Performance monitoring frameworks in the health sector

Country notes

BANGLADESH

Context

The Bangladesh SWAp was launched in the 1990s and since then it has supported a series of health sector programmes, the latest being the Health, Nutrition and Population Sector Programme (HNPSP). Before the HNPSP, the Health and Population Sector Programme (HPSP) ran from 1998 to 2003.

The HNPSP officially began in 2003, but various delays meant that it did not actually start until 2005. It is due for completion in 2010. The HNPSP supports the priorities and investments set out in the HNP Strategic Investment Plan (SIP) 2003-2010.

The HNPSP focuses on three major reform areas:

1. Strengthening public health sector management and stewardship capacity through development of pro-poor targeting measures, as well as strengthening sector-wide governance mechanisms;
2. Health sector diversification through the development of new delivery channels for publicly and non-publicly financed services; and
3. Stimulating demand from poor households for essential services through health advocacy and demand-side financing options.

During programme preparation and in the first year of execution, several development partners decided to pool their funds and entrust their administration to the World Bank. Arrangements for a multi-donor trust fund were set up, and in October 2006 the Government of Bangladesh (represented by the Ministry of Health and Family Welfare) and the World Bank signed a partnership arrangement.

Overall, the HNPSP is a sector programme worth US$4 billion with government funds making up 66% of the total. The pooled fund contains approximately US$ 750 million, and parallel funds administered directly by development partners total approximately US$ 649 million[1].

Sector monitoring framework

The World Bank HNPSP Programme Appraisal Document (PAD) notes that a strong monitoring and evaluation mechanism should be clearly laid out with input, process, output and outcome indicators for tracking implementation progress over the duration of the programme.

The PAD includes a Results Framework[2] consisting of 62 indicators. Annex B of the partnership agreement sets forth the Annual Planning Cycle and the Meeting Schedule for the Ministry of Health and development partners.

The HNPSP undergoes an Annual Programme Review (APR) every April. This includes an independent review of the sector undertaken by a team of consultants. Based on the APR, a process of joint analysis by Government and development partners produces conclusions and recommendations in a final aide memoire[3]. One of the responsibilities of APR consultants is to review progress against the Results Framework, which means that information on progress against the Results Framework must be collected by March each year.

1. Figures approximate as of April 2007. Source: Bangladesh Annual Programme Review of the Health, Nutrition and Population Sector Programme 2007, Report of the Independent Review Team. Technical Annex, Health Economics and Financing.

2. Annex 3A, pp.36-42.

3. Aide memoires for 2005, 2006 and 2007 can be downloaded from http://www.hnpinfobangladesh.com

This Results Framework is one of two monitoring frameworks put forward early in the Programme – the other is the Strategic Performance Indicators and Monitoring Plan, detailed in the HNP Strategic Investment Plan July 2003-June 2010. In practice, this second framework has been discarded, and all monitoring and evaluation processes now use the PAD Results Framework as their reference.

Linkages with poverty reduction

The HNP Strategic Investment Plan 2003-2010 identifies 5 key objectives and related service priorities. The objectives are linked to both the health MDGs and the priorities set out in the 2003 National Strategy for Economic Growth and Poverty Reduction (equivalent to the I-PRSP). They are:

1. Reducing maternal, neonatal and childhood mortality and improving maternal and childhood nutrition;
2. Reducing total fertility to replacement level;
3. Reducing the burden of TB and malaria and preventing and controlling HIV/AIDS;
4. Reducing injuries and implementing improvements in emergency services; and
5. The prevention and control of major non-communicable diseases (NCDs).

The HNPSP aims to accelerate progress towards the country's health goals by expanding health services coverage and putting in place various policy reforms to improve the equity and efficiency of service delivery. Component 1 of its Results Framework comprises 15 specific MDG and I-PRSP output and efficiency indicators, and both the Annual Programme Reviews and the yearly aide memoires report specifically on advances against HNP-related MDG and PRSP goals.

Comments

In Bangladesh, there are a number of obstacles to the effective use of a sector monitoring framework. Some are related to issues of reliability, quality and timely delivery of information. Information on many indicators from the Results Framework is often not available at the time when it is needed (i.e. prior to or during the Annual Programme Review), and even when it has been made available (such as in 2006) the validity of the indicators was questioned. This was due to either the measurability of the indicator or to the reliability of the sources.

For example, the APR of the NHNPSP (2007) reports that 35 out of 62 indicators had recorded either no progress or that no information was available. Furthermore, after two years of implementation, the six core indicators that were meant to serve as performance-based triggers for funding levels can still not be measured convincingly, mainly because there is no consensus about the methodology to be used. Consequently, the main discussions around the Results Framework at APR time continue to be about methodology and validity of indicators, not about progress in the sector. And, as a result, the Annual Programme Reviews, which in principle should devote time and space for government and development partners to analyse progress against the Results Framework, have been constrained in doing so.

Another issue is that the Results Framework has been designed to serve the monitoring needs of the International Development Association/World Bank and development partners. SWAp-related monitoring frameworks in most countries with a health SWAp are expected to mainly serve the needs of the implementing agency – in this case the Ministry of Health and Family Welfare – and to unify reporting and monitoring arrangements. This is not the case in Bangladesh, where the Results Framework has to compete with a large number of parallel, programme-related information systems which are not integrated.

In addition, the Results Framework includes a very large number of indicators, many of which require annual reporting. The effort and resources for data collection and analysis needed are probably beyond the capacity of the government health system, and to a large extent are unjustifiable given the questionable value attached by many to the Results Framework in the first place.

These issues help to explain the limited use of the HNPSP monitoring frameworks in Bangladesh to date. Other reasons include:

- Contextual factors: the indicators are supposed to be "analysed" in the course of the APR (which lasts only three weeks) together with many other issues - which compromises the usefulness of the Results Framework.
- Technical and cost factors: the Health Management Information System cannot routinely provide information on many of the indicators, meaning that measuring many of them would require costly (at times annual) surveys. This does not seem financially feasible.
- Lack of a baseline: in 2007, baseline information was not available for 42 out of the 62 indicators, and it was unclear whether baseline information of sufficient quality would ever be produced because of the costs involved.[4]
- Programmatic and managerial factors: the Ministry of Health and development partners have limited qualified staff to put the results of a monitoring framework into context. If the indicators are not properly interpreted their value is likely to be perceived as low and the incentive for continued data collection is lost.

All in all, to date, stakeholders have not been able to use the HNPSP monitoring framework for its intended purposes. The Results Framework was described at the 2006 APR as "overly ambitious, complex and, for the most part, un-measurable"[5].

All the issues mentioned so far seem to suggest that there are fundamental flaws in relation to sector monitoring under HNPSP. This is further compounded by an apparent lack of appetite for data and information within the Ministry of Health and Family Welfare and within Government as a whole. Information and evidence do not play a key role in decision-making, in part because of the bureaucratic and hierarchical nature of government service. Thus, the Results Framework loses much of its potential for effective sector monitoring as it is often seen as something that concerns the APR consultants, not the line directors, programme managers and other staff responsible for implementation of services and national programmes.

The framework can appear as an isolated effort within a health system that does not use and is not driven by information. In theory, the large numbers of indicators are seen as a way to improve the quality of the information and decision-making. In practice, the size of the framework leads to subjectivity and lack of focus. This is something that the SWAp stakeholders should address.

However, there is general agreement about the need to strengthen monitoring and evaluation capacity for the HNPSP and for the Ministry of Health and Family Welfare. To this end, a Monitoring and Evaluation Unit (MEU) was established within the planning wing of the Ministry in December 2006. The Unit was tasked with putting in place the HNPSP M&E agenda and coordinating M&E activities for the programme. A Task Group has been formed to lead the process. MEU now needs to further define its workplan, establish adequate financing and staffing, contract relevant technical assistance and update the Results Framework. Over time, the MEU will have to deal with all the other issues mentioned here and with HNPSP programme reporting in particular.

4. APR 2007 Report produced by Independent Review Team.

5. Monitoring and Evaluation and Management Information Systems of HNPSP. Independent review of the HNPSP at the 2006 APR. (Sonja Schmidt, April 2006).

Key documents

HNP Strategic Investment Plan: July 2003 - June 2010 (Ministry of Health and Family Welfare, Planning Wing, 2004)

Partnership arrangements between the Government of Bangladesh and Development Partners concerning support for the implementation of the Health, Nutrition and Population Sector Programme (HNPSP)

Project appraisal document on a proposed credit in the amount of SDR 196.1 million (US $300 million equivalent) to the People's Republic of Bangladesh for a Health Nutrition and Population Sector Program (World Bank, 2005)

Bangladesh Health, Nutrition & Population Sector Programme: Annual Programme Review 2007. Main Consolidated Report: Key Findings, Conclusions and Recommendations (Independent Review Team, 2007)

Other relevant documents are available at: http://www.hnpinfobangladesh.com/

Performance measures

Indicators	Definition	Baseline	Information / Data Sources / Comments
1. % of births attended by skilled personnel	Percentage of deliveries of target population conducted by skilled personnel (excluding TBAs) during the last one year. Disaggregated by socioeconomic status	2004: 13.4 BDHS	Sources: BDHS, MICS, SDS, Rapid Assessment
2. Percentage of DPT3 coverage	Percentage of children immunized by DPT3 within first year of life. Disaggregated by gender and socioeconomic status	2004: 81.0 BDHS	Sources: EPI Coverage Survey, BDHS, MICS, SDS, HKI, Rapid Assessment
3. Percentage of measles immunization	Percentage of children immunized against measles within first year of life. Disaggregated by gender and socio-economic status	2004: 75.7 BDHS	Sources: EPI Coverage Survey, BDHS, MICS, SDS, HKI, Rapid Assessment
4. Percentage of children 1-5 years receiving vitamin A supplements in last 6 months	Percentage of children (9-59) receiving vitamin A capsules in the 6 months preceding the survey	2004: 81.8 BDHS	Sources: EPI Coverage Survey, BDHS, MICS, SDS, HKI, Rapid Assessment
5. % of women with long lasting birth control methods	% of women on long-lasting birth control methods of all methods used (male and female sterilization, Norplant and IUDs)	2004: 7.2 BDHS	Sources: BDHS, SDS, Rapid Assessment
6. CPR, with proportions for method mix	Percentage of currently married couples aged 15-49 years who are currently using contraception (specified by method)	2004: 58.1 BDHS	Sources: BDHS, SDS, Rapid Assessment
7. Age at first birth	Average (median) age of women at first birth	2004: 17.7 BDHS	Sources: BDHS, SVRS, Rapid Assessment
8. Detection of smear -positive TB cases	Annual TB case detection rate of smear-positive incidence cases. Disaggregated by gender and socioeconomic status	2004: 46% NTP	Sources: National TB Control Program (NTP)
9. TB cure rate	% of TB cases cured of the total detected cases	2004: 85% NTP	Sources: National TB Control Program (NTP)
10. % of population using bed nets (in endemic areas)	% of population using bed nets in endemic areas	No data available	
11. % of 15-24 year olds who used a condom with non-regular partners	% of 15-24 years olds who used a condom with non-regular partners	No data available	

Indicators	Definition	Baseline	Information / Data Sources / Comments
12. % of adults (age 15-55) who use tobacco	% of adults (age 15-55) who use tobacco. Disaggregated by gender and age	2004: 29.6% BDHS (men age 15-54)	Sources: BDHS, Rapid Assessment
13. % of women receiving counselling after injury	% of women who receive counselling after injury of all injured women who attended a facility	No data available	
14. Number of public awareness messages on injury/ accidents per capita	Number of public awareness messages on injury/ accidents per capita per year	No data available	
15. % of blood screened before transfusion	% of blood screened before transfusion among total number of transfusions	No data available	
16. Infant Mortality Rate (IMR) (per 1000 live births)	Number of deaths in a year of children under 1 year of age, per 1000 live births in same year. Disaggregated by gender and socioeconomic status.	2004: 65 BDHS	Sources: BDHS, SVRS, Rapid Assessment
17. Under 5 Mortality Rate (per 1000 live births). Male/Female	Number of deaths in a year of children under 5 years of age per 1000 live births. Disaggregated by gender and socioeconomic status.	2004: 88(BDHS)	Sources: BDHS, SVRS, Rapid Assessment
18. Maternal Mortality Ratio (MMR) (per 1,000 live births)	Number of maternal deaths in a year due to pregnancy-related causes during pregnancy or within 42 days of childbirth, per 1000 live births in same year. Disaggregated by socioeconomic status.	No data available	Sources: SVRS
19. % U5 underweight	Percentage of under-5 children who are underweight	2004: Moderate and severe 47.5%(BDHS), Severe: 12.8% IPHN/HKI	Sources: BDHS, IPHN/HKI, BBS/UNICEF Child Nutrition Survey, Rapid assessment
20. % of severe stunting (24 to 60 months of age)	% of children 24 to 60 months of age who are severely stunted	2004: 16.9 (BDHS) 12.4 for rural Bangladesh (in HKI surveillance project)	Sources: BDHS, IPHN/HKI, BBS/UNICEF Child Nutrition Survey, Rapid assessment
21. Total Fertility Rate (TFR) per woman aged 15-49 years	The average number of children that would be born to a woman during her reproductive lifetime under current age-specific fertility rates. Disaggregated by socio-economic status.	2004: 3.0 (BDHS)	Sources: BDHS, SVRS, SDS, Rapid Assessment
22. Met need for EOC	Proportion of women estimated with obstetric complications treated at facilities.	No data available	Sources: EOC Project

Indicators	Definition	Baseline	Information / Data Sources / Comments
23. % Increased in utilization of HNP services by the two lowest quintiles.	Proportion of increase of service recipients of HNP services from the two lowest quintiles out of the total number of service recipients utilizing the services.	No data available	Sources: PHSUS-HEU, Rapid Assessment
24. Emergency Health Response Strategy implemented and working to agreed standards	Emergency Health Response Strategy implemented and working to agreed standards	No data available	
25. Urban HNP Strategy developed and implemented	Existence of Urban HNP Strategy Developed and implemented	No data available	
26. NCD Prevention Strategy developed and implemented	NCD Prevention Strategy developed and implemented	No data available	
27. Environmental Action Plan (safeguard indicators) approved by MOHFW	Self Explanatory: Physical presence of environmental action plan with the approval of MOHFW	No data available	
28. % of districts with disease surveillance report	Percentage of districts sending timely and complete disease surveillance reports on monthly basis.	No data available	Sources: Director DDC, IEDCR
29. Expansion of hospital autonomy	Number of hospitals that has been functioning with autonomy out of the total number of hospitals in the system.	No data available	
30. Strategy of LLP developed and implemented	Self Explanatory. Physical presence of LLP strategy and its implementation	No data available	
31. Feasibility study for financial decentralization to district level	Self Explanatory. Feasibility study designed and conducted for financial decentralization to district level	No data available	
32. Regulatory framework (including quality assurance) for non-public providers	Self Explanatory. Presence of regulatory framework for non-public providers.	No data available	
33. Accreditation system for public and private service providers	Existence of accreditation system for public and private service providers	No data available	
34. Commissioning ESD from non-public providers through MSA	Self Explanatory: Commissioning ESD from non-public providers through MSA	No data available	

Indicators	Definition	Baseline	Information / Data Sources / Comments
35. Establishment of Performance Monitoring Agency (PMA) for commissioning of non-public providers	Establishment of Performance Monitoring Agency (PMA) for commissioning of non-public provider	No data available	
36. Demand side financing models (including voucher schemes, user fees, social and private insurance etc.) piloted and evaluated	Self Explanatory. Demand side financing models including voucher schemes, user fees, social and private insurance etc. piloted and evaluated	No data available	
37. Share of total government budget allocated to MOHFW budget	Percentage of government budget allocated to MOHFW that includes both revenue and development allocations.	2004: 6.5% National Budget 2004-05 and 5.7% Revised National Budget 2004-05	Sources: National budget
38. MOHFW HNP ADP budget compared to HNP actual expenditure (GOB and DP)	Ratio of MOHFW HNP ADP budget and HNP actual expenditure	2004:	Sources: CDPU/OCGA
39. Proportion of total MOHFW expenditure allocated to the 25% poorest districts	Self Explanatory. Proportion of financial allocation to the 25% poorest districts in relation to other districts.	21.5% (2004-05)	Sources: CDPU/OCGA
40. % of audit objections fully settled within 12 months after completion of fiscal year	Self Explanatory. Percentage of audit objections fully settled within twelve months after completion of fiscal year	No data available	Sources: Local and foreign audit office
41. Proportion of users in the two lowest quintiles who receive consultation and drug treatment free-of-charge in public health facilities	Proportion of users from the two lowest quintiles in relation to other quintiles who receive consultation and drug treatment free-of-charge in public health facilities	No data available	
42. Medium Term Expenditure Framework	Development of a Medium Term Expenditure Framework	No data available	Sources: PETS
43. Institutional arrangement for integration of nutrition into SWAp at national and district levels designed and agreed	Follow up of development of plan and preparation for implementation for integration	No data available	
44. Institutional arrangement for integration of HIV/AIDS into SWAp at national and district levels designed and agreed	Development of plan and implementation for integration	No data available	

Indicators	Definition	Baseline	Information / Data Sources / Comments
45. Regulatory framework (including quality assurance) for pharmaceuticals in place	Formulation of an HS, FP and PMIS delivering management information to agreed specifications	No data available	
46. Proportion of health care utilization at facility level by two poorest SES quintiles among attendees: CCs and / or Satellite Clinics and /or EPI spots: UHFWCs; UHCs; Medical college hosptals; District Hospitals	It is the proportion of users from the two lowest quintiles in relation to other quintiles by health care utilization at facilities.	No data available	
47. Steps taken to improve presence of staff present at upazila level	Type of administrative measures taken to improve presence of staff at upazila level	No data available	
48. Implementation of improved planning and budgeting procedures to agreed specification	Self Explanatory: Implementation of improved planning and budgeting procedures to agreed specification	No data available	
49. HS, FP and PMIS delivering management information to agreed specifications	HS, FP and PMIS delivering management information to agreed specifications	No data available	Sources: HMIS and FPMIS reports
50. Performance audit linking finance and performance	Performance-based resource allocation and release of fund	No data available	Sources: PA report
51. Institutional arrangement for community and stakeholders participation	Institutional arrangement for community and stakeholders participation in place and duly practiced	No data available	
52. (HSUF) Health Service Users Forum	Establishment of Health Service Users Forum	No data available	
53. Tribal HNP plan (Safeguard indicators)	Formulation of a Tribal HNP plan (Safeguard indicators)	No data available	
54. Memorandum of Understanding (MOU) agreed, signed and implemented	Self Explanatory	No data available	

Indicators	Definition	Baseline	Information / Data Sources / Comments
55. % of performance-based finance disbursed	Self Explanatory	No data available	
56. PSO established and functional	Self Explanatory	No data available	
57. HR Task Force established with TORs and operational	Self Explanatory	No data available	
58. Performance-linked staff incentive systems in place	Performance-linked staff incentive systems initiated and implemented	No data available	
59. Contracts awarded within initial bid validity period	Self Explanatory	2004: 91.7% (2004-05)	Sources: CMSD-DGHS, Director (Logistics & Supply)-DGFP
60. Proportion of commodities distributed by DGHS and DGFP versus received by service delivery providers	Self Explanatory	No data available	
61. Reducing mis-procurement	The action of cancelling that portion of the loan/credit for which goods, works and services have not been procured in accordance with the agreed provisions in the credit/ agreement	No data available	Sources: Procurement records
62. Letter of credit be opened (when applicable) within 14 days of signing the contract.	% of Letters of Credit (LC) opened (when applicable) within 14 days of signing the contract.	No data available	Sources: Procurement reports

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