Case Study for Session 7, Module 2

How to Buy a $12 Package at $3.50,  
A Bangladesh Case Study

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How to Buy a $12 Package at $3.50, A Bangladesh Case Study

Case Materials

A. Case Materials

   I. The Case: an edited time-log
   II. Attachment One: Delphi Technique Voting Scores
   III. Attachment Two: The Final Prioritized Package from the Program Implementation Plan
   IV. Discussion Questions (To handed after the case is presented)

B. Background Materials

   I. Bangladesh and the health and population sector at a glance.
   II. Putting the poor at the center of our work (Short write up on the development of the program from an income-equity perspective)
**How to Buy a $12 Package at $3.50, A Bangladesh Case Study**

(The World Bank and the Ministry of Health have had a productive and long standing relationship almost since the independence of Bangladesh from Pakistan. The Bank has led a consortium of donors and development agencies in supporting health and population sub-sectors through technical assistance and resources.)

The time-log presented below describes the events leading to and during project preparation for the Bangladesh Health and Population Program Project (HPPP) also known by the Government of Bangladesh as Health and Population Sector Program (HPSP) and previously known as the Fifth Bangladesh Health and Population Program (HAPP-5)\(^1\).

**Log Entry Number 1:**
December 7, 1995, Ministry of Health and Family Welfare, Dhaka:

A meeting took place between the office of Secretary of Health and Family Welfare and World Bank staff members to discuss the nature of the next phase of Bank and consortium support. There was a sense of urgency because the existing project, the Fourth Population and Health Project (FPHP\(^2\)), was expected to end in less than two years. While a consensus was not reached during the half day meeting, some important themes emerged:

1. The project approach has helped Bangladesh improve health and family welfare outcomes but it is too expensive, it has left the Ministry without a sustainable management structure, and there is little coordination between the more than one hundred projects supporting the Ministry.\(^3\) (the Ministry and the consortium could not agree on a solution mostly because neither group understood what was meant by a program approach)

2. The functional integration experiment between the two service delivery directories (health and family planning) has failed, leaving the Ministry with redundancies in delivery of services, management and monitoring. (the Ministry and the consortium could not agree on a solution and the Ministry felt it ironic that the same donors that pushed for a separate branch for family planning 15 years ago were now interested in integration)

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\(^1\) Historic Note: Naming World Bank projects may seem trivial to most people but the amount of time and resources spent on the subject reflects the importance attached to it by Bank Management. The history behind the naming of HPPP (or HPSP but not HAPP-5) may be a topic worthy of a Ph.D. thesis from the London School. At issue were at least four important topics: (i) Should health come before population?, (ii) should it be the fifth in a series or a new way of doing business?, (iii) is it a project, a program, or both?, and (iv) HAPP sounds too much like Happy.

\(^2\) Note that population came before health in the fourth project.

\(^3\) The Fourth Project alone supported 66 sub-component projects ranging from malaria to MIS and health economics.
3. Given the recommendations of the World Bank’s 1993 World Development Report, the Ministry was interested in developing and financing an essential services package of cost-effective health and population services that addresses the burden of disease in Bangladesh. Unlike the other two themes, the Ministry and consortium representatives agreed to the objectives and started mapping out a strategy to achieve them.

[Editors Note: to keep this case study simple, all references to and entries about the first two themes from the original time-log have been deleted. Readers should keep in mind, however, that eventual agreements on the first two themes, project approach and integration, did play important roles in the development of a services package]

**Log Entry Number 2:**
January 23, 1996, Ministry of Health and Family Welfare, Dhaka:

Representatives of the consortium visiting mission for the Health and Population Sector Strategy met with Ministry of Health and family Welfare Officials to review mission findings and to discuss the main messages of the draft mission aide-memoire.

On the subject of the Essential Services Package, the mission agreed with the government on the following:

1. A technical working group will be created to focus on devising a package of health and family welfare interventions to be delivered.

2. The technical working group will focus on selecting the interventions, identifying the level of services delivery for each intervention, and identifying the inputs needed to provide the intervention (personnel, training, supplies, drugs, …)

3. The technical working group will have at its staring point the package identified in the 1993 World Development Report: Investing in Health. The selected interventions, however, should reflect the burden of disease in Bangladesh and the capacities of the system to deliver these interventions.

4. The technical working group and all involved with the sector strategy should keep in mind that Bangladesh only spends 3.5 dollars per capita per year on publicly provided or purchased health and population services, while the recommendations of the World Development Report 1993 was that at least 12 dollars per capita per year is spent on the package.

5. The development of Bangladesh-specific cost-effectiveness measures for all the possible interventions will take too much money and time.

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4 Six other technical working groups were created to focus on other important areas such as support services, management, finance, etc.. All references to the other technical working groups has been edited out.
Log Entry Number 3:
September 26, 1996, World Bank Resident Mission, Dhaka:

Members of the development partner consortium\(^5\) met with Ministry staff to discuss developments since the January mission. The World Bank staff member tasked to participate in the technical working group on the Essential Services Package had circulated an alarming memo that motivated this meeting. The concerns raised in the memo can be summarized as\(^6\):

1. The technical working group working on the package has evolved into four groups:
   - Child health
   - Reproductive health and population services
   - Communicable diseases
   - Simple curative care

2. Each of the subgroups has grown in size with more government and development partner participants

3. Each of the subgroups has been developing a wish list of interventions with no attention paid to cost or priorities.

After discussions, it was decided that some additional inputs were needed to facilitate the work on developing the package. Specifically:

1. WHO will finance a health economist consultant to determine how much is currently being spent on the interventions being considered for the package.

2. The Health Economics Unit of the Ministry will be asked to update their paper on the resources available for the package and meet with each technical group (and all the subgroups) to re-explain severe budgetary constraints.

3. The World Bank health economist working with the Finance technical working group, will be asked to work with the technical working group developing the package to help them develop a plan for prioritization of the essential services package shrinking it from the theoretical 12 dollars to the real-life 3.5 dollars available.

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\(^5\) The Bangladesh Development Partners consortium for health and population is made up of donors, lenders, and technical agencies. Donors include AusAID, Canadian CIDA, The European Commission, Japan, German KfW and GTZ, The Netherlands, Swedish SIDA, the UK’s DfID, and the United States’ AID. Technical agencies include WHO, UNFPA, and UNICEF. Lenders include the World Bank and Asian Development Bank.

\(^6\) Once again, the time-log has been edited to delete all issues not directly relevant to the prioritization of an essential services package. In this entry, references to issues such as linkages between the four subgroups, training requirements, and comments about the relative generosity of WHO, the host for the technical working group, over the World Bank in providing tea and cookies, were deleted.
Log Entry Number 4:
Summaries of the WHO economist consultant and Health Economics Unit reports:

Since the objective of the consultancy was to provide a quick set of estimates of the current public expenditures on elements being considered, the WHO consultant used top down costing methodology using the definitions provided by the Technical Working Group on developing the package.

<table>
<thead>
<tr>
<th>ESP Item</th>
<th>Annual Costs $US (000)</th>
<th>Cost per capita $US</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reproductive Health</td>
<td>176,000</td>
<td>1.47</td>
</tr>
<tr>
<td>1.1 Family Planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 Maternal Health and Neonatal Care</td>
<td>24,079</td>
<td>0.20</td>
</tr>
<tr>
<td>2. Child Health</td>
<td>20,018</td>
<td>0.17</td>
</tr>
<tr>
<td>2.1 EPI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2 EPI Plus</td>
<td>12,060</td>
<td>0.10</td>
</tr>
<tr>
<td>2.3 School Health</td>
<td>1,523</td>
<td>0.01</td>
</tr>
<tr>
<td>2.4 Disease Surveillance</td>
<td>1,303</td>
<td>0.01</td>
</tr>
<tr>
<td>3. Disease Control</td>
<td>4,060</td>
<td>0.03</td>
</tr>
<tr>
<td>3.1 TB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2 Leprosy</td>
<td>1,249</td>
<td>0.01</td>
</tr>
<tr>
<td>3.3 Tropical Diseases (includes vector control)</td>
<td>1,861</td>
<td>0.02</td>
</tr>
<tr>
<td>3.4 Control of Diarrheal Disease</td>
<td>5,001</td>
<td>0.04</td>
</tr>
<tr>
<td>3.5 Integrated management of Child Illness</td>
<td>2,120</td>
<td>0.02</td>
</tr>
<tr>
<td>4. Nutrition</td>
<td>11,217</td>
<td>0.09</td>
</tr>
<tr>
<td>5. STD and HIV/AIDS</td>
<td>4,500</td>
<td>0.04</td>
</tr>
<tr>
<td>5.1 STD Treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2 Prevention</td>
<td>2,000</td>
<td>0.02</td>
</tr>
<tr>
<td>6. IEC</td>
<td>15,800</td>
<td>0.18</td>
</tr>
<tr>
<td>7. Additional Services</td>
<td>131,600</td>
<td>1.10</td>
</tr>
<tr>
<td>TOTAL</td>
<td>420,704</td>
<td>3.50</td>
</tr>
</tbody>
</table>

The Health Economics Unit at the Ministry updated their resource envelope work and summarized the simulation results and presented them to each of the technical working groups (and the mushrooming sub-groups). The message was simple, even if health and population was made a priority sector by the Ministry of Finance, resources are still very limited.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Baseline</th>
<th>Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% of Gov</td>
<td>Per capita</td>
</tr>
<tr>
<td>1998/99</td>
<td>8.0%</td>
<td>3.5</td>
</tr>
<tr>
<td>1999/00</td>
<td>8.0%</td>
<td>3.6</td>
</tr>
<tr>
<td>2000/01</td>
<td>8.0%</td>
<td>3.7</td>
</tr>
<tr>
<td>2001/02</td>
<td>8.0%</td>
<td>3.8</td>
</tr>
<tr>
<td>2002/03</td>
<td>8.0%</td>
<td>3.9</td>
</tr>
</tbody>
</table>
**Log Entry Number 5:**
October 6, 1996, World Bank Resident Mission, Dhaka:

Following up on the September 26 meeting recommendations, the World Bank health economist met with members of the Technical Working Group working on the package to help devise a prioritization approach. Not surprisingly, the meeting was difficult to manage. Most of the time was spent discussing the criteria to be used in making financing decisions. After many compromises a list was agreed to:

- Potential health impact of intervention (cost-effectiveness);
- cost (unit cost per capita);
- provision feasibility (technical capacity to provide);
- public need/public health importance (burden of disease);
- scope of private provision and finance; and
- economic criteria (public goods, externalities, etc.).

The group agreed to meet again in to start applying the prioritization criteria to each of the interventions being considered by the four sub-groups.

**Log Entry Number 6:**
October 15, 1996, Ministry of Health and Family Welfare, Dhaka:

Building on the agreement of the October 6 meeting, the same group advanced the prioritization agenda by methodically applying the criteria to each intervention. The group developed a matrix that listed the interventions on the vertical and the scores assigned to them for each criterion on the horizontal. The group also identified the following issues and solutions:

1. They did not know how to move forward with prioritization beyond the matrix.

   **Suggested Solution:** devise a voting scheme for prioritization.

2. They could not achieve consensus on the weights given to each of the prioritization criterion.

   **Default Solution:** assign equal weights.

3. They did not have Bangladesh-specific cost-effectiveness numbers for most of the interventions being considered.
Suggested Solution: Use the 1993 World Development Report Numbers to determine the set to be considered but do not use cost-effectiveness to rank interventions within the set.

4. Because of the highly consultative approach used by the Ministry to develop the package and the strong participation by government staff, NGO representatives, advocacy groups, and the development partners, expectation from the package are high. It will be difficult to cut out low priority interventions.

Suggested Solution 1: The voting methodology and activity has to be transparent and include representatives of the advocacy groups.

Suggested Solution 2: If it is politically difficult to completely cut out an intervention, consider phasing in it as a way of cutting costs.

5. The group was concerned that the development of the package will have to take into account the two other structural changes being discussed, namely the change from a project to a program approach and the integration of the health and family planning. Both changes have implications to service delivery and staffing.

Suggested Solution: Slow down the development of the package until clear indications are available for the direction of the other reforms.

Log Entry Number 7:
August, 1997, Ministry of Health and Family Welfare, Dhaka:

The visiting consortium pre-appraisal mission met with the Project Preparation Team to discuss the latest developments the preparation of the services package. The Project Preparation Team gave a presentation and mapped out the way forward for completing the task. Relevant highlights from the presentation:

- A series of workshops have been held to address the issue of prioritization. Participants had to understand the prioritization criteria and agree on ratings for interventions. A two stage prioritization approach was agreed to. First the participants used the non-economic criteria (the first three listed in log entry 5). The second stage applied the economic criteria.

- Using a modified Delphi technique for voting the 17 Prioritization Task Force members individually scored each intervention according to the criteria. Scores were then averaged and circulated. After a discussion of the scores a second round of voting took place. Two trends were evident:
  -- All task Force members scored almost all interventions very high on the ten-point scale.
  -- Re-scoring did not change the results much.

- The scores from the voting exercise were provided to the Project Preparation team and the Health Economics Unit of the Ministry to use the economic criteria for the
second stage of prioritization (see scores in attachment one). [Editors Note: while the discussion about the first stage of prioritization was detailed, the discussion about the second stage was vague]

• It was very difficult to completely eliminate a number cost-effective and important interventions so the decision was taken to phase them in.

• The Technical Working Group not only identified the interventions but devised an operational plan for delivering it at each of the three primary care level, Community, Union, and Thana. Furthermore, bottom-up costing was done to identify real costs at each level.

The visiting pre-appraisal mission was impressed with the amount and quality of work the Ministry had undertaken but was concerned about one issue. The draft first year budget presented by the preparation team showed expenditures at US$519 million, while the resource envelope analysis shows the expected available resources for the first year to be US$440 million; a financing gap of US$79 million for the first year alone. The financing gap widens even more when year 2 through 5 of the program are considered.

After the hard work of limiting the package, the prospect of cutting yet another US$79 million was not good news for the Preparation Team. After a long discussion, the team agreed to prepare a “contingency operational plan” for the lower budget (US$440) for the appraisal process.

**Log Entry Number 8:**
February 7, 1998, Ministry of Health and Family Welfare, Dhaka:

The visiting consortium appraisal mission met with the Project Preparation Team to appraise the package of services and the operational plan. The mission accepted the proposed operational plan (the detailed operational plan is presented in attachment two) and invited the government to negotiate the program in Washington in May and set a World Bank Board presentation on June 30.

**Log Entry Number 9:**
June 30, 1998, the World Bank Head Quarters, Washington:

The World Bank Board approved the five-year US$2.9 billion Bangladesh Health and Population Program Project. [The World Bank, through IDA, would finance US$250 million of the total package]
II. ATTACHMENT ONE

DELPHI TECHNIQUE VOTING SCORES

(I have the tables in hard copy)
III. ATTACHMENT TWO

THE FINAL PRIORITIZED PACKAGE FORM THE PROGRAM IMPLEMENTATION PLAN

(I have the tables in hard copy)
BACKGROUND MATERIALS

I. Bangladesh and the health and population sector at a glance

Country Profile:

Bangladesh is a low-income country with a population of around 125 million people, of whom 87 percent live in rural areas, and an average GNP per capita of US$ 240 (World Bank, 1995). The ranking of the country in terms of Human Development Index (HDI) stands at 135 among 160 countries (UNDP, 1993). Literacy rates for both men and women are at present just above 35 percent. The country is administratively divided into five major divisions where each consists of around 10 districts on average.

The economy is still predominantly reliant upon agriculture, which accounts for over 45 percent of GDP. During the last two decades, the country has been going through an economic transition, which is characterized by the increasing presence of the service sector (from 28 percent to 40 percent) in the national accounts. However, low investment and savings rates are perhaps the most serious macro-economic weaknesses of the economy.

Widespread poverty is observable throughout the. According to one estimate using calorie in-take as a measure of poverty (Sen, 1992), around 44.68 million people of Bangladesh were poor in 1985/86. This would give Bangladesh the dubious distinction of having the highest incidence of poverty per square kilometer in the world. Around 44 percent and 48 percent of the urban and rural population live below the poverty line respectively.

Many political changes have taken place over the years. After gaining independence from Pakistan in 1971, Bangladesh followed a Westminster type parliamentary system for three years and then switched to a presidential system. From 1975 to 1990, the country experienced successive military dictatorships with very limited democratic norms. In 1991, true democracy emerged in Bangladesh with a free and fair election. The present government, which took power in June 1996, aims to intensify its anti-poverty policies, with a clear emphasis on community participation in the social services, like health and education, particularly for the poor and especially the women.

Health System

Health care has been a major concern of all the governments in Bangladesh. The health and population budget currently accounts for around 3 percent of GDP. The population growth rate has decelerated from 4 percent in the early 1970s to a moderate 1.84 percent in 1997 (BBS 1997). The total fertility rate has declined from 6.7 per woman in 1973 to

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8 Poverty line is defined in terms of average daily calorie in-take of 2112 k.cal per person.
3.3 per woman in 1997 (BDHS 1996/97). Maternal and infant mortality rates stand at 3 and 77 per 1000 live births in 1997 respectively (BDHS 1996/97). Despite these, however, Bangladesh still remains as one of the few countries in which life expectancy at birth is lower for females (57 years) than males (58 years).

In Bangladesh, there are a variety of types of health care service providers delivering care throughout the country. The public sector is the largest in terms of personnel and investment. Non-public sector comprises of NGOs, missions, private-for-profit and private not-for-profit organizations. However, unfortunately, their health care coverage and activities depend on their geographical presence. Very few large NGOs have well-established facilities to offer quality services to the poor. In general, the NGOs are located in the rural areas to serve the needs of the poor, particularly women. Private-for-profit organizations largely serve the urban elite and formal sector employees and they mainly render curative services for major illnesses.

The public sector health system of Bangladesh follows a vertical projected approach where individual project serves the target population. These have resulted in a widespread duplication of service delivery and coverage. The health and population sector has a three tiered service delivery strategy. Primary health care services are rendered at community outreach, Union and Thana levels. These services include prevention of diseases with a very limited scope for curative care. Secondary health care services are offered at District level where some curative services are dealt with. Major curative services that can be labeled as tertiary level services are offered at specialized and medical college hospitals in cities and municipalities across the country. The health and population sub-sectors are divided by their scope of work, and there seems to exist an antagonistic feeling between the two “wings” – health services and family planning - of the Ministry of Health and Family Welfare (MOHFW).
Table 1: Health Sector Indicators

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<tr>
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</thead>
<tbody>
<tr>
<td>CDR (per 1000 pop.)</td>
<td>12.0</td>
<td>8.5</td>
<td>7.9</td>
<td>7</td>
</tr>
<tr>
<td>CBR (per 1000 pop.)</td>
<td>30.0</td>
<td>27.0</td>
<td>24.9</td>
<td>22</td>
</tr>
<tr>
<td>IMR (per 1000 live births)</td>
<td>80.0</td>
<td>78.0</td>
<td>77.0</td>
<td>55</td>
</tr>
<tr>
<td>MMR (per 1000 live births)</td>
<td>4.5</td>
<td>4.5</td>
<td>3.6</td>
<td>3.0</td>
</tr>
<tr>
<td>Life Expectancy (Years)</td>
<td>55</td>
<td>58</td>
<td>58.1 (Male)</td>
<td>60 (Male)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>57.6 (Female)</td>
<td>59 (Female)</td>
</tr>
<tr>
<td>Population covered by PHC (%)</td>
<td>80</td>
<td>45</td>
<td>50</td>
<td>70</td>
</tr>
<tr>
<td>EPI Coverage (under 1 year in %)</td>
<td>85</td>
<td>66</td>
<td>66</td>
<td>85</td>
</tr>
<tr>
<td>Delivery assisted by trained personnel (% of preg. Women)</td>
<td>50</td>
<td>12</td>
<td>14</td>
<td>80</td>
</tr>
<tr>
<td>Antenatal Care (% of preg. women)</td>
<td>60</td>
<td>35</td>
<td>40</td>
<td>80</td>
</tr>
<tr>
<td>Nutrition (per capita daily average intake in Kcal)</td>
<td>2100</td>
<td>1950</td>
<td>1950</td>
<td>2300</td>
</tr>
<tr>
<td>Control of Diarrhea (% of ORS use)</td>
<td>90</td>
<td>66</td>
<td>70</td>
<td>90</td>
</tr>
<tr>
<td>Control of TB (% of cases found)</td>
<td>50</td>
<td>30</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

Sources: GOB, UNICEF.

Table 2: Selected Indicators of the Population Sub-sector

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Growth Rate (%)</td>
<td>2.07</td>
<td>2.0</td>
<td>1.82</td>
<td>1.96</td>
<td>1.84a</td>
<td>1.4</td>
</tr>
<tr>
<td>TFR (per woman)</td>
<td>4.0</td>
<td>3.8</td>
<td>3.4</td>
<td>3.78b</td>
<td>3.3</td>
<td>2.6</td>
</tr>
<tr>
<td>CPR (%)</td>
<td>41</td>
<td>43</td>
<td>50</td>
<td>46</td>
<td>49</td>
<td>62</td>
</tr>
</tbody>
</table>

Sources: GOB, DHS, BBS and United States Agency for International Development (USAID)

* Bangladesh Bureau of Statistics

b Bangladesh Demographic and Health Survey, Mitra and Associates, 1997

FFYP: Fifth Five Year Plan
BACKGROUND MATERIALS

II. Putting the poor at the center of our work

The World Bank is a member of a consortium of lenders, donors and technical agencies providing financial and technical assistance to the Government of Bangladesh in the health and population sector. The consortium finances a project supporting the Government’s five-year Health and Population Sector Program. The focus on the poor and on improving the government’s investment in the health of the poor is at the heart of the design and monitoring of implementation.

This short write-up describes a program preparation process and design elements that strengthened the focus on the poor. Before turning to program design, it is important to recognize two enabling factors. A strong political commitment by the Government to reaching the villages, the poor and vulnerable coupled with the Bank's assistance strategy aimed at improving services for the poor, especially women and children, provided the context for program development. An important step was the development of a Health and Population Sector Strategy that guided program design.

I. The Poor and the Process of Designing The Sector Program

I.a. Incorporating the Poor into the Goals of the Sector Program

In February of 1997, a Logical Framework workshop brought together more than one hundred participants representing different elements of the Bangladesh Government, the NGO community, development partners, and civil society. The main objective of the workshop was to build consensus on sector goals and on how to achieve and measure these goals.

Table 1: Four Cells from the Logical Framework of the Program

<table>
<thead>
<tr>
<th>Goal</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved health and family welfare status among the most vulnerable women, children and poor of Bangladesh.</td>
<td>1. Increased pct of population, esp. of women, children and poor needing ESP who receive appropriate, timely, affordable, accessible, client-centered, one-stop ESP (reproductive health care, child health care, communicable disease control, simple curative/limited care), which meet govt/community quality standards (see detailed indicator matrix)</td>
</tr>
<tr>
<td>1. MMR reduced</td>
<td>2. IMR m/f reduced</td>
</tr>
<tr>
<td>2. IMR m/f reduced</td>
<td>3. &lt;5 MR m/f reduced</td>
</tr>
<tr>
<td>3. Malnutrition m/f reduced</td>
<td>4. Communicable diseases controlled m/f (STD/HIV, TB, etc.)</td>
</tr>
<tr>
<td>5. Unwanted fertility reduced</td>
<td>6. 60-65% of annual public expenditure for sector allocated to ESP.</td>
</tr>
</tbody>
</table>

The resulting Logical Framework for the program included references to the poverty focus as well as monitoring indicators that related to health and family welfare outcomes.

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9 Consortium donors include Canadian CIDA, The European Commission, German KfW and GTZ, The Netherlands, Swedish SIDA, and the UK’s DFID. Technical agencies include WHO, UNFPA, and UNICEF.

10 The Program was designed by the Ministry of Health and Family Welfare. The World Bank team assisting the ministry was led by Philip Gowers (for lending) and Regina Bendokat (for ESW).
(e.g. health and fertility status) and outputs (e.g. use of life-saving services) for the poor. Although this alone does not guarantee that design included a poverty focus, it was used repeatedly during preparation to reinforce the focus on the poor and ensured that the success or failure of the Program will be based on the ability to reach and help the poor.

I.b. Listening to the Poor

Situational analysis conducted during strategy development indicated that many of the health and population services were not reaching the poor. To improve program design, analysis was required regarding which segments of society were not gaining from publicly provided services and why they were not. Quantitative (passive) and qualitative (active) tools were used to help answer some of these basic questions.

Using data from a nationally representative household survey conducted by the Bangladesh Bureau of Statistics, benefit incidence analysis was conducted to measure the size of the public subsidy reaching each income group. The survey allowed for analysis of utilization patterns of public sector services across income groups. The poorest segments of Bangladeshi society were less likely to seek care at public hospitals and sub-district health complexes. The only level of care delivery where the poor and the rich were likely to seek care equally was the lowest level of service delivery at community centers. These facts, combined with the higher unit cost for using hospitals and health complexes, suggests that the poor in Bangladesh have realized a considerably smaller share of the health subsidy than the rich.

Figure 1: Use of different levels of health care services when ill, by income group

While quantitative analysis measured the magnitude of inequality and hinted at some of its causes, it could not provide the depth of information needed for program design. A more active form of listening was then used (qualitative data collection and analysis) in order to better understand the underlying issues. First, stakeholder analysis and mapping identified potential users of the public facilities. Consultations were then conducted using Participatory Rapid Assessment techniques. Inputs from primary stakeholder consultations informed policy makers at different stages of the design. Table 2 summarizes the main reasons given by the participants for the limited use of public facilities that were designed to be free of charge.
### Table 2: Why vulnerable groups, including the poor are not seeking care

<table>
<thead>
<tr>
<th>Price of seeking care</th>
<th>Other demand factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• High real costs (transport and waiting time)</td>
<td>• Lack of knowledge about service availability (illiteracy)</td>
</tr>
<tr>
<td>• Hidden costs (illegal payments to doctors and gatekeepers)</td>
<td>• Behavior of providers (rude and not helpful to the poor)</td>
</tr>
<tr>
<td>• Uncertainty related to illegal payments (easier to pay private providers)</td>
<td>• Non-availability of qualified providers</td>
</tr>
<tr>
<td></td>
<td>• Drug shortages</td>
</tr>
</tbody>
</table>

### II. Design Features for Improving Impact on the Poor

By making sure that program goals explicitly focus on the poor and by listening to the voices of the poor, program designers included a number of elements that should improve the performance of the sector.

#### II.a. Focusing on the diseases affecting the poor

In designing a package of services, attention was paid not just to the most cost-effective interventions and the system of delivery. Planners recognized that while the epidemiological transition was underway in Bangladesh many “diseases of the poor” persisted. The services package was prioritized to address diseases that disproportionately impact the poor.

#### II.b. Increasing and protecting resources to the services and facilities serving the poor

In addition to designing a services package that was pro-poor, the program increased and protected funding for the services package. In each of the five years of the program, no less that 60 percent of all public resources spent on health (including donor funds) would be used to deliver the package. As a byproduct of this agreement, more resources will flow to the facilities that are more likely to serve the poor as identified in the analytical work (section I.b).

To ensure that investments in new hospitals will not drain resources from the delivery of the package at lower level facilities, the program will analyze the recurrent cost implications to new capital investments before undertaking them. And given the importance that poor clients assign to having drugs and supplies at the facilities, the program will ensure that adequate funding for non-salary recurrent costs will be protected from new investments and the constant pressure to increase wages and hiring.

#### II.c. Addressing the knowledge gaps of the poor

The qualitative analytical work identified the lack of knowledge about the availability of basic life-saving services as a significant determinant of low demand by the poor. This indicated the need to strengthen the role of the government in Behavior Change Communications. As a result, the program strengthened the fiscal commitment to information dissemination for behavioral change and explored more effective ways of reaching the poor and vulnerable. The program creates an independent body funded by the government that emphasizes the use of multiple communication channels to reach the poor and encourage improved knowledge and behavior change.
II.d. Empowerment
One of the most striking findings from the qualitative work was the extent to which the poor were helpless in facing the health system and health services providers. Repeatedly, participants in focus groups spoke of the lack of balance in their relationship with the health sector. Program designers recognized that it may be impossible to completely rectify the power balance but developed two activities to help address empowerment. First the program adopted a “client bill of rights” that would be disseminated widely and made prominent at all health facilities. The second policy decision was to create Health Facility Committees at both community and sub-district levels. These Committees would include elected local officials and representatives from women’s organizations, non-governmental organizations, and other groups that are usually excluded.

II.e. Making listening a habit
Given the important role that listening to the poor and vulnerable played in program design, the designers decided to fund an annual independent data collection activity that both monitors improvements in helping the poor and suggests ways to continually improve. The program will use service delivery surveys, which combine qualitative and quantitative methods, to focus on the issue of the use of essential services by vulnerable groups. These surveys will be representative and will take place before each of the annual performance reviews. Flexibility in the design of the program allows for adjustments to be made annually and will take advantage of listening to what the clients are saying.

III. Implementation, Implementation, Implementation
The design of the Bangladesh Health and Population Sector Program focuses aggressively on the poor, but is it implementable? The program became effective in August of 1998 but has experienced start-up delays due to extreme and long-lasting flooding from the monsoon rains of 1998. The first annual performance review will take place in April of 1999 but the first opportunity to determine if all the design elements are working as planned will be the following annual review in the year 2000. It will be important at that point to start asking some difficult questions:

• Is the program having an impact on the health and family welfare of the poor?
• Are political economy forces reorienting resources to services that serve the privileged?
• Can resources be further targeted using direct and indirect methods?
• Is the services package too rigid to take into account varying needs of the poor?
• Are the empowerment mechanisms effective?
• Are the policy makers still listening to the poor?