)		Performance Rating	
Month/Year	Count	Specialty	Implementation Progress	Development Objective
Identification/Preparation				
1/28/1996 - 2/11/1996 and 3/2/1996 - 3-18-1996	*13*	Including representatives of 5 consortium donors		
8/29/1996 - 9/19/199	*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/Negotiation				
Appraisal 2/12/98				
Negotiation 5/18/98				
Supervision				
PSR 03/23/1999	*1*	TTL	U	S
APR 04/18/1999 - 05/02/1999	*10*	Team Leader (Sr. Population Specialist) (1); Financial Analyst (1); Procurement Specialist (1); Disbursement Officer (1); Financial Management Specialist (1); Lead HD Specialist (1); Operations Officer (2); Sr. Population Adviser (1); Management Specialist (1)	S	S
PSR 6/24/1999	*1*	TTL	S	S
APR 11/18/1999 - 12/09/1999	*3*	Team Leader (Sr. Population Specialist) (1); Lead HD Specialist (1); Operations Officer (1)	U	S
PSR 1/13/2000	*1*	TTL	U	S
APR 3-4/2000		(size and professional composition of Review Team not available	U	S
PSR 6/14/2000	*1*	TTL	S	S
PSR 10/25/2000	*1*	TTlL	S	S
PSR 12/17/2000	*1*	TTL	S	S
Technical Review 04/01/2001 - 06/21/2001	*4*	Team Leader (Sr. Population Specialist) (1); Sr. Institutional Development Specialist (1): Sr. Public Health Specialist (1): Sr Operations Officer (1)	S	S
PSR 6/25/2001	*1*	TTL	S	S

	APR 10/20-11/2/2001	*12*	Team covered Public Health Services (3); Logistics and Organization (1); Human Resources Development (3); Behavior Change Communications (2); Monitoring Systems (2); Financial Management (1)	S	S
	PSR 12/12/2001	*1*	TTL	S	S
	APR 5 and 6/2002		(size and professional composition of Review Team not available		
	PSR 6/23/2002	*1*	TTL	S	S
	PSR 12/22/2002	*1*	TTL	S	S
	APR 1/12-27/2003	*9*	(professional composition of review Team not available)		
	PSR 6/25/2003	*1*	TTL	S	S
	PSR 12/23/2003	*1*	TTL	S	S
	PSR 6/22/2004	*1*	TTL	S	S
	PSR 12/28/2004	*1*	TTL	S	S
	APR 4/3/2005 - 4/26/2005	*10*	Sr. Economist (Health) (1); Lead Public Health Spec. (1); Sr. Counsel (1); Program Assistant (1); Consultants (procurement and Disbursement (2), Sr. Financial Management Specialist (1); Senior Finance Officer (1); Health Specialist (1); Research Assistant (1)	S	S
	ISR 7/29/2005	*1*	TTL	S	S
ICR					
	09/26/2005 - 10/06/2005	*5*	Team Leader (Sr. Public Health Specialist) (1); Consultant (Project Adviser) (1); Operations Officer (1); Public Health Specialist (1); Team Assistant (1);		

Supervision work performed mainly through the Resident Mission, Dhaka as an ongoing process**.** **PSRs** produced by TTL in Dhaka on a regular basis from on-site knowledge. Substantive formal supervision was conducted as part of **Annual Performance Reviews** supported by out-of-country staff and consultants, replacing traditional "mission" approach. The Health Program Support Office (HPSO) which was financed by the 6 donors contributing to the financing pool, including IDA (accounting for 60% of the cost) included the TTL in all years, and also provided in-country supervision of procurement and financial management; with staffing of between 7 staff years per year (except 1998-99 and 2000-01).

(b) Staff:

Stage of Project Cycle	Actual/Latest Estimate	
	No. Staff weeks	US$ ('000)
Identification/Preparation	35	82
Appraisal/Negotiation	166.1	577
Supervision	447.19	1,048
ICR	20	41
Total	668	1,748

Annex 5. Ratings for Achievement of Objectives/Outputs of Components

(H=High, SU=Substantial, M=Modest, N=Negligible, NA=Not Applicable)

	Rating
☐ *Macro policies*	○ *H* ○ *SU* ○ *M* ○ *N* ○ *NA*
☒ *Sector Policies*	○ *H* ○ *SU* ● *M* ○ *N* ○ *NA*
☒ *Physical*	○ *H* ○ *SU* ● *M* ○ *N* ○ *NA*
☐ *Financial*	○ *H* ○ *SU* ○ *M* ○ *N* ○ *NA*
☒ *Institutional Development*	○ *H* ● *SU* ○ *M* ○ *N* ○ *NA*
☒ *Environmental*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
Social	
☒ *Poverty Reduction*	○ *H* ○ *SU* ○ *M* ● *N* ○ *NA*
☒ *Gender*	○ *H* ○ *SU* ○ *M* ● *N* ○ *NA*
☒ *Other (Please specify)*	○ *H* ○ *SU* ● *M* ○ *N* ○ *NA*
Health Status	
☐ *Private sector development*	○ *H* ○ *SU* ○ *M* ○ *N* ○ *NA*
☒ *Public sector management*	○ *H* ○ *SU* ● *M* ○ *N* ○ *NA*
☐ *Other (Please specify)*	○ *H* ○ *SU* ○ *M* ○ *N* ○ *NA*

Annex 6. Ratings of Bank and Borrower Performance

(HS=Highly Satisfactory, S=Satisfactory, U=Unsatisfactory, HU=Highly Unsatisfactory)

6.1 Bank performance	*Rating*			
☒ *Lending*	○ *HS*	● *S*	○ *U*	○ *HU*
☒ *Supervision*	○ *HS*	● *S*	○ *U*	○ *HU*
☒ *Overall*	○ *HS*	● *S*	○ *U*	○ *HU*

6.2 Borrower performance	*Rating*			
☒ *Preparation*	○ *HS*	● *S*	○ *U*	○ *HU*
☒ *Government implementation performance*	○ *HS*	○ *S*	● *U*	○ *HU*
☒ *Implementation agency performance*	○ *HS*	○ *S*	● *U*	○ *HU*
☒ *Overall*	○ *HS*	○ *S*	● *U*	○ *HU*

In order to harmonize project performance criteria between ICRs and OED evaluations, OPCS has updated ICR guidelines to include the same rating scale. However, the ICR template has not been updated. Thus, although harmonized criteria are used in the text, ICR tables continue to use the previous rating scale.

Annex 7. List of Supporting Documents

Development Partners and Government of Bangladesh: Annual Program Reviews

1. April 19-May 2, 1999; Aide Memoire and Technical Review
2. November 1999; Aide Memoire
3. April 2000; Aide Memoire and Review of Operational Plans
4. April 2001; Technical Review (Measham and Merrick, WB)
5. October 20-November 2, 2001; Aide Memoire and Technial Review
6. June 2002; Aide Memoire and Independent Technical Team Report
7. January 12-26, 2003; Aide Memoire and Independent Technical Report (an APR was not conducted in 2004)
8. April 3-26, 2005; Aide Memoire and Independent Technical Report
9. Sept-Oct 2004. End of Programme Review of HPSO
10. January 2003, Status of Performance Indicators, 2002, Streatfield, P.K., Mercer, A., Siddique, A.B., Khan, Z.U.A., Ashraf, A.

Government of Bangladesh:

1. High Level commission on Organization and Management of Health and Family Planning Sector; September 1997
2. Health and Population Sector Strategy, January 1997
3. Implementation Monitoring and Evaluation Division (IMED): HPSP Evaluation; February 2003
4. Action Plan for Completion of Agreed Reform Agenda; July, 2003
5. Assessment of the Community Clinic: Effects on Service Delivery, Utilization and Quality of Services, Charles Normand, Mustak Hassan Md. Iftekhar, and Syed Asizur Rahman, November 2002, Health System Development Program, Health Economics Unit, MOHFW

Canada (CIDA)

1. The Third Service Delivery Survey 2003, CIETcanada and MOHFW, Dhaka, March 2004.

Netherlands

1. IMEconsult; Review of the Health Program Support Office (HPSO); July 2002

United Kingdom (DFID)

1. Institute for Health Sector Development; Management Capacity Appraisal for Sector Wide Management; October 1977
2. Health Systems Resource Center; End of Program Review- HPSO; October 2004
3. Project Completion Report, August 9, 2004

World Bank

1. Identification Mission Report; January, 1996
2. Initial Executive Project Summary, February 8, 1996
3. First Preparation Mission Report; March 2-18, 1996

4. Reconnaissance Mission on Health and Population Sector Strategy; May, 1996
5. Second Preparation Mission Report, February 20-March 6, 1997
6. Pre Appraisal Mission Report, September 1997
7. Pre Appraisal Mission Reports; February 12-March 25, 1998
8. Project Appraisal Report (approved) June 1, 1998
9. Development Credit Agreement, June 30, 1998
10. Project Status Reports/ Implementation Status Reports; 3/99; 6/99;1/00;6/00; 10/00/12/00; 6/01; 12/01; 6/02/ 12/02; 6/03; 12/03; 6/04; 12/04; 6/05; 7/05
11. QAG Quality of Supervision Assessment, QSA3, July 21, 1999
12. OED: Maintaining Momentum to 2015? An Impact Evaluation of. Interventions to Improve Maternal and Child Health in Bangladesh, August 2005
13. Project Appraisal Document; Health, Nutrition and Population Sector Program, March 2005
14. Interim Poverty Reduction Strategy, Health, March 2003
15. Correspondence and Memoranda; 2003, 2004 covering: proposal to impose partial suspension; decision to impose partial suspension; proposals for lifting partial suspension; Government of Bangladesh agreement to conditions lifting partial suspension
16. Independent Procurement Review (Draft). Bangladesh. May, 2005. Contract No. 7133184, SGS Nederland B.V.

Other:

1. Use of Family Planning Services in the Transition to a Static Clinic System in Bangladesh: 1998-2002. Alex Mercer, Ali Ashraf, Nafisa Lira Huq, Fariha Hasseen, AH Nowsher Uddin and Masud Reza. International Family Planning Perspectives 31:3, Sept. 2005.