

EVALUATION REPORT



JOINT UNICEF BANGLADESH-GOVERNMENT OF BANGLADESH HEALTH PROGRAMME MID-TERM EVALUATION 2017-2020

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**Joint UNICEF Bangladesh-Government of
Bangladesh Health Programme
Mid-Term Evaluation 2017-2020**

**Final Report
Volume I
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Joint UNICEF Bangladesh-Government of Bangladesh Health Programme Mid-Term Evaluation 2017-2020 Final Report

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Joint UNICEF Bangladesh – Government of Bangladesh Health Programme Mid-Term Evaluation 2017-2020

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CONTENTS

EXECUTIVE SUMMARY	5
LIST OF TABLES AND FIGURES	13
LIST OF ABBREVIATIONS	14
INTRODUCTION	18
METHODS	22
RESULTS	38
CONCLUSION	102
LESSONS LEARNT	108
RECOMMENDATIONS	112
REFERENCES	115

EXECUTIVE SUMMARY

Background

UNICEF Bangladesh, in collaboration of the Ministry of Health and Family Welfare (MoHFW), is implementing a large-scale joint country health programme to address challenges that are linked to global health priorities and targets. The programme focuses on three main areas: i) health service interventions across the country focused on the district health system, including maternal and neonatal health, adolescent health, and Extended Programme on Immunisation (EPI); ii) health system strengthening focused on Community Health, Health Management Information System (HMIS), District Evidence-Based Planning and Budgeting (DEPB), and Leadership Development Programme (LDP); and iii) humanitarian support mainly focused on the Chittagong Hill Tract areas. Programme activities are implemented in partnership with the Government of Bangladesh (GoB) and other national stakeholders. The health programme builds on the UNICEF 2012-2016 Country Programme and focuses on the new programme cycle as defined in the 2017-2020 Country Programme.

Methods

The evaluation focused on the UNICEF Programme's overall progress in achieving its overarching objectives over the first two years of implementation (2017-2018). The evaluation focused on the current country programme (2017-2020) but in some cases examined linkages with the previous programme (2012-2016), and links to cross-sectoral support such as water, sanitation and hygiene (WASH) and disability. The emergency humanitarian responses are covered to some extent where relevant. The evaluation has followed the OECD/DAC evaluation criteria of Relevance, Coherence, Effectiveness, Efficiency, Impact, Connectedness and Sustainability.

A mixed-method design was adopted for the evaluation. This design incorporated six components to address the 33 evaluation questions outlined in the Terms of Reference (ToR). The qualitative methods included a desk review, focus group discussions (FGD) and key informant interviews (KIIs), while the quantitative methods included secondary data analysis, observations of health facilities, consultations and community group meetings and an exit survey of end-beneficiaries. The evaluation methods, data collection tools and consent process were reviewed and approved by the Institutional Review Board (IRB) of the Institute of Health Economics (IHE), University of Dhaka.

Fieldwork was conducted over two months in six districts, one City Corporation and at the national level. Interviews with policy makers and development partners at the central level were conducted by the report authors, while field-based data collection was conducted by quantitative and qualitative enumerators and medical doctors from Mitra and Associates.



Data was analysed by evaluation areas, and quantitative and qualitative data are presented simultaneously in the report. We used Stata to analyse quantitative data and NVivo for thematic analysis of qualitative data. Preliminary findings and end results were presented to UNICEF and Ministry of Health & Family Welfare (MoHFW) officials. Draft and final reports were produced summarising the evaluation findings.

This evaluation has important key considerations, limitations and constraints. Primary data was not collected before the programme began and there is no control data to allow the evaluation to consider the counterfactual (i.e. what would have happened in the absence of this programme). The focus was on the UNICEF-GOB programme of support, not the entire GOB sector programme. Attribution is difficult to impute, given the joint implementation with GOB and other programmes, so the evaluation primarily focused on UNICEF/GoB contribution to the results. The health programme built on the UNICEF 2012-2016 Country Programme and focused on the new programme cycle as defined in the 2017-2020 Country Programme. As the evaluation took place before the finalization of the country programme, the evaluation team had some idea of the programme direction however could not be fully sure how it would end. Finally, resource constraints limited fieldwork to six districts and one City Corporation.

Findings

RELEVANCE

The programme is closely aligned to GoB's own policy documents and strategic plan for the 4th Health, Population, Nutrition Sector Plan (HPNSP4). UNICEF has been a core partner and non-pool funder since the start of the Health Sector Wide Approach (SWAp) process and is actively involved in the planning process. Within each programme area, interventions focus on the indicators and areas that are lagging. The changing context, including needs of a middle-income country and the nature of development partner engagement, suggests the programme will need to reorient in the future by focusing on the changing disease burdens (e.g. non communicable disease), greater engagement in urban areas, changing roles for development partner funding, and new indicator(s) to assess programme effectiveness. Indicators associated with outcomes have baseline values and targets for 2020. However, some of the baseline values are for the country as a whole rather than, for programmes that are specific to particular areas, for the areas that UNICEF are working in.

COHERENCE

The programme draws from a situation analysis that makes clear links between population needs and interventions. UNICEF's contribution is based on historic strengths (e.g. EPI, maternal and neonatal health), emerging international areas of focus (e.g. adolescent health) and more recent but well embedded health systems strengthening (HSS) support (HMIS). Although the programme is internally coherent, there are some misconceptions of the interventions amongst partners, and programme and strategy development documents lack reference and linkage to other partner programmes.

EFFECTIVENESS

With a few exceptions, output monitoring indicators and spending suggest activities are on track, and outcomes as measured by HMIS and available sample surveys are moving in a positive direction. Where they are not, there are indications that outputs will be delivered during the last two years of the programme. Programme effectiveness could be enhanced in several areas: i) greater linkage of community/communication for development (C4D) interventions with supply-side programme components; ii) a more consistent approach to development, synthesis and communication of evidence, including comparisons with similar programmes; and, iii) increasing focus on quality as well as quantity of data collected through the HMIS. Although it is unsurprising that much monitoring has focused on quantity of service roll-out, it will be important to start monitoring the content and quality of services if the envisaged gains in health outcomes are to be achieved. Human resource availability remains a severe constraint to delivery of quality services.

IMPACT

It is too early to establish and attribute programme impact. However, HMIS data suggests major indicators are improving and for some indicators, there does seem to be greater improvement in UNICEF areas. These changes will require more rigorous evaluation at the end of the programme. Impact indicators are, in principle, available through the HMIS, although it will be important to ensure availability of indicator data for the period before, during and after execution. Funding for each programme component, and to each beneficiary area, would improve the accuracy of analysis. Work is required to ensure accurate attribution of spending, although district level analysis may require some further apportionment.

EFFICIENCY

Although we cannot yet establish overall value for money (VfM) or cost-effectiveness, there is good international evidence for the cost-effectiveness of many individual components of GOB-UNICEF health programme. Incorporation of the UNICEF programme in overall health sector programme helps to reduce the duplication of efforts with support from other development partners. The budget is mostly being spent evenly across the programme, with concomitant achievements in outputs as assessed by the measured indicators. The focus on vulnerable areas and groups has potential for substantial gain for resources expended. However, issues of human resource availability and other access barriers could undermine overall achievement. UNICEF is working closely with MoHFW and its responsible directors and operational plan line directors and this collaboration has been highly regarded. UNICEF-UNFPA collaboration was also reported to be effective. The UNICEF health team is also working closely and efficiently with other cross-cutting teams including gender, WASH, and education.

CONNECTEDNESS

The health programme is part of a broader life-cycle country strategy. The necessary links with other units in the country office mostly exist and are well used. More linkage could be made with gender.



Greater utilisation of C4D to help link supply and demand sides of the programme could increase impact, particularly to vulnerable groups. The programme is extremely well connected to government and a number of development partners. Our assessment suggests that greater sharing of results across partners with similar programmes could improve the quality of components and evidence base. There is some linkage with national non-government organisations in service delivery, but the programme focuses on the public sector. The programme would benefit from a strategy for working with the private sector, particularly given the increasing importance of urban areas.

SUSTAINABILITY

Sustainability of programme components remains a core issue. Improving the evidence base on impact of interventions is a core component in planning for intervention incorporation and scale-up, particularly for interventions that are relatively new or implemented on a pilot basis. Evidence is at the heart of the UNICEF approach and theory of change, but our assessment suggests there is some way to go to build a convincing and well-communicated evidence base. The extent to which programme components can be sustained is also substantially dependent on government systems, the ability to deploy and motivate staff, and the way in which financial rules allow programmes to be decentralised and developed locally.

Conclusions

Key conclusions from this evaluation are listed below (relevant RQs in brackets).

- Some output indicators may need revising to include activities that were not included before but are happening now or have now been considered as priority (e.g. climate, women friendly hospital initiatives) or where the indicator provides a less sensitive measure of programme effectiveness (e.g. knowledge indicator for community interventions). (RQ2)
- The indicators included in the ToC and rolling work plan (RWP) are based on country-wide measures. To be SMART, for the programmes that are specific to districts outcome indicators need to have a baseline and monitored actual values for the areas in which the programme is working. (RQ3)
- To respond to the changing economic and social conditions, the future programme should focus less on direct implementation and move towards technical advisory work (e.g. HSS) and piloting and evaluating small scale interventions for later scale up (e.g. QI). This requires a continuance of the current programme direction of travel rather than a radical re-thinking. (RQ5)
- HSS support is extremely important. UNICEF might become more active in ensuring that system advice and support is consistent with those of other actors (development partners and government). Highlighting where HSS support will have less impact because of other constraints is key. (RQ7)
- UNICEF has a substantial contribution to Universal Health Coverage (UHC) particularly focused on: i) quality improvement, expanding on its pilot work at key public hospitals; ii) local planning



of resources through the District Evidence-Based Planning & Budgeting (DEPB) initiative; and, iii) promoting primary care as a vital part of Universal Health Care (UHC) strategies. (RQ8)

- There needs to be clearer communication of certain activities and their impact particularly around DHIS2 and the linkage to DEPB systems, SCANU effectiveness and beneficiary impact and lessons from QI initiative. (RQ10)
- The programme is internally coherent, however, strategy development documents lack reference and linkage to other partner programmes, often making it unclear why UNICEF is choosing to engage instead-of or together-with other partners. (RQ 12)
- The focus on evidence is vital to delivering effective interventions. We suggest that this function could be improved through a clearer knowledge transfer strategy including guidelines for evidence reporting, comparisons with similar interventions and a clear communication strategy. (RQ15)
- The adolescent programme is already being scaled across the sector. We anticipate that evidence from this programme including package content and scalability will be of considerable international interest and we recommend that more attention is given to the precise composition of the adolescent package. (RQ16)
- The DHIS2 has become well embedded in the HMIS. The targets of achievement in the RWP might be revised to reflect data quality, by tracking one or two core indicators that can be linked to other surveys (e.g. skilled attendance at delivery). Targets could also focus on coverage of non-government facilities. (RQ17)
- Given the substantial interest in the QI initiative, priority should be given to documenting the initiative's experience and assessing evidence of impact. (RQ17)
- Community groups are functioning, but more support and monitoring may be required to ensure that the voice of members who should benefit from services is heard effectively. (RQ20)
- Greater attention needs to be given to facilitate measurement of programme impact, to ensure correct indicators are collected and including a credible baseline and control areas. (RQ25)
- At the local level, staff availability is identified as the most important factor in reducing efficiency of service provision. Greater attention may be required to ensure adequate staff are available to maximise the returns on investment, including through the DEPB process. (RQ28, RQ33)
- More support may be required to some priority districts to help ensure that results can be delivered on time given constraints at the local level. (RQ27)
- More attention may be required in understanding the reasons for differential uptake of different aspects of adolescent services and why it appears that services in some facilities are underutilised. (RQ29)
- Some attention may be required to ensure that the source of funding for activities is clearer to partners and funders. (RQ30)



- There are non-government collaborations including with the for-profit private sector, but these are limited. Given the importance of this sector, particularly in the growing urban areas, UNICEF will need to engage more with the private sector and needs a strategy for such engagement. (RQ31, RQ5)
- UNICEF has great potential to improve planning and sustainability of services through the DEPB activity. The potential of DEPB is limited by the extent to which government allows local planners flexibility to utilise resources, including staffing. Building capabilities at local level, and acceptability of the process at national level, should be an important part of future support for this initiative. (RQ33)

Finally, reflecting the above conclusions we suggest greater focus is given to four areas: 1) evidence – the way in which evidence is assembled and compared with other programmes and communicated with stakeholders; 2) indicators – ensuring that indicators, both physical and financial, are appropriately disaggregated across areas of the country and over time to allow sensitive assessment of programme impact; 3) monitoring the quality of care given so that assessment of impact can also look at the content of services provided to the population; and, 4) engagement with the private sector – to develop engagement with a rapidly changing health system with a plurality of providers.

Lessons learnt

A dominant theme of this assessment is the creation and curation of evidence for better policy making. During this assignment we looked at a number of assessment reports of project components. These had a variety of research designs and were often based on solid data sets, including baseline and endline, usually using primary data collection methods. This evidence might be enhanced in a number of ways.

Firstly, research could pay more attention to other initiatives happening in the sector, both in Bangladesh and in the region. Secondly, incorporation of cost-effectiveness and VfM would add to the usefulness of the information, particularly when considering scale up. Finally, given the increasing quantity of useful HMIS data through DHIS2, more thought might be given to undertaking evaluations using administrative data. The second area of focus is on how the information is made available to stakeholders. Policy impact research suggests that evidence needs to be presented in a number of ways to be of relevance to policy makers. Substantive reports and publications, which are preferably peer reviewed, are needed to establish the scientific basis for a programme. But other forms of evidence, such as policy briefs, contributions to strategy and modelling the scale-up of small to medium size pilots in financial and physical terms, are also important.

Monitoring of the health programme is undertaken through a series of systems, starting from the rolling work-programme through the spending reports, and reports on achievement of indicators. A major challenge for the programme has been to decentralise budgets and activities. Some of the difficulties in obtaining information, and carrying out analysis, arose because this process is still a work in progress. Some of the output indicators do not seem particularly sensitive to the real impact of the programme.

One issue here is that some targets have already been exceeded; for example, for adolescent health and the community monitoring indicators. A further issue is that some indicators do not seem to be a particularly good measure of the effectiveness of the programme.

We found that for some programmes quality of care is already being addressed comprehensively. In other areas, more attention to the delivery of quality services particularly to vulnerable groups is needed. This may be particularly true for more complex services such as adolescent care and newborn services such as SCANU.

Our assessment found that UNICEF is engaging with the private sector in a number of ways; including work on EPI and adolescent health in urban areas and garment sector standards. None of these engagements are straightforward but are likely to be necessary given the changing context in the country. A practical first step would be to develop guidelines or principles for such engagements.

Recommendations

The key recommendations from this evaluation are listed below.

1. We suggest revising the output indicators to include activities that were not included earlier but are now considered as priority (e.g. climate, women friendly hospital initiatives). Moreover, areas where the indicator provides a less sensitive measure of programme effectiveness (e.g. knowledge indicator for community interventions) need revision.
2. In addition to direct implementation, the future programme should focus more on technical advisory work, as well as piloting and evaluating small scale interventions for later scale up.
3. Based on existing strengths, UNICEF's support to UHC in the future should focus particularly on: i) quality improvement, expanding on its pilot work at key public hospitals; ii) local level planning of resources through District Evidence-Based Planning & Budgeting (DEPB) initiative; and, iii) promoting primary care as a vital part of UHC strategies.
4. UNICEF should ensure that the contributions of other partners are reflected in strategy development documents. This could improve the overall coherence and point to potential gaps in support.
5. A clearer knowledge transfer strategy including guidelines for evidence reporting and comparisons with other similar interventions, as well as a clear communication strategy need to be formulated by 2022 to improve the evidence generation function.
6. While the HMIS is well integrated and functioning, the data quality and completeness can be improved by comparing indicators with national surveys and by expanding the coverage by including non-government facilities.
7. Adolescent services are becoming well embedded but take-up of services is still quite uneven.



More attention is needed to understand the reasons for differential use of services across facilities and on the service users to ensure that provision reflects user needs.

8. Given the importance of the private sector, particularly in the growing urban areas, UNICEF needs to engage more with this sector and facilitate a formation and endorsement of strategy for such engagement by 2022.
9. Cost effectiveness and VfM assessments of the interventions should be included in the testing and piloting for scale up where and when possible.

LIST OF TABLES AND FIGURES

Table 1:	UNICEF supported priority programmes	20
Table 2:	Evaluation questions and work stream	25
Table 3:	Instruments to be used to cover each programme area	26
Table 4:	Instruments to be used in each purposively selected area	27
Table 5:	RWP activities and indicators	57
Table 6:	Quality of care and satisfaction with services	62
Table 7:	Mean number of equipment at SCANU per facility and proportion of functionality	67
Table 8:	Use of SCANU, functionality and staff availability	67
Table 9:	UNICEF supported policies and UNICEF programmes supporting implementation	68
Table 10:	Details of the community group meeting	83
Table 11:	Outcome indicators derived from the DHS	87
Table 12:	Changes in health outcomes 2017-2018	87
Table 13:	AFHS services as reported in the HMIS	88
Table 14:	Priority districts by division	93
Figure 1:	Phases of evaluation	34
Figure 2:	Trends in child and neonatal deaths (2000-2017)	45
Figure 3:	Patients' satisfaction by different aspect of the service	63
Figure 4:	Patients' agreement on key service standards	63
Figure 5:	Duration of consultation, by types of health worker	64
Figure 6:	Duration of consultation, by types of patients	64
Figure 7:	Use of adolescent services by gender, by facility	65
Figure 8:	Use of adolescent corner and reason for consultation	66
Figure 9:	Indicator scores of country profile of health information system	75
Figure 10:	Crude benefits-incidence of programme spending, 2017-2018	78
Figure 11:	Proportion of community group members, by affiliation and gender	83
Figure 12:	Distribution of community group members by age group and gender	83



LIST OF ABBREVIATIONS

AFHS	Adolescent Friendly Health Service
ANC	Antenatal Care
APR	Annual Programme Review
ARI	Acute Respiratory Infection
BCC	Behaviour Change Communication
BENAP	Bangladesh Every Newborn Action Plan
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Surveys
BRAC	Bangladesh Rehabilitation Assistance Committee
C4D	Communication for Development
CAPI	Computer Assisted Personal Interviewing
CBHC	Community Based Health Care
CC	Community Clinic
CCC	Core Commitments for Children
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CES	Coverage Evaluation Survey
CfSC	Communication for Social Change
CHCP	Community Health Care Provider
CPAP	Continuous Positive Airway Pocket
CRCT	Cluster Randomised Control Trial
CS	Civil Surgeon
CEMONC	Comprehensive Obstetric and Neonatal Care
CSG	Community Support Group
DAC	Development Assistance Committee
DEPB	District Evidence-Based Planning & Budgeting
DFID	Department for International Development
DGHS	Directorate General of Health Services
DGFP	Directorate General of Family Planning
DH	District Hospital
DHS	Demographic Health Survey
DHIS2	District Health Information Software 2
DNCC	Dhaka North City Corporation
DNSO	District Nutrition Support Officers
DP	Development Partner
EmONC	Emergency Obstetrics and Newborn Care
ENAP	Every Newborn Action Plan
EPI	Expanded Programme for Immunization

EPMM	Ending Preventable Maternal Mortality
EQUIST	Equitable Impact Sensitive Tool
ERC	Ethical Review Committee
ESP	Essential Service Package
EWEC	Every Woman Every Child
FGD	Focus Group Discussion
FPI	Family Planning Inspector
FYP	Five Year Plans
GAP	Gender Action Plan
GAVI	Global Vaccine Alliance
GIZ	German Society for International Cooperation
GoB	Government of Bangladesh
GVAP	Global Vaccine Action Plan
HEF	Health Economics and Financing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HNP	Health, Nutrition and Population
HPNSDP	Health, Population and Nutrition Sector Development Programme
HPNSP	Health, Population and Nutrition Sector Programme
HRD	Human Resource Development
HSM	Hospital Services Management
HSS	Health Systems Strengthening
IDI	In-Depth Interview
IFA	Iron-Folic Acid
IHE	Institute of Health Economics
IMCI	Integrated Management Childhood Illness
IRB	Institutional Review Board
JPGSPH	James P. Grant School of Public Health
KfW	German Development Bank
KII	Key Informant Interview
KMC	Kangaroo Mother Care
M&A	Mitra and Associates
LCG	Local Consultative Group
LDP	Leadership Development Programme
LLP	Local Level Planning
MCH	Maternal Child Health
MCRAH	Maternal, Child, Reproductive and Adolescent Health
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MIS	Management Information System



MNCAH	Maternal, Newborn, Child and Adolescent Health
MNCH	Maternal, Neonatal and Child Health
MNH	Maternal & Neonatal Health
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MoPMA	Ministry of Primary and Mass Education
MoSCA	Ministry of Social Welfare
MoLGRD	Ministry of Local Government, Rural Development
MoWCA	Ministry of Women and Children Affairs
MPDSR	Maternal and Perinatal Death Surveillance and Response
MRC	Medical Research Council
NCDC	Non-communicable Diseases Control
NGO	Non-Governmental Organisation
NIPORT	National Institute for Population Research and Training
NMR	Neonatal Mortality Rate
NNHP	National Newborn Health Programme
NNS	National Nutrition Services
NPAN	National Plan of Action on Nutrition
N-QIC	National Quality Improvement Committee
NSU	Newborn Stabilization Units
ODK	Open Data Kit
OECD	Organisation for Economic Co-operation and Development
OP	Operational Plan
OPM	Oxford Policy Management
PDCA	Plan-Do-Check-Act
PHD	Partners for Health and Development
PIP	Programme Implementation Plan
PMR	Planning, Monitoring and Research
PNC	Postnatal Care
QI	Quality Improvement
QIS	Quality Improvement Secretariat
RAM	Results Assessment Module
RMG	Ready Made Garments
RMH	Reproductive and Maternal Health
RMO	Residential Medical Officer
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
RQ	Research Question
RWP	Rolling Work Plan
SAARC	South Asian Association for Regional Cooperation
SACMO	Sub Assistant Community Medical Officer

SBCC	Social and Behavioural Change Communication
SCANU	Special Care Newborn Units
SCF	Save the Children Foundation
SDG	Sustainable Development Goals
SEARO	South-East Asia Regional Office
SIP	Strategic Investment Plan
SSK	Shasthyo Surokhsha Karmasuchi
STATA	Statistical Software
STI	Sexually transmitted infections
SWAp	Sector-Wide Approach
TG	Task Group
ToC	Theory of Change
WFHI	Women Friendly Hospital Initiative
WHA	World Health Assembly
WHO	World Health Organisation
WFHI	Women Friendly Hospital Initiative
WS	Work Stream
ToR	Terms of Reference
UHC	Upazila Health Complex
UFPO	Upazila Family Planning Officers
UHC	Universal Health Coverage
UHFPO	Upazila Health and Family Planning Officer
UN	United Nations
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Fund
UNSG	United Nations Secretary-General
USAID	United States Agency for International Development



INTRODUCTION

Background

Bangladesh has experienced major improvements in health outcomes over the last two decades. Infant mortality fell from 87 per 1000 live births during 1989-1993 to 24 per 1000 live births in 2017, while under-five mortality declined from 133 per 1000 live births to 31 per 1000 live births in the same period (BBS, 2017). Likewise, maternal mortality ratios fell from 384 per 100,000 live births in 2001 to 176 in 2015 (WHO et al., 2015). Nutrition indicators have also improved in the last decade with a ten percent decline in stunting from 51% in 2000 to 41% in 2011. However, the slower improvements in neonatal mortality rate (NMR) have been identified as a public health concern. According to the Bangladesh Demographic and Health Surveys (BDHS), the NMR was 32 per 1000 live births during 2007-11 and is still around 28 per 1000 live births (NIPORT et al., 2016). These deaths are attributable to complications of preterm births or low birth weight, birth asphyxia and neonatal infections. Inequity in healthcare access and utilisation, as well as unequal health outcomes between the rich and poor, are still to be addressed. Home deliveries in 2014 were markedly higher for those in the lowest wealth quintile (84.7% of live births), being almost three times than that of the citizens in the highest wealth quintile (30% of live births). Beyond the richest quintile, less than 25% of women utilised four or more antenatal care (ANC) services, the proportion declining with economic status (NIPORT et al., 2016). Only 10.5% of the women in the poorest income quintile utilised four ANC's or more. The majority of the 15 worst performing districts in MCH belong to chars, coastal areas and the Chittagong Hill Tracts. These are amongst the poorest districts, according to headcount poverty, the top three being Rangpur, Barisal, and Khulna. Hence, to improve the national health status of Bangladesh and reduce health inequity, it is imperative that these areas receive adequate attention (HEART, 2017). In addition, childbirth continues to pose a threat to the lives of women due to complications in pregnancy, delivery, and postpartum.

In response to global challenges to reduce mortality for children and mothers, the UN Secretary General's Global Strategy for Women's and Children's Health in 2010 and its accompanying Every Woman Every Child initiative, *Committing to Child Survival: A Promise Renewed in 2012*, the Every Newborn: an Action Plan to End Preventable Deaths (ENAP) was developed. ENAP also aims to support countries in reducing preventable neonatal deaths and reach the SDG targets for newborn deaths and stillbirths. ENAP is also closely linked to the Ending Preventable Maternal Mortality (EPMM) plan, which aims to reduce preventable maternal mortality by 2030, and to the most recent UNSG's Global Strategy for Women's, Children's and Adolescent's Health.

Following these global strategies and action plans, the GoB developed the Bangladesh 'Every Newborn Action Plan' (BENAP) and the 'Maternal Health Strategy'. Both these documents have been developed and endorsed by GoB and other development



partners. Via the health system strengthening component, UNICEF is also supporting the development of strategies and plans in a number of areas including immunisation, neonatal and child health services, and quality improvement.

Joint UNICEF-GoB Health Programme

UNICEF Bangladesh in collaboration with the MoHFW, elaborated the health programme to address country challenges that are also linked to global health priorities and targets. The health programme focuses on three main areas: i) health service interventions across the country and focused on the district health system including maternal and neonatal health, adolescent health and EP; ii) health system strengthening, focused on Community Health, Health Management Information System (HMIS), District Evidence-Based Planning and Budgeting (DEPB) and Leadership Development Programme (LDP); and, iii) humanitarian support, focused mainly on the Chittagong Hill Tract areas. The joint programme is operationalised in a rolling GOB-UNICEF work plan that identifies how the programmes link to two main outcomes in the country support programme: outcome 1 on women, infants/young children, and outcome 3 on adolescent girls and boys. The plan details activities under each outcome together with a responsible partner, estimated dollar allocation, and implementation quarter.

The activities of the programme are implemented in partnership with the GoB and other national stakeholders. The health programme builds on UNICEF 2012-2016 Country programme and focuses on the new programme cycle as defined in the 2017-2020 Country Programme. The UNICEF country programme also focuses on other cross-cutting issues and means that the health programme needs to collaborate with other sectors. In addition, UNICEF is also responding to the large humanitarian crisis of the Rohingya refugees, including responding to measles and diphtheria outbreaks.

Some of the key UNICEF supported priority programmes in the areas of maternal, neonatal and women’s health and in health system strengthening are listed below.

Table 1 UNICEF supported priority programmes

Maternal, Neonatal and Women’s Health		
1	NNHP-IMCI (KMC & NSU)	National Newborn Health Programme - Integrated Management Childhood Illness (Kangaroo Mother Care & Neonatal Stabilisation Unit)
2	NNHP-IMCI (ENC)	National Newborn Health Programme - Integrated Management Childhood Illness (Essential Newborn Care)
3	MPDSR	Maternal and Perinatal Death Surveillance and Response
4	WFHI	Women Friendly Hospital Initiative

5	CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
6	SCANU	Special Care Newborn Units
7	QI-PDCA	Quality Improvement --Plan-Do)-Check-Act
8	EPI	Expanded Programme on Immunisation
9	AFHS	Adolescent Friendly Health Services
10	Urban Health	Urban Health
Health System Strengthening		
11	Community Health	Community Health
12	HMIS	Health Management Information Systems
13	DEPB	District Evidence Based Planning & Budgeting
14	LDP	Leadership Development Programme

Objectives of the evaluation

This evaluation aims to assess the strengths and weaknesses of the health programme in pursuing overarching objectives and to assess the contribution of multiple programme interventions. We have looked at the first two years of implementation (2017-2018) and provided insight on the current direction of the programme (2019-2020). As such, the focus of the evaluation was not to principally look at the concrete gains at the level of the beneficiary but more at the outcomes to upstream beneficiaries, such as health service providers and administrators. We have also attempted to validate results with beneficiary level outcomes through information gathered through desk review, direct observation, and surveys. We have analysed intended and unintended effects of the programme and explored the reasons why certain aspects of an intervention or overall programme have or have not been implemented and achieved expected results as planned. The scope of this evaluation is mainly centred on the UNICEF-GoB joint health programme. The emergency humanitarian responses in health were to some extent covered where relevant.



METHODS

Evaluation approach

The evaluation focused on the UNICEF Programme's overall progress in achieving its overarching objectives. The evaluation encompassed both the service delivery components delivered in districts, particularly Maternal and Newborn health (including SCANU), EPI (including cold chain) and Adolescent Health and health system strengthening components including policy and plan development, HMIS, DEPB and Community Support.

The evaluation focused on the current country programme (2017-2020) but in some cases has investigated linkages between the previous programme (2012-2016) and the current one, and also links to cross-sectoral support such as WASH and disability. The evaluation has followed the OECD/DAC evaluation criteria of Relevance, Coherence, Effectiveness, Efficiency, Impact, Connectedness and Sustainability.

Relevance is the extent to which the activity is suited to the priorities and policies of the target group. This criterion was reviewed in relation to the national policies of Bangladesh as embodied in the current sector programme, and related policies and targets as outlined in Programme Implementation Plan (2017-2021), and whether these are in line with wider goals including Universal Health Coverage and Sustainable Development Goals (SDG).

Coherence is the extent to which priority program elements were selected comprehensively considering the comparative strengths of the organisation, expectations of the government and capabilities of other actors to support delivery of high-quality health services.

Effectiveness is the extent to which the activity has achieved its objectives. The criterion was assessed in relation to the objective of the programme and targets anticipated, both quantitative and qualitative. However, the focus of the evaluation was on the current programme phase which started in 2017, focusing on the first two years of implementation where data was available. Hence, there were restrictions in the analysis to potential for the programme to be effective rather than assessing the overall effectiveness at this stage.

Efficiency relates to three questions whether: i) activities are cost-effective; ii) objectives were achieved on time; and iii) the programme is implemented in the most efficient way compared to alternatives. The review has examined available evidence on the overall expenditure of the UNICEF programme against the achievements in terms of beneficiaries covered and services delivered. A quantitative comparison with alternative routes to similar goals was not possible given the time limitations of the review but was discussed in more general terms.



Impact is the positive or negative changes brought about by the intervention. This is likely to include health and other SDG indicators, particularly relating to the good health and wellbeing goal (SDG 3) and targets to achieve universal health coverage including access to quality essential care and financial risk protection. Since the impact of health sector strengthening is hard to attribute in a quantitative way, which is measurable through standard health sector indicators, the evaluation has used qualitative interviewing with key stakeholders to understand the extent to which this support was required and has been impactful. It also included unintended (negative or positive) consequences arising from the activities. As stated earlier, the brief implementation period means that it was not possible to undertake a full outcome focused impact evaluation even if data was available. This phase of the programme is still at an early stage and required data was also not available on impact to allow for a comparison of the before and after effect compared to a control group. For the purposes of this review, we had proposed to limit the impact assessment to a focus on use of services compared, where feasible, to what might have happened without the intervention together with a qualitative assessment of the consequences for the health system including those that are unintended.

Connectedness relates to whether the programme has been effectively connected to other relevant programmes, that activities are carried out in a context that takes longer-term and interconnected problems into account, and were set and strengthened key and innovative partnerships such as Health Sector Consortium and the Government-NGO-private sector partnerships for promoting health service and delivery.

Sustainability relates to whether benefits of the activity are likely to persist after support from development partners is withdrawn. It also relates to the extent to which government could scale up the benefits.

Evaluation Questions

The ToR lists 33 research questions (RQ) relating to the OECD/DAC evaluation criteria which cover the breadth of the UNICEF health programme. The UNICEF programme is at mid-stage of implementing the current programme. This means that the extent to which we were able to fully answer each question varied. In each case we have looked for evidence that a) provides a full an answer to the question as possible; and, b) suggests what the programme might do to ensure positive outcomes towards the end of the programme.

In subsequent sections, we provided an overview of the main research methods that were used in this evaluation.

Overarching Design

A mixed-method design was adopted to conduct the evaluation. It employed six different work streams to answer the main evaluation questions. The qualitative approach included a desk review, focus group discussion (FGD), key informant interviews (KIIs), while the quantitative method included secondary

data analysis, observation, and an end-beneficiary survey. To ensure data validity, information has been triangulated by making use of data from four sources, which include in-depth interviews, FGDs, observations and surveys.

UNICEF currently has health programmes operating across the country with different programmes implemented in different areas and some support, particularly in health system strengthening, for national and local structures that benefit all areas. For our study sample we selected six districts, plus one city corporation (Dhaka North), which covered the range of UNICEF programmes. Our initial intention was to select these districts randomly, but later we applied purposive selection to ensure that the main interventions delivered by UNICEF were included in our sample areas as not all interventions are delivered in every district.

We identified and assessed cross-cutting and inter-related development themes that emerged as central to achieving equity and underpinned progress in all programmes and interventions, for both the short- and long-term. The priority cross-cutting themes included, but were not limited to, empowering women and adolescents, capacity development and strengthening systems and institutions, and embedding effective planning and monitoring.

Components

The methodology of this evaluation incorporated six components, attempting to address the various ToR questions. The specific themes explored by the various work streams were determined through a mapping exercise. For each method outlined below we highlighted the main ToR research questions we intended to address. This may have changed as we progressed through the evaluation and better understood the programme and data available. Key-informant and focus group discussions often obtained similar types of information, and the precise tool used depended largely on the groups identified as key interlocutors.

The matrix below shows how each key evaluation question was addressed in each work stream.

Table 2 Evaluation questions and work stream

Questions	WS1: Desk review	WS2: FGDs	WS3: KII with stakeholders	WS4: Secondary data analysis	WS5: Survey with end-beneficiaries	WS6: Direct observations
RELEVANCE	X	X	X			
COHERENCE	X	X	X			
EFFECTIVENESS		X	X	X	X	X



Questions	WS1: Desk review	WS2: FGDs	WS3: KII with stakeholders	WS4: Secondary data analysis	WS5: Survey with end-beneficiaries	WS6: Direct observations
EFFICIENCY	X	X	X	X	X	X
IMPACT			X	X	X	X
CONNECTEDNESS			X			X
SUSTAINABILITY			X			

Source: Terms of Reference (ToR)

As per our anticipation, the tools selected under each workstream has covered all the programme areas included in the UNICEF support (Table 3). Tools focused on district level facilities and users collected more of the effect of service interventions while the qualitative focus group and KIIs, particularly at the national level, were more sensitive in assessing the operation of health system interventions.

Table 3 Instruments to be used to cover each programme area

Programs:	Workstreams	WS1	WS2			WS3		WS4	WS5	WS6		
		Review of	FGD & in-depth interviews			KIIs		Secondary Analysis of Data	Exit survey of users	Direct observation		
		Health Service Providers	Community Groups	Beneficiaries	GOB (National)	District/Upazila	Facilities			Clinical service	Community groups	
MATERNAL, Neonatal and Women's Health	NNHP-IMCI (KMC & NSU)	X	X	X	X	X		X	X	X	X	
	NNHP-IMCI (ENC)	X	X	X	X	X		X	X	X	X	
	MPDSR	X	X	X	X	X		X	X		X	
	WFHI	X	X	X	X	X		X	X		X	
	CEmONC	X	X	X	X	X		X	X	X	X	
	SCANU	X	X			X	X	X		X		
	QI-PDCA	X	X			X		X	X		X	
EPI	EPI	X			X	X		X	X	X	X	
Adolescent Health	AFHS	X	X	X	X	X		X				
Urban Health	Urban Health	X	X	X		X	X	X				

Health System Strengthening	Community Health	x		x		x		x				X
	HMIS	x	x			x	x	x				
	DEPB	x				x	x	x				
	LDP	x	x			x	x	x				

¹We have added a seventh area at UNICEF's request following the discussion at the Reference group. This is subject to UNICEF approval on additional funding.

The fieldwork was conducted in six districts, one City Corporation and at the national level. Districts were chosen purposefully to ensure that both health service and HSS interventions were represented after consultations with UNICEF and the reference group. We followed the following procedures in choosing districts:

1. A summation of the number UNICEF programmes operating in each district, based on a list provided by UNICEF was calculated, districts with 10 or more programmes operating were provisionally selected for inclusion in the study.
2. We additionally selected Dhaka North City Corporation (DNCC), which was considered to better represent the urban health programme and Kurigram, to ensure coverage of this initial pilot area for the Quality Improvement Interventions.
3. This gave a total of nine districts plus one CC. It was agreed with the Reference Group that we would sample six districts plus one CC. The districts selected are Dhaka North CC, Jamalpur, Kurigram, Moulvibazar, Patuakhali, Cox's Bazaar and Tangail¹.

The instruments were implemented across the areas selected as summarised in Table 4. The evaluation attempted to capture the multifaceted nature of the UNICEF programmes, aiming to represent all interventions and key areas of activity including LDP, QI and work with the tea estates. A description of each tool is provided in the next section.

Table 4 Instruments to be used in each purposively selected area

Tool:	Selected districts:	National	Dhaka North City Corporation	Jamalpur			Kurigram			Moulvibazar				Patuakhali			Cox's Bazar			Tangail			Total
				DH	UHC	CC	DH	UHC	CC	DH	UHC	CC	Tea Estate	DH	UHC	CC	DH	UHC	CC	DH	UHC	CC	
WS2 FGD & In-depth Interviews	Health Service Providers		2	3	2	3	2				2	3	2	3	2	3	2	3	2		29		
	FGD Community Groups				1		1			1			1			1			1		6		
	Beneficiaries: mothers of children in SCANU			2		2						2		2		2		2			10		
	Beneficiaries: mothers seeking maternal health services		2		1		1				2		1		1				1		9		
	Beneficiaries: adolescent girls			1			1				1	1			1		1				6		
	Beneficiaries: adolescent boys				1		1				1		1		1				1		6		

Six FGDs were arranged with Community Groups/Community Support Groups (CSG) at the community level. The FGDs with community representatives explored their perception about the quality of care provided, success of the programme in terms of increasing demand and improving use of health facilities for the care especially by the poor and vulnerable groups, any challenges faced in accessing care, possible ways to improve the service provision especially through establishing linkages between communities and facilities for effective service use, whether and to what extent the linkage has been established among CC, CG/CSG and local government/NGO network, payment mechanism and associated household cost to access care, or to buy medicine or any service charge imposed by the service providers.

Data collection

One facilitator and one rapporteur conducted the FGDs which participants ranging from 7 to 13 members. A semi-structured tool was designed for the in-depth interviews and FGDs to keep the discussion within the framework of the topics of concern. In addition to taking notes by trained note takers, the sessions were audio recorded for future analysis. The in-depth interviews were conducted by one enumerator who took notes at the same time.

Key Informants' Interviews

Collectively, 30 key informants were interviewed both at central and local levels with separate guidelines prepared for each group. At the central level, KII were arranged with relevant senior level policy makers within MoHFW, development partners, UNICEF staff, both national and regional level and NGO representatives. These discussions shed light on relevance, overall coordination, financial management and constraints from their perspectives, and brought understanding to whether program interventions are heading in the right direction to meet the objectives of the UNICEF programme, addressing equity, quality and efficiency. Selection of the respondents were based on the roles they play in the programmes (especially of IMNCI, SCANU, community health system strengthening, leadership, AFHS, EPI cold chain, and urban health), knowledge of the subject matter, willingness to be interviewed and access to information.

At the local level, KII were conducted with local level managers and service providers, which included the project manager at DNCC, Superintendent, Upazila Health and Family Planning Officers (UHFPO), and Upazila Family Planning Officers (UFPO). These KIIs assisted in making policy recommendations for future implementation to improve the program and enhance service use with adequate quality, addressing equity, and effective monitoring and supervision to impact improved health outcomes.

The list of informants was finalised in consultation with UNICEF. In some cases, the key informant was revisited based on the ground reality, for example, staff turnover and/or unavailability of respondent during the data collection period. Senior members of the evaluation team conducted these interviews.



Data collection

All qualitative data was analysed thematically. By reviewing the data, a code list was prepared, and thematic analysis was completed manually. In the thematic analysis, codes and sub-codes together generated a concept. Several such concepts through phenomenological interpretations then developed a theme. The senior researchers went through the recordings and notes, coding, and analysis for validation.

The survey team maintained confidentiality while issues or concerns were raised or perceived during data collection, especially with collected data on issues related to gender and reproductive health and behaviour. Anonymity and confidentiality of such information was maintained throughout the evaluation process of data collection, processing, analysis, and report writing as respondents were assured about the confidentiality of the information by the team during consent taking.

Secondary Data Analysis

We have reviewed available data and conducted a series of secondary data analysis to assess the baseline for various indicators, and where possible assess progress (see Annex D). The secondary data analysis focused on two things; firstly, the use of information from surveys to provide background, contextual information to the programme including baseline information and trends, and secondly, the use the information, where possible, to track progress with implementing key programme activities. This relied on administrative data from HMIS/DHIS2 and relevant surveys conducted immediately before and during the programme. The focus was on the core interventions of the programme including the 14 monitoring indicators included in the UNICEF-GOB Workplan.

Data sources included the data from the HMIS and District Health Information System 2 (DHIS2) of the Directorate General of Health Services (DGHS), HMIS of Directorate General of Family Planning, UNICEF's Social Policy, Evaluation Analytics and Research (SPEAR) unit, UNICEF baseline surveys, MMR surveys, Health Facility Survey 2014, Urban health Survey, EPI CES and other relevant studies. Review of MIS and other data for selected interventions included the period from January 2017 to December 2018.

User Survey

A survey with users was conducted to understand the perception of UNICEF's work, quality of service being received and characteristics of service users. The objective was to provide a snapshot of the experience of services by users. All users surveyed had their care observed to assess the quality of services and adherence to protocols. The survey focused on maternal, newborn in SCANU facilities, infant/child health, and adolescent services.

The survey was conducted in the catchment areas of a sample of 18 health facilities, where the facilities were chosen following four steps. The survey was undertaken in the five purposively selected districts that ensure coverage of the health programmes and interventions provided by UNICEF. At the second step, the district hospitals and one randomly selected UHC were selected. At each facility, 20 patients

were randomly selected for the service observations and exit survey. The calculated sample size for the user exit interviews and direct observation of the services was 360 users. The statistical assumptions are infinite population, 85% confidence level, expected frequency of 50%, margin of error 5%, design effect 1.8, number of clusters 15 and cluster size of 20.

Data collection tool

The questionnaires were developed in English and then translated into, and printed in, Bangla. The data collection tool was carefully reviewed to ensure compilation of appropriate questions and language consistency. We used a structured questionnaire, and data for the exit survey was collected using Computer Assisted Personal Interviewing (CAPI).

Pretesting the data collection tools

It is a good practice to pre-test a questionnaire after the initial design and formatting is completed. A survey is designed for a specific population group and, without having input from that population, we cannot assure ourselves that questions and statements are well written and capture the information we intended to collect (Campanelli, 2008). Pre-testing can also provide information about probable response rates of a survey, the cost and timeframe of the data collection, the effectiveness of the field organisation, and the skill-level of the data collection staff (Visser et al., 2000).

Hence, the various questionnaires were pre-tested in the field before the actual implementation of the survey. Two teams were deployed for this purpose of pre-testing the tools. The first team consisted of one doctor and three non-doctors who conducted the direct observation of facility, service provision and exit interviews. The second team included four facilitator/note takers, one organiser and one supervisor, who conducted various focus group discussions (FGDs) and direct observation of the community support group. Before going out into the field, verbal permission was obtained through proper channels. Along with the two teams, senior representatives from OPM and Mitra and Associates also participated.

The first step involved briefing the UHFPO about the purpose of the visit. The team were then taken to the AFHS Corner, Maternal Health Service area and EPI area of the Upazila Health Complex (UHC) and introduced to the concerned personal for facilitating the pre-test.

The doctor of the pre-testing team, directly observed the following:

- Services provided by Sub Assistant Community Medical Officer (SACMO) to four adolescent patients at the AFHS corner;
- Services jointly provided by Medical Officer (MO) and SACMO, to three neonatal patients; and,
- A health facility with the assistance of the UHFPO, Statistician, EPI Cold Chain Assistant, SACMO and Computer Operator/Office Assistant.

The non-doctors conducted nine exit interviews, which comprised of five adolescents and four mothers of children less than two-years-old.



The FGD team conducted three FGDs at the Upazila Health complex, namely with a group of male adolescents, mothers of children less than two-years-old and with service providers. The average time required for each of these groups was 35 minutes, 62 minutes, and 56 minutes, respectively. This was followed by the direct observation of Community Support Group (CSG) meeting and another FGD with a few members of the CSG.

Training of enumerators

Training was conducted by deploying three teams for four days from 25 February 2019 to 2 March 2019 including two days for in-house training, one day for field practice at Shaheed Tajuddin Medical College Hospital, Gazipur. Piloting was conducted to assess the whole questionnaire under actual survey conditions. The primary benefit of this activity was to identify problems before implementing the full survey. Piloting included assessing the validity of each question (whether the question is capturing information it is intended to measure to meet the goals and objectives of the study) and analysing the various aspects of the questionnaire as a whole (Chaudhary and Israel, 2000). This was followed by a day of discussion for the final review.

Data collection

Data collection was conducted from 3 March 2019 to 13 March 2019 covering various types of health facilities in seven districts including Tangail, Patuakhali, Jamalpur, Kurigram, Cox's Bazar, Maulvibazar & Dhaka (DNCC) by deploying three teams. Each team consisted of eight members including one doctor, one research officer, one supervisor/organiser, three interviews and two in-depth interviewers/facilitators. In addition, one extra doctor and one in-depth interviewer/facilitator were kept in the office for supporting attrition.

The data collectors conducting exit surveys used the Open Data Kit (ODK) software system to enter the data. Once the data was saved to the device, the data was uploaded to a server during connectivity allowing transfer of stored data to a server. Once on the server, the data was validated and exported to the statistical software, STATA for analysis.

Direct Observation

A series of direct observation of: i) health facilities, ii) service users; and, iii) health community groups/committees was conducted to assess service delivery practices.

The direct observation tools were used to observe health facility practices and procedures. A quality-monitoring checklist was developed to assess technical aspects of quality of service delivery at facility level. The quality monitoring check-list covered structure, process and outcome dimensions of quality of care (Donabedian, 1980) and included availability of trained human resources (consultants, doctors, nurses and other support staffs), equipment and instruments, cleanliness, privacy, emergency preparedness and availability and practice of evidence based techniques, such as, use of protocols for

treatment of selected care. The tool also assessed information management including use of the HMIS.

Direct Observation of service provision to users was conducted to assess service providers' practice and their adherence to guidelines for selected interventions, and to explore the knowledge and attitude of end-users relating to the service. Using a random sampling method, and anticipating the sampling interval based on the conservative estimate of the patient load, trained medical personnel observed the doctor's service provision to 20 end-users per facility.

Direct Observation of the operation of the six Community Group (CG) was completed in the six selected unions having community clinics. The operation of the CG was observed using a checklist which included questions on functioning, participation, topic of discussion.

Data Quality

The data collection team leaders were core staff from Mitra and Associates (M&A) possessing extensive experience of both field research and the locality. They underwent training prior to the training of the enumerators. The enumerators chosen to participate in this survey had sufficient experience and were familiar with, or from, the area they worked in. Enumerators were trained at the M&A office by the research staff who accompanied them to the field as team leaders. OPM researchers also facilitated the training to supervise and clarify any concerns.

As the data from the exit survey was collected in CAPI form, errors were reduced to a minimal for several reasons. Firstly, it reduced enumerator error as skip logic and filters cannot be ignored or mistaken, as on paper. Secondly, using electronic data collection software allows for quasi-simultaneous quality control whereby the project officer can download all the data collected thus far to check for inconsistencies, errors and for completeness of data. Moreover, electronic data collection does not require additional data entry, which reduces error typical of paper survey data entry where the person would misinterpret the answers on the paper form.

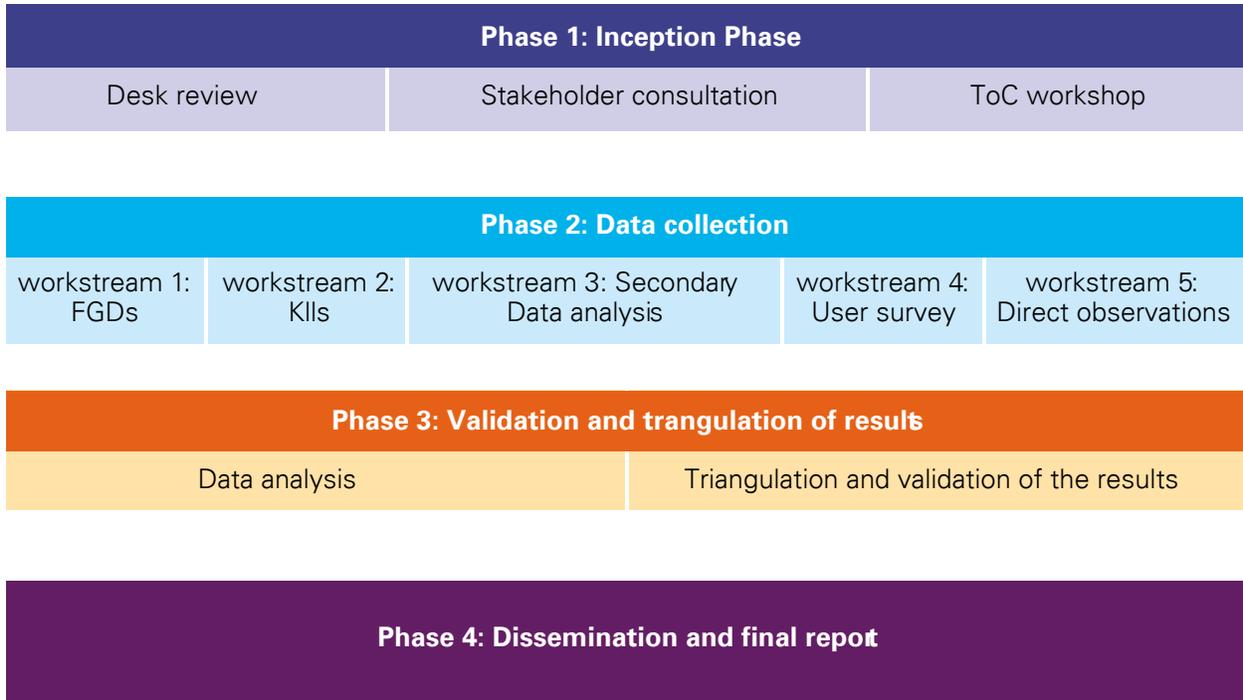
The data entered in the CAPI system was downloaded at the end of each day. The data came out in Excel format which was then analysed using Stata. Any additional cleaning was done in Stata, while keeping appropriate records (i.e. DO-files) of all the changes made so that any problems or errors could be back-tracked and logged. Daily, the project officer and manager performed data quality checks where any inconsistencies were identified across enumerators and geographical areas.

Implementation

The evaluation was structured in four phases (Figure 1) each containing distinctive tasks.



Figure 1 Phases of evaluation



Phase 1: inception phase

The first phase was the inception phase. In this phase the team reviewed all relevant literature and documentation; based on the review finalised a detailed methodology and timeline; prepared all the fieldwork tools, survey details and analysis plans; reviewed and analysed secondary data, and finally secured ethical clearance. In more detail, it consisted of:

A Desk Review: The objective of this component was to review and synthesise the health programme, the implementation activities and coordination between different stakeholders. During this phase, various health Programme documents including UNICEF Country Programme Documents, other documents describing cross-sectoral activities were reviewed. The team created a list of documents shared by UNICEF, identified the need of a few more documents, and requested that UNICEF share the documents, to which UNICEF responded accordingly.

A Reference Group Meeting and other preliminary consultations: At the developmental stage, this was used to consult with key stakeholders, including the evaluation Reference Group, to understand and finalise the evaluation questions and the study objectives, study design and topics to be covered by the tools, along with key indicators and an analysis plan. While some clarifications have been made, no major revisions in the ToR or scope of the evaluation were made.

A Tools Preparation: Draft qualitative and quantitative tools for data collection were developed, which were later refined and revised incorporating the learnings and inputs from the ongoing desk review, stakeholder consultation and the ToC workshop. Manuals for enumerators and interviewers were developed in addition to a protocol to conduct the qualitative and quantitative data collection.

An Inception report: The report outlined the overall design, approach, and methodology of the evaluation, the inception phase activities including the preliminary findings based on desk review and thematic areas and questions that were later addressed by each work stream (Annex E).

Ethical clearance: The developed study design and tools were submitted, along with an application for receiving ethical clearance, in accordance with international standards and UNICEF Ethical guidelines for research & Evaluation. The protocol was submitted for approval to the Institutional Review Board (IRB) of the Institute of Health Economics (IHE) of the University of Dhaka. After the application was reviewed and queries were responded to, ethical approval to conduct this study was received from the IRB (see Annex F). Since the approval was obtained from a recognised local IRB, the study qualified for the exemption from OPM Ethical Review Committee (ERC).

Phase 2: Data collection and methodological approach (including sample size)

The second phase included fieldwork and data entry phase. The team initially started with key informant interviews and focus group discussions. Concurrently the team made the final preparations for fieldwork, such as hiring field staff, designing the data entry programme, and piloting the research tools. Fieldwork was then implemented followed by data collection and data entry.

Phase 3: Data analysis and validation

After completion of the data collection phase, the team progressed to the analysis and reporting stage in phase three of the project. Data collected through the various workstreams were integrated and validated. Triangulation strengthened the validity of the findings for different aspects of the evaluation framework. The quantitative data were analysed in Stata and thematic analysis were carried out with the qualitative data. The quantitative and qualitative data were used simultaneously in the report and were used for validation of each other.

Phase 4: Dissemination

Findings from the study will be disseminated in the form of a report and a presentation to key stakeholders in the form of a consultation workshop. Important feedback gathered from the consultation workshop and written comments on the draft report, will then be incorporated to finalise the report. The results will be disseminated to the MoHFW and UNICEF of UN agencies, donors, and other stakeholders.

Key considerations, limitations, and constraints

Any evaluation will have limitations and constraints placed on it by the nature of the programme and resources available. The following are noted:



The assessment is largely a process evaluation. Primary data was not collected before or after or compared with a control. Since the purpose of this evaluation was not to see the impact of any specific programme, this evaluation is not designed using a rigorous experimental or quasi-experimental method. Therefore, it was not possible to fully understand the counterfactual, i.e. what would have happened in the absence of this programme. However, where possible, we made use of other assessments that have examined change across the time period relative to a comparison, but these were limited to certain interventions and the short time period meant that even these comparisons provided limited information.

Resources were limited. Resources for undertaking fieldwork is limited to six districts plus one City Corporation. We have endeavoured to select areas to cover all programme areas, but we could not rule out differential effects across different contexts that we were unable to fully describe in a relatively small and non-random sample.

Evaluation focus. The focus was on the UNICEF-GoB programme of support, not the entire GoB sector programme.

Attribution versus contribution. The activities of the programme were implemented in partnership with the GoB and other national stakeholders. The evaluation has primarily focused on UNICEF/GoB contribution to the results. Attribution, given the joint implementation with GoB and other programmes, has been difficult to impute. Rather, the process has attempted to understand whether the programme can reasonably be expected to add value and achieve the intended effects.

Unit of analysis: The health programme is built on the UNICEF 2012-2016 Country programme and focused on the new programme cycle as defined in the 2017-2020 Country Programme. As such the focus of the evaluation was not to look at the concrete gains at the level of the beneficiary but at the outcomes to upstream beneficiaries such as health service providers and administrators. Where possible the evaluation has validated results with beneficiaries' level outcomes and through other information gathered either using FGDs, Survey or direct observation of end-users. The evaluation has therefore been an interim and focused on plausible effects rather than final impact. However, UNICEF has separately commissioned other evidence generation activities focusing at the specific intervention level and are evaluating programmes at the beneficiary level.

Assessment of cross-cutting issues and humanitarian crisis: The UNICEF country programme focuses on other cross-cutting issues and the health programme collaborates with other sectors. Where possible, the evaluation sought to understand how UNICEF's health programme considers and influences issues related to gender, climate change, water, and sanitation, urban health, and emergency preparedness.

Ethical Considerations

We have obtained ethical clearance from the Institutional Review Board (IRB) of University of Dhaka (see Annex F). The application was also submitted to the Ethical Review Committee (ERC) of OPM, but since

OPM ERC exempts ethical approval from recognised national IRBs, it did not have to go through the complete review process.

We have ensured a consistent approach to obtaining informed consent at every stage of the survey. All interviews were conducted by trained staff safeguarding privacy. If possible, the interviews at the health facility were conducted in a private room. Interviewers described and outlined the contents of the interview, the purpose of the study and the approximate length of the interview. The confidentiality of answers was stressed, and the voluntary nature of participation was emphasised to the respondents. An informed consent protocol was developed specifically for this survey. Participants of the end-beneficiary survey were requested to provide informed verbal consent before data collection while the service providers were requested to provide written consent. A verbal ascent was obtained from adolescents while informed consent was obtained from their parents. Participation was voluntary and there was no influence or coercion on the participants. The potential vulnerable group for this survey were the patients, in particular children with disabilities. To address this there was a session for the enumerators on safeguarding, which Dr Rashid Zaman, a trained safeguarding tutor and member of the OPM ethics committee, facilitated.

We have initially planned to conduct FGDs with the users and mothers with young children. However, we have observed during the pretesting and piloting that to conduct FGDs, the respondents may have to wait for a long time and have therefore conducted in-depth interviews instead of FGDs.

Strict confidentiality protocols were maintained. Personal identifiers were linked with unique ID codes and kept confidential and not reported. Similarly, the consent forms, which may also contain names and identifiers, were collected and stored securely.



RESULTS

In this section, we describe the main results of the assessment based on a combination of primary qualitative and quantitative evidence mixed with document reviews and secondary data, including data on programme financial and physical progress. Results are presented by research question. Anonymised codes relating to the various KIIs and FGDS are referenced throughout most of the text. In a few places these are suppressed for purposes of confidentiality.

Relevance

Summary: The programme is closely aligned to GOB's own policy documents and strategic plan for the 4th Health, Population, Nutrition Sector Plan (HPNSP4). UNICEF has been a core partner and non-pool funder since the start of the Health Sector Wide Approach (SWAp) process and is actively involved in the planning process. Within each programme area, interventions focus on lagging indicators and areas. The changing context, including needs of a middle-income country and the nature of development partner engagement, supports some reorientation of the programme towards those needs; a process already started in the current programme.

RQ1: How closely aligned is the Health Programme, its interventions, and plans, with relevant planning and policy frameworks of the GoB (including the health sector plan and the SWAP)?

The history of the Government of Bangladesh's (GoB) and UNICEF programme development and implementation are closely entwined. The GoB planned to implement the Vision 2021 and the associated Perspective Plan through two medium term development plans, known as Five Year Plans (FYP) with the first spanning FY11-15 (known as the 6th FYP). Within the broader context of the MDGs, the Government's vision for the health, nutrition and population sector was explicitly expressed in the 6th FYP as "...the vision for the health sector is to create conditions whereby the people of Bangladesh have the opportunity to reach and maintain the highest attainable level of health" (General Economic Division, 2011). This was later incorporated into the 2011 Health Policy of the country.

The UNICEF-GoB Health Programme 2012-16 was developed during the 6th FYP. A number of core targets included in the 6th FYP in the context of Vision 2021 were



directly in line with the Health Programme, including reduction of under-five mortality rate, infant mortality rate and the maternal mortality ratio, and an increase in immunisation coverage and births attended by skilled health workers. The latter part of the Health Programme (2017-20) had similar alignment with the 7th FYP. Outcomes and outputs set in the Health Programme 2017-20 are directly complementary to the Health, Nutrition and Population (HNP) broad objectives of the 7th FYP, including – “To ensure access and utilization of HNP services for every citizen of the country, with particular emphasis on elderly, women, children, poor, disadvantaged and those living in difficult areas”; “To ensure adolescent and reproductive health care”; “To improve nutritional status of children and women”; and “To improve the quality of hospitals and maternity services and to make these accessible especially to the women, children and poor” (Planning Commission, 2015). Certain indicators set in the health programme, for example the proportion of live births attended by skilled health personnel (doctor, nurse, midwife, auxiliary midwife); Proportion of children (12-23 months) fully immunised; and number and proportion of health facilities delivering adolescent friendly services in UNICEF priority districts are directly related to the HNP targets set in the 7th FYP. This suggests close alignment between the health programme and HNP strategies and objectives.

Bangladesh implemented a 3rd health sector SWAp in 2011, the Health, Population and Nutrition Sector Development Programme (HPNSDP 2011-16). The SWAp focused on achievement of the Millennium Development Goals (MDGs), particularly MDG 4, 5, 6 and part of the MDG 1 and 8 and also health related vision 2021 (MOHFW, 2017, Ministry of Health & Family Welfare, 2016). As a result, the strategic objectives of HPNSDP were very much aligned with those of the MDGs. A new OP named Maternal, Neonatal and Child Health Care was put in place under DGHS for emphasising MNCH issues separately. MNH services were planned to address needs during preconception, pregnancy, childbirth, and the immediate postpartum period by increasing the number of skilled birth attendants. Nutrition services were introduced in all facilities providing MNCH services under DGHS and DGFP, particularly the IMCI corners. Seven out of the eight priority indicators of HPNSDP were relevant to improved MNCAH services. UNICEF participated in the development process of the Strategic Investment Plan (SIP) as well as the Programme Implementation Plan (PIP) of HPNSDP. As a result, these priorities could be included as programme priorities in the UNICEF-GoB Health Programme that was initiated in 2012 and continued till 2017 – a timeline which was almost in parallel to the 3rd SWAp.

Alignment of the programme continued with the programme priorities of the subsequent SWAps. Strategy 7 of the 4th Health, Population and Nutrition Sector Programme (4th HPNSP), i.e. the 4th SWAp, expresses the GoB strategy to improve equitable access to and utilisation of quality health, nutrition and family planning services during the period of 2017 to 2022. This is the main service delivery component of the 4th HPNSP and the major cost driver of the sector where the majority of human resources and supplies are focused. Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) is amongst the priority programme areas of the 4th HNPSP and the major interventions related to this area are covered under this strategic objective. To improve RMNCAH, the Program Implementation Plan (PIP) of the 4th HNPSP includes interventions which are closely related to the UNICEF-GoB Health Programme. The design effectively included strategies and priorities aligning with the strategic objectives

of these GoB plans and frameworks. A rights and equity-based programme links well to the GoB strategic framework and higher-level planning documents. From this perspective, the interventions and plans of UNICEF-GoB Health Programme are well aligned with the relevant planning and policy frameworks of GoB.

UNICEF is a substantial contributor to the health sector and a development partner whose influence goes far beyond the funding provided. The GoB PIP, suggests that UNICEF will contribute around \$15 million to the 4th HPNSP (MOHFW, 2017). This is a substantial amount although is dwarfed by the contributions of other development partners such as Gavi (\$500 million), Global Fund (\$146m) and USAID (\$40m). The UNICEF contribution amounts to around one percent of total partner funding for the programme but funding from other partners is also allocated through UNICEF as an implementing partner. In the 2018 APIR, for example, while around 3% of core funding for RMNCH came from UNICEF, as an implementing partner UNICEF accounted for 10.5% of financial support (based on calculations from (Independent Review Team, 2019)).

Discussions with UNICEF and government partners suggest that UNICEF has been actively involved in the development of 14 operational plans during HPNSP. Explicit reference in the UNICEF rolling workplan (2017-2018) is made to nine operational plans: Community Based Health Care (CBHC), Health Economics and Financing (HEF), Management Information System (MIS), Human Resource Development (HRD), Hospital Services Management (HSM), Maternal, Child, Reproductive and Adolescent Health (MCRAH), Maternal, Neonatal, Child and Adolescent Health (MNCAH), Non-communicable Diseases Control (NCDC) and Planning, Monitoring and Research (PMR). In turn, HPNSP refers to support from UNICEF. In the Programme Implementation Plan (PIP) for example, UNICEF is shown as a major contributor to the MCHAH and MCRAH operational plan (MOHFW, 2017).

Key informants agreed that that the programme links closely to the GoB programme. One respondent mentioned that this linkage gives GoB strong ownership of activities and is also mindful of the tradition of active NGOS in the country². Not only does the programme link closely to the GoB programme but it also gives GoB ownership of the activities. The newborn programme area in particular has established a strong partnership that is well aligned. Respondents agree that UNICEF has played a strong role to establish consensus across partners in this area, something which is helped by UNICEF being a pool funder³. One partner suggested active engagement is stronger with DGHS and could be developed further with DGFP⁴. A government respondent pointed out that this is a planned approach with UNFPA focusing, for some things, mainly on DGFP while UNICEF engages with DGHS⁵ UNICEF is an active partner with DGFP for adolescent health.

RQ 2: How aligned are the health programme interventions with the outcomes and results the

² NAT_KII_1, NAT_KII_2

³ Nat_KII_4

⁴ Nat_KII_4

⁵ Nat_FGD_20



programme expects to achieve?

The programme focuses on access and utilisation of higher quality social services by women, infants, and children (Outcome 1) and adolescent girls and boys particularly by the most disadvantaged (Outcome 3). These outcomes are aligned with a number of goals in the HNPSP4 including reduction in the under-five, neonatal and maternal mortality rate (Goals 1-3) and readiness of public facilities to provide an essential service package (goal 7). The focus on the disadvantaged aligns with the continued disparity in health outcome indicators between geographic areas of the country (disadvantaged districts, urban slums) and socio-economic groups (BBS and UNICEF, 2014) (NIPORT et al., 2013).

Despite notable progress in health indicators across the country, wide disparities with regard to under-five mortality continue to exist between males and females (65 vs. 52 per 1,000 live births respectively) and between rural and urban areas (61 vs. 49 per 1,000 live births respectively). There are regional differences in under-five mortality and maternal mortality, particularly between Sylhet and Khulna. Moreover in urban slums, rates of under-five mortality are higher and antenatal care and immunisation coverage lower than the national average (NIPORT et al., 2013). Hence, challenges remain to improve equity across geographical regions, by gender, and between different wealth quintiles in order to achieve Universal Health Coverage (UHC). The UNICEF-GoB Health Programme was designed, in this context, to foster convergence in addressing multidimensional deprivations that affect children. The life-cycle approach was adopted to enhance collaboration across UNICEF as well as with external stakeholders to address these challenges.

Across the interventions to achieve the outcomes of the programme, a focus on a life-cycle approach is evident. Newborn interventions (chlorhexidine cord care, antenatal corticosteroid for pre-term birth, essential newborn care including Kangaroo Mother Care (KMC) and special care units (SCANU), neonatal sepsis management), care during labour, childbirth and first week of life, and EPI programmes of UNICEF covers the maternal, neonatal and child periods, while a focus on adolescent health addresses the teenage years (UNICEF Bangladesh, 2017). The health programme has specific focus on interventions to improve quality of services in hard-to-reach areas and low performing districts and urban slums.

To achieve the planned scale-up of service delivery, and to ensure quality, the health programme included complementary interventions to strengthen health systems and improve governance and stewardship. Interventions to strengthen the HMIS is essential to improve monitoring and supportive supervision. Utilisation of web based DHIS2 for reporting, for example, can strengthen vaccine management, EmONC, IMCI and newborn interventions. Improving supply chain interventions (i.e. making cold chain and logistics systems functional) is important for expanding EPI in low performing and difficult to reach areas. The interventions relevant to decentralised training are supportive capacity and knowledge development for service providers as well as the caregivers and community people in promoting the overall well-being of infants, young children, and their mothers. Overall, the interventions designed in the health programme are relevant and aligned to achieving the intended outcomes and results.

⁶ RQ18, RQ20

The work programme specifies outcome and output indicators that are to be used to monitor these four-year programme activities. The link between the choice of intervention and outcome measures are well justified. The output indicators are useful in providing a shorter-term measure of programme effectiveness. As observed in other sections⁶, in some cases these are less useful either because some activities do not appear to be assessed by any indicator (e.g. climate activities) or because the indicator chosen provides a less sensitive measure of programme effectiveness (e.g. the knowledge indicator used to assess the impact of community interventions).

RQ3: Is the ToC being followed? Does it include all the factors necessary for the ToC to be relevant? Does it need to be adjusted in any way?

The country programme provides a ToC narrative and diagram for each of the four focal outcomes (Government of Bangladesh and UNICEF, 2016). The ToC, provided in the ToR, relates to outcome one and outcome six, which focuses on use of quality services and empowering positive behaviours with interventions focused on: i) evidence and policy-dialogue; ii) equity-responsive services and partnership; and iii) partnership and participation. The ToC logic hinges on a number of assumptions in particular around continued government and development partner financial and political commitment to HPNSP4 and the organisation not being overwhelmed by emergency, humanitarian crises. Outcome indicators are defined for each outcome together

The logic of the ToC (Annex B) is broadly clear with linkage from implementation strategies to overall vision. The risks and assumptions mentioned are key to success. The main components of implementation - evidence generation, partnership and participation and service delivery - clearly form the basis of current activities and financing.

The assumptions on which the programme depends are clearly articulated as areas of risks. In some theories of change, the links between particular assumptions and outcomes/impacts are made specific so that it is possible to see which of the assumptions must hold and which risks threaten delivery⁷. Although we understand that incorporating all possible links can be difficult, such articulation can then help at the next stage to think about what happens if the assumptions do not hold. The assumption that government ensures frontline workers and minimises staff turnover, for example, is clearly critical to many of the UNICEF activities and some outputs. Being clearer about which outputs are at risk and a risk mitigation strategy, if this assumption does not hold, could help to modify the programme and make the ToC an active tool for management. Making such links explicit can help to identify which of the activities (if/then boxes) may be impacted by assumptions and risks.

Indicators are associated with both outcomes and outputs. There are five indicators associated with outcome 1 and one with outcome 3. These outcomes each have baseline values and targets for 2020. Baseline values are for the country as a whole mostly drawing on the 2014 DHS (NIPORT et al., 2016)

⁷ Further discussion in https://assets.publishing.service.gov.uk/media/57a08a5ded915d3cfd00071a/DFID_ToC_Review_VogelV7.pdf



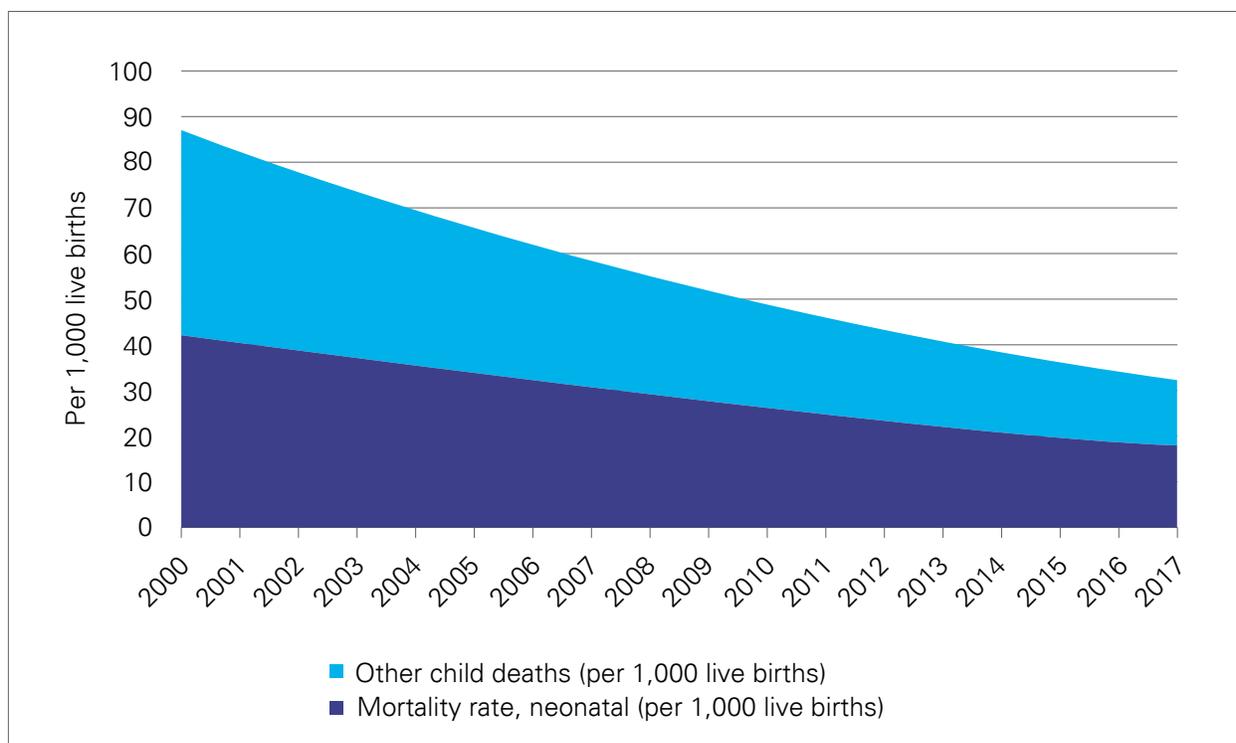
rather than, for programmes that are specific to particular areas, for the areas that UNICEF are working in (although some programmes are cross country, so national level data is more relevant). We realise that this is not always an easy task since district level activities are undertaken in different sets of districts for different activities.

By contrast, the output indicators are focused directly on the achievements resulting from programme inputs in intervention areas. These are tightly defined and measurable. In principle it should be possible to link these to activities and financial allocations and to disaggregate them by area (division) of work. In practice it has proved tricky to link financial and inputs to progress with indicators. Indicator progress can be obtained from internal forms although these do not disaggregate by division and the review team made use of divisional end-of-year reviews (in power point form) to understand geographic break-down. Financial indicators are expressed by division in the RWP 2018-19. Greater sensitivity in tracking progress could be provided if the RAM indicators are broken down in a similar way.

The consolidated ToC in the ToR includes outputs for both women, infants, and young children (outcome 1) and also adolescents (outcome 3). The overall outcome at the top of the ToC needs to reflect this since adolescents are not included.

RQ4: How closely linked are the specific interventions chosen with the full scope and scale of beneficiaries' needs in Bangladesh, both in an emergency and a development setting?

The interventions chosen map well to maternal, neonatal, child and adolescent needs as identified in relevant surveys. The emphasis on quality of care and demand for services is particularly important. Although in general UNICEF's country interventions map to the overall focus of the global organisation, the content of specific interventions are tailored to the country context. Key background studies that describe beneficiary needs include the DHS, 2014, Urban Health Survey, 2013 and vaccination Coverage Evaluation Survey, 2016. These in general suggest generally improving MNH indicators, but highlight key areas of need including a) the continuing presence of early marriage but preference for later marriage amongst beneficiaries; b) continued large differences in birthing practice across income groups and between rural and (formal) urban areas; c) despite the steadily fall in child mortality the persistence of high neonatal mortality (Figure 2); d) the persistence of poor child health outcomes in particular areas (e.g. Sylhet area including tea gardens); and, e) high EPI, crude EPI coverage, but substantial differences across districts partly as a result of differential drop-outs.

Figure 2 Trends in child and neonatal deaths (2000-2017)

Source: World Development Indicators, (World Bank, 2019)

The UNICEF programme interventions can be mapped to these needs. Interventions cover child marriage (a) through the adolescent health programme and community health activities (including C4D); encouraging safer birthing practices (b) are covered by the range of maternal interventions in particular MPDSR, WFHI, CEmONC and quality improvement; attention to neonatal health (c) is targeted through newborn interventions including KMC, NSU, ENC and SCANU; encouraging vaccination take-up and reducing drop out, and, € is targeted through the national level support to the EPI programme.

Disparities across areas, and within vulnerable population groups (d) is explicitly targeted through the focus on more vulnerable districts including, as mentioned in HPNSP4, unmet needs of services in former enclaves, tea gardens, urban slums and garments factories (MOHFW, 2017). The UNICEF-GoB Health programme have included this issue in the programme design. Discussion with service recipients, for example, confirmed to the importance of developing maternal and neonatal services within tea gardens⁸. Services received by recipients include iron and vitamin supplementation, ANC, normal delivery, and vaccination. UNICEF signed an agreement with six City Corporation to enhance service delivery including EPI, HMIS and Newborn health. Through the Mothers@Work programme, for example, it has reached more than 7,000 young working women in the RMG sector (UNICEF, 2017).

⁸ IDI_SP_Maternal Health_3



The substantive focus on newborn health is targeted and appropriate. This was supported by one KII respondent who observed success in reducing the general death rate but continuing high mortality among babies⁹. We also found during the facility observation that all six sampled district hospitals have functioning SCANU and are being widely used. The mean number of admitted neonates at the time of the observation was 24.7. The mean number of baby cots was 18.5 indicating a bed occupancy rate of 133%.

Two features of the UNICEF interventions are particularly important to beneficiaries: i) the emphasis on improving the effective supply of services by improving their quality (QI initiative but also other support including SCANU); and ii) improving knowledge and stimulating demand at the community level (through the support to community health and C4D activities). The importance of stimulating demand within the community was mentioned by community key informants¹⁰. This includes both providing services at home and motivating people to come to community clinics for routine services and before deliveries. This area was also mentioned in relationship to ensuring that vaccination rates are increased and drop-outs avoided¹¹. One question we do have for the programme is whether the interventions in any one district to stimulate demand are always coordinated with improvements on the supply side, given the evidence that both in the same areas are needed to ensure service delivery.

The influx of Rohingya, refugees, including 700,000 children, from northern parts of Myanmar's Rakhine state into Bangladesh, re-started in 2017. UNICEF scaled up its humanitarian interventions in Cox's Bazar district including a focus on preventing outbreaks of communicable diseases, such as measles, cholera and diphtheria, improving maternal and neonatal outcomes and addressing other risks and vulnerabilities, including acute malnutrition of children under age five, and violence, abuse and exploitation – which were the immediate need of the Rohingya refugees.

RQ5: How well is the programme preparing for changing needs as Bangladesh transits to a middle-income country

According to World Bank indicators, in 2014 Bangladesh became a low-middle income country (per capita income of \$1,070 or greater)¹². This largely arbitrary threshold is indicative of profound changes occurring in the country including: urbanisation, the proportion of the population living in urban areas has increased from 19% in 1990 to 35% in 2017; health status, life expectancy at birth has increased from 58 in 1990 to 73 in 2016; infant outcomes, infant mortality per 1000 live births has fallen from 99 in 1990 to 27 in 2017; patterns of employment, employment in agriculture has fallen from 65% of the workforce in 2000 to 37% in 2018; as well as a fast growing economy than has averaged over 5% for the last decade¹³. The Bangladesh health sector is also becoming less dependent on international financing; the proportion of public funding from domestic resources has increased from 59% in 2000 to 78% in 2015 (Health

⁹ KII_manager2

¹⁰ IDI_Ado_Girl2, FGD_CC_1, IDI_SP_Child Health3, IDI_Ado_Girl1

¹¹ IDI_Health seeking mother4

¹² <http://datatopics.worldbank.org/world-development-indicators/stories/the-classification-of-countries-by-income.html>

¹³ NAT_KII_1, NAT_KII_5, NAT_KII_13

Economics Unit, 2016). Despite these achievements, substantial inequalities in accessing good health and health care remain. Bangladesh also lags behind other countries in extending full risk pooling to the population, a vital element of achieving UHC as reflected in SDG 3. A recently published index assessing achievement across dimensions of breadth, depth and cost-sharing in reaching UHC suggested a score of 32% behind both India (34%) and Pakistan (36%) despite generally showing better basic health indicators than these two countries (Khan et al., 2019).

The current Five Year Plan articulates the need [to improve services for a rapidly increasing urban population (Planning Commission, 2015). This relates not only to the overall quantity of services but also to the better coordination of a multiplicity of funders and providers and regulation of the non-government sector. This analysis is supported by the 2013 Urban Health Survey which demonstrates the dominance of NGO and for-profit private health services (NIPORT et al., 2013). It also acknowledges the huge inequalities in access to essential services including RMH across urban populations.

The country programme is already adapting to changing country circumstances. The focus on urban health is a recognition of changing population dynamics. The concentration of effort in certain areas of the country is a recognition that while much has improved economically and in health terms, there are still vulnerable populations that have been left behind. Development partners agree that while international support for the sector will continue for some time, change in the nature of funding is inevitable with less emphasis on direct support for services and more on rights including, social protection and the productive sectors¹⁴. Less emphasis will be given by development partners to implementation and more towards prioritisation, policy development and scale-up. Several respondents suggested that UNICEF must move away from micro-interventions and gap filling of resources¹⁵¹⁶. The greater focus of the current programme on support to policy and collection of evidence is part of a concerted effort to strengthen core functions of the health system as the country itself increasingly funds services from domestic resources (activity 1.1.1 & 1.1.3). Emphasis is also being given to the production of evidence and learning from innovative projects (e.g. quality improvement).

Our review suggests three areas where UNICEF might further focus attention in considering the next sector plan:

Responding to the changing disease burden: A government respondent suggested some of the existing programmes will need to adapt to the changing disease burden¹⁷. As an example, the services for adolescents may need to include a focus on obesity and diabetes in some areas. Allowing variation across districts in the content of the intervention is thought necessary given intra-country variation in circumstances, a process that might be facilitated through the DEPB work¹⁸. The changing disease

¹⁴ NAT_KII_6, NAT_KII_7

¹⁵ NAT_KII_6, NAT_KII_13

¹⁶ Nat_KII_21

¹⁷ NAT_KII_6, NAT_KII_2

¹⁸ NAT_KII_2



pattern also requires a change in the type of data collected reflecting, for example, adolescent wellbeing as well as infant/child health outcomes¹⁹. A greater focus on urban needs may require a change in the emphasis of services directed to core beneficiaries. In urban areas, for example, women particularly in informal settlements, are more susceptible to cardiovascular disease and diabetes. Indoor air pollution in crowded urban dwellings can also lead to increase the incidence of chronic respiratory diseases.

Greater engagement with a multiplicity of providers in urban areas: The programme is already engaging with urban populations. Given rapid urbanisation, the focus on these areas will need to increase, and will require a greater focus on the population of cities. It was suggested that this will need to go beyond what is provided through programmes currently²⁰. One respondent thought that the dominance of the private sector in urban areas means that UNICEF needs a clearer strategy for engaging with the for-profit private sector, particularly around maternal health²¹.

Changing role for DP funding: The reducing role for DP funding and increasing domestic resources has important implications for the nature of engagement by UNICEF and other development partners. The experience of other middle-income countries is that DPS still have an important role to play in supporting development of national policy, and strengthening core health system functions. In the current programme, UNICEF is already engaging much more at the policy level including in creating evidence on what works.

Universal Health Coverage: The country is becoming increasingly able to support more comprehensive risk pooling for the population to allow extension of UHC (see RQ 8).

RQ6: Has the Health Strategy 2017-2020 appropriately reflected and contextualised UNICEF common principles such as UNICEF Strategic Plan, SDGs, Convention on the Rights of the Child, the Core Commitments for Children in Emergencies, WHA resolutions, SEARO resolutions, global programme goal (EWEC (Every Woman Every Child), GVAP (Global Vaccine Action Plan), Global Health Strategy, ENAP (Every Newborn Action Plan), Health Systems Strategy, Community Health, etc.)?

The interventions are designed to improve maternal, neonatal, child and adolescent health, aligning well with SDG 3 goals. Through the knowledge and capacity development and supplementation interventions, the health programme is working towards improving nutrition status, and from that perspective, SDG 2 is partially addressed. Due to the inclusiveness and equitable interventions, the SDG 4 and 5 goals are also reflected in the health programme. SDG 6 and SDG 16 are also incorporated in the cross-cutting and coordinating activities of the health programme with other internal and external stakeholders.

¹⁹ NAT_KII_4, Nat_FGD_20

²⁰ NAT_KII_7

²¹ NAT_KII_7

UNICEF is one of the 12 United Nations (UN) agencies contributing to the UNDAF Social Services for Human Development pillar, to ensure that 'deprived populations in selected areas, particularly women, children and youth benefit from increased and more equitable utilization of quality health and population, education, water, sanitation and HIV services'. A rights-based approach is a central tenet of UNICEF's approach to development. Rights as reflected in the Convention on the Rights of the Child (UNICEF, 1990) and Every Woman Every Child Global Strategy have been incorporated into the country programme including the focus on birth registration, intrapartum and disability and rights of adolescents (Every Woman Every Child, 2015). The convention also emphasises the benefits from social insurance (Article 26). This raises the question of whether UNICEF and/or other development partners should place more emphasis on wider rights to essential health services for example by advocating more strongly for primary care to be part of insurance packages, which is not currently the case with the SSK scheme.

Under the health programme, UNICEF is responding to the large humanitarian crisis of the Rohingya refugees by responding to measles and diphtheria outbreaks, which follows the policies and frameworks set in the Core Commitments for Children in Humanitarian Action (CCCs). The Headline Result of 'Reducing Neonatal Mortality' under Outcome 1 is included to extend support to MOH&FW and coordinate with other development partners, sectors and agencies for the effective implementation of Bangladesh Every Newborn Action Plan (UNICEF, 2018a). The expansion of EPI in hard-to-reach and low performing areas and introduction of new vaccines like pneumococcal, Rotavirus and cholera is in line with the Global Vaccine Action Plan (GVAP). The WHA resolutions, SEARO resolutions and Global Health Strategy are also intimated in the programme priorities. A focus on child and adolescent, maternal, and reproductive health and gender, equity and human rights reflected in the UNICEF strategy are central to SEARO's programmes for the region²².

Two background UNICEF documents are key to the development of the future sector strategy. The Strategy for Health 2016-2030 focuses on an end to preventable maternal, newborn and child deaths and promotion of the health and development of children (UNICEF, 2016b). The second goal recognises the needs of 'older children and adolescents' shifting the focus of support from life-saving interventions around child-birth to include improving the quality of life through better access to services and behaviour change. The current strategic plan for 2018-2021 (UNICEF, 2018b), which was published after the country programme, focuses on a life-course strategic approach that elaborates the Strategy for Health with a ToC that is also reflected in the country programme document.

The UNICEF Bangladesh country programme aligns well to the core UN and UNICEF documents. The UNICEF country programme is based on outcomes relating to four areas: i) young children and their mothers; ii) girls and boys of primary-school age; iii) adolescents as agents of change; and, iv) social inclusion and awareness of children's rights (Government of Bangladesh and UNICEF, 2016). The country health programme focuses on outcomes i) and, iii). The focus on maternal, newborn and child health and immunisation reflects overall UNICEF priorities as outlined in the older 2014-17 Strategic Plan

²² <http://www.searo.who.int/entity/en/>



(UNICEF, 2014). It aligns to the country UNDAF 2017-2020 which emphasises equal rights, access and opportunities (United Nations Bangladesh, 2016).

The country programme reflects a series of other international strategies and conventions. The immunisation programme, focusing as it does on reducing inequalities in vaccination access and improving drop-out rates, closely reflects the Global Vaccine Action Plan 2011-2020 which emphasises equitable access and improved vaccine delivery systems (WHO, 2013). Similarly, the strengthening of maternal and newborn health, including approaches to reducing neonatal mortality such as kangaroo care, advocated in the 2014 Every Newborn Action Plan (WHO, 2014) has become a central part of the country programme.

Aspects of both 2016 strategies are evident in the current health country plan. The emphasis on adolescents is strongly reflected in the 17/20 document in a way that was not nearly so evident in the previous country programme; where the few references to adolescents was largely about access by adolescent girls to maternal and reproductive health (UNICEF, 2014, UNICEF, 2018b). The general strengthening of the health system is picked up in cross-country programmes to improve core building blocks of the health system particularly information systems, through the strengthening of the DHIS2/HMIS, governance through the Leadership Development Programme and planning and financing, through the support to District Evidence Based Planning and Budgeting .

Key informants agreed that the country programme aligns well with these documents and in many ways is seen as region or world leading in their implementation²³. It was suggested that in some areas the Bangladesh programme is ahead of other countries particularly around adolescent health, which is a relatively new dimension of the UNICEF international programme but already well embedded in Bangladesh²⁴.

RQ7: How appropriate is UNICEF's current approach for health systems building focusing on health system strengthening in light of Bangladesh's context of lower middle-income country?

A health system strengthening approach (HSS) was developed across UNICEF in 2016 (UNICEF, 2016c). This links to the overall strategy for health, but emphasises a move away from vertical programmes towards general improvements in the system. It focuses on an approach that reduces bottlenecks in service delivery with an emphasis on closing equity gaps in MNCH and related outcomes to contribute to universal health coverage (UHC), and broader child development. The most internationally visible aspect of the HSS work appears to be the focus on HMIS, which has been well disseminated and attracted regional attention²⁵. The feeling of most respondents is that the HSS focus is appropriate, and will become more so in the future.

²³ NAT_KII_8, NAT_KII_2

²⁴ NAT_KII_3

²⁵ NAT_KII_8

²⁶ NAT_KII_6

One of the comments on the HSS work by respondents is that whilst it is important, the link between the support and other components (building blocks) outside the control of UNICEF means that the benefits may not be fully realised²⁶. A recurring example of this is shown in the lack of adequately trained staff, which prevent, for example, full functioning of interventions in HMIS and maternal care. A further example is the finance function that is still dominated by tight Ministry of Finance rules over spending authority at ministry, and particularly at the local level. This may render support such as DEPB less effective because districts cannot fully budget for their local plans. While these criticisms are salient, they arguably make engagement in the HSS sphere more important rather than less. While UNICEF cannot support all aspects of the health system, it might become more active in encouraging support from other partners across the health system, working to ensure that system advice is consistent with the inputs of other actors. Highlighting where issues, such as human resource constraints and financing controls, are inhibiting the effectiveness of other HSS interventions is also important here.

RQ8: What should be UNICEF Bangladesh’s role in the universal health coverage/ health insurance discussion that is now being prioritised by the Government?

Achieving UHC is a key part of the GoB’s strategy to achieve health related SDGs. The PIP mentions UHC numerous times including as a main objective (page xv, (MOHFW, 2017)). Extending risk pooling to the population through health insurance has been identified as an important component of the UHC strategy. The 2012 Health Financing Strategy foresees an extension of health insurance to the population, first through the piloted extension of subsidised insurance for the poor, and later to other groups (Health Economics Unit, 2012). This has been implemented during HPNSP4 through the development of the SSK pilot led by the Health Economics Unit with support from a variety of development partners.

The current programme of activities of UNICEF already supports UHC in a number of ways. Improvement of maternal health services and indicators is seen by the PIP as a vital ingredient for the achievement of UHC (page 42, PIP). Good maternal health services are often viewed as a tracer for a strong health system, and support from UNICEF for maternal services at different levels helps to underpin UHC progress. It also includes support for the system of birth registration and DHIS since useful information is seen as vital for the implementation of UHC (see page 38, of the PIP). The PIP (page 23) stresses the need to demonstrate VfM from health sector spending in order to advocate for increased resources. UNICEF’s focus on generating evidence is a potentially valuable contribution to this advocacy provided the evidence is robust and well communicated.

A number of development partners are supporting health financing aspects of UHC, including KfW (SSK development), the World Bank and the WHO. At the national strategy level, this is a reasonably crowded and well-informed space where there is not an obvious gap for UNICEF to fill. UHC however, means more than raising funding and developing insurance schemes. It requires that funds are allocated wisely throughout the system and that services funded are high quality. There are three areas where UNICEF’s input is already present and might develop more in the future.

²⁶ NAT_KII_6



- i. Quality improvement is a key dimension of UHC and HEU has expanded its remit to include a quality improvement secretariat in 2015 (see page 153 of the PIP). Discussion of UHC is often dominated by issues of financing and efficiency and pays insufficient attention to quality of care, yet without quality improvement efforts to extend UHC, will have limited impact (Dayal and Hort, 2015). UNICEF has been providing support to quality improvement initiatives and a number of interlocutors mentioned the importance of this contribution.²⁷ There is some concern that this work has not been scaled and the results fully communicated. There may also be an argument for focusing on the quality of the private sector, particularly given the importance of the sector in urban areas.
- ii. Improving allocation of resources through local (Zila and Upazila) level planning has a long history in Bangladesh. First efforts to develop local level planning began during HPSP (1998 to 2003) including needs based planning and local strategic plans (Ensor et al., 2001). Efforts were revived during HNPS (2003-2011) (Ensor and Begum, 2010) and now being implemented under HPNSP4 through district evidence based planning (DEPB) (Jahan et al., 2018). DEPB is supported by UNICEF, and is the only partner currently assisting with this process. There was a feeling by respondents that while the national funding context is well covered, inputs at the local level are an important part of UHC support and should continue and possibly even expand.²⁸ One concern here is that this remains a high-risk endeavour unless the Government, including Ministry of Finance, is behind the work; as illustrated by relatively little progress made in this area in the past despite considerable effort. The indicator for this area may need to be refined to go beyond a count of plans developed, to include measures of impact, such as proportion of budget programmed through the plan and even changes in budget allocation going to priority areas.
- iii. The role of primary care is vital to UHC but often strangely neglected. In common, for example, to schemes in India and China the SSK organised by the HEU excludes outpatient care from the package. Yet evidence suggests that strong primary care is vital for UHC in order to control costs and ensure that services are delivered effectively (Lagomarsino et al., 2012). One respondent suggested that UNICEF could be doing more to advocate for a strong primary care component in the UHC plans, together with other UN agencies.²⁹

RQ9: Where within the Health Sector has the UNICEF Health Programme been established as a critical actor that must remain present? Where has UNICEF not achieved critical status and needs to either become better or to consider exiting in favour of a better equipped stakeholder?

UNICEF is an established critical partner in the area of newborn and childcare and now adolescent care. It is an emerging critical partner in HSS particularly in HMIS.

²⁷ KII_manager2, NAT_KII_4

²⁸ NAT_KII_2

²⁹ NAT_KII_8

In a number of areas, UNICEF is a highly visible and influential stakeholder. It is a long-established partner in helping to plan and deliver interventions for EPI and Maternal health. The Government clearly sees UNICEF as a critical partner in both these areas.³⁰ In EPI, UNICEF plays a critical role in establishing and maintaining the cold chain, capacity development of GoB workers, ensuring quality of procured vaccines, and awareness development of the caregivers. GoB respondents felt that immunisation in urban and hard-to-reach areas is still a critical issue for MoHFW and for which UNICEF support is still required.³¹ The importance of support in maternal and neonatal services including SCANU, KMC and EmOC, was mentioned in a number of interviews at local level as well as all respondents at national level.³² It is also seen as an increasingly critical stakeholder in the delivery of services in hard to reach areas.³³

The challenge around exiting this area may be less about the service areas supported than how the support is provided. UNICEF's critical role in providing basic supplies, including medicines and training materials is often cited³⁴ as well as delivering training.³⁵ A more strategic, advisory role, discussed in RQ7, may require UNICEF to pull back from direct support of services, at least at a scale that goes beyond evaluated pilots. Support to HMIS to track services and enable, for example, more accurate identification of dropouts from EPI to some extent represents this changing role.

UNICEF is seen as increasingly important in providing adolescent care. The programme is well embedded in government and well known regionally.³⁶ Their role in providing community facing services to teenagers is appreciated.³⁷ During the stakeholder interviews, there were a few critical comments about the scope of the education provided. It was suggested, for example, that education on, for example, safe-sex, drug addiction and child marriage, be extended to parents³⁸ to ensure they properly understand the issues and could communicate with their children. There is some discrepancy here with information from programme managers who suggest that activities do include parents.

HSS is a relatively new area for UNICEF. UNICEF is clearly a critical partner in the delivery of an accurate and responsible HMIS, support that is well embedded and well regarded. In other HSS areas, it is probably too early to say that UNICEF has established itself as a critical partner. Nevertheless there was general consensus by respondents that this is an appropriate and important area particularly as UNICEF's own role evolves. Many partners (WHO, USAID, SCF, DFID, GIZ) provide support to HSS currently, or have done in the past. This is an obvious area for collaboration to ensure that support is consistent across the sector. The work on district planning (DEPB) has enormous potential, provided that government systems allow localities to take increasing control of services and finance.

³⁰ Nat_FGD_20

³¹ Nat_FGD_22

³² FGD_CC_1, IDI_SP_SCANU_1, KII_manager1

³³ KII_manager1

³⁴ NAT_KII_4, IDI_Ado_Girl1, IDI_SP_Child Health1, FGD_CC_1

³⁵ KII_manager2

³⁶ NAT_KII_4, NAT_KII_3, NAT_KII_1

³⁷ IDI_Ado_Girl2, IDI_Ado_Girl1

³⁸ IDI_Ado_Girl1



Although climate change is a hugely important issue, the current focus of the programme is still developing, as this is a new programme area (for 2019). A situation analysis has been conducted, and training health staff on resilience and preparedness have been designed but activities have not yet started³⁹. The activities required an indicator for monitoring purposes.

Coherence

Summary: The programme draws from a situation analysis that makes clear links between population needs and interventions. UNICEF's contribution is based on historic strengths (e.g. EPI, maternal and neonatal health), emerging international areas of focus (e.g. adolescent health) and more recent but well embedded health systems strengthening (HSS) support (HMIS). Although the programme is internally coherent, there are some misconceptions of the interventions among partners, and programme documents lack reference and linkage to other partner programmes.

The overall objectives of the programme, as they relate to outcomes, are mostly well understood by stakeholders. Government stakeholders seem clear about the objectives of the programme and knowledgeable about the type of support offered. Unsurprisingly their knowledge and focus, particularly those involved in specific programmes, tends to be around the areas for which they are responsible. Field level service providers see UNICEF as a good training and logistics service provider, but often do not seem to have clear idea about the overall programme under which the services are being provided⁴⁰.

Some misunderstandings, particularly by other development partners, about the nature of interventions arose during the interview process. It appears it is not clear to some people how the HMIS system, supported by UNICEF, relates to what is used by DGFP and whether the systems are in principle compatible. A second issue is that although the objective of the Quality Improvement Initiative appears to be reasonably understood in principle, several stakeholders said that the detail of what has been done has not been fully communicated and questioned why lessons could not be shared across other districts. One respondent also felt that UNICEF was focusing over much on the secondary care level which probably reflects a lack of knowledge about community based interventions and also possibly a lack of awareness of the way in which UNICEF and UNFPA share out responsibility for support at different service levels. We emphasise that we are not arguing that these statements are true rather we share them because we believe that there is some scope for better communication with partners of the way this support is being offered and how it relates to other activities across the sector.

³⁹ NAT_KII_16

⁴⁰ IDI_SP_DHIS2_1; IDI_SP_EPI_2

RQ11: How comprehensive are the projects chosen as a necessary and sufficient suite of interventions to support high-quality health services and robust health system, and in particular those that are most likely to: a) reduce neonatal mortality, improve the quality of MNCAH services and prevent HIV transmission and early HIV infant diagnoses and treatment; b) improve coverage of EPI in low-performing districts; c) ensure adolescent friendly health services?

As suggested in RQ1-2, RQ6, RQ12, the programmes chosen by UNICEF are closely linked to health needs particularly relating to indicators that have not improved across the country as much as expected including neonatal mortality and vaccination in some areas. A range of programmes address these issues across MNCAH, adolescents and EPI⁴¹. Based on the ToC, the programmes are seeking to derive evidence on the effectiveness of these programmes with a view to scale-up. The HSS focus suggests a system-wide approach which, amongst other things, should promote coherence across programmes.

Neonatal mortality: The programme incorporates a range of neonatal interventions including newborn priority interventions, care for the neonate including KMC, NSU and SCANU,

EPI coverage: Support focuses on cold-chain management and training, technical assistance on introduction of new vaccines and electronic monitoring including crucially the EPI e-tracker to track dropouts from the programme. Dropouts are a key reason effective coverage varies so much across the country. Support on tracking fits well with the more general support given by UNICEF to the HMIS system.

Adolescent services: The adolescent health programme that operates both in facilities and communities is an important step to providing targeted services to this group. The adolescent interventions in facilities rely on the introduction of corners which are seen as a demarcated and safe spaces where users can consult with staff. During the review, in interviews and documentation, there was some criticism of the corner approach as a way to perpetuate the vertical programme approach to delivery of services (Independent Review Team, 2019). A related comment was that a user commented that the corners could dispense advice but when they asked about EPI said they would have to go elsewhere for services.⁴² While vertical programmes should be avoided, if possible, we understand that ensuring that this group accesses services in a confidential way necessitates a demarcated space. The HMIS suggests that use of these services is increasing, and our facility surveys find that services are appreciated. At this stage, the approach is a necessary step to ensuring increased use of services by this group. The field data suggests there is much variation in the level and type of user of services. For example, the patient exit survey data suggests a higher proportion of users from the top quintiles were visiting district hospitals than the bottom quintiles where advanced care are available, whereas the proportions are similar in upazila health complexes.

⁴¹ The HIV programme was outside the remit of the assessment.

⁴² IDI_SP_Child Health3



Although there is little UNICEF can do to change services overall structures, there may be action that can be taken to link up programmes across the agency and with other partners. This includes ensuring cross-sector learning from partners implementing similar strategies. The recent APR, for example, urges that quality improvement initiatives are rolled out and integrated into DGHS to ensure closer coordination and links with the service delivery infrastructure (recommendation 33) (Independent Review Team, 2019). UNICEF are already acting in these areas with visits for government and DP staff to Kurigram to review the QI model.

RQ12: Taking, as a starting point, the Bangladesh Situation Analysis, did UNICEF select priority programme elements with due consideration for its comparative strengths, governmental expectations, and the capacities of other sector actors?

A number of situation analyses of the Bangladesh health sector have been undertaken as background to the current programme. In particular, the 2015 country situation analysis focused on the situation of children and women highlighting six cross-cutting priorities: strengthening systems and institutions; embedding effective planning at local level; mainstreaming gender and empowering women; empowering adolescents; ending child marriage; and improving services and opportunities for children and women in urban slums (UNICEF, 2015a). The analysis draws on available evidence in-country, linked to international agreements and UNICEF goals particularly around rights, gender, and equity. The focus on children, women and adolescents reflect ongoing organisational concerns, while the emphasis on strengthening local planning capabilities is grounded in the awareness that services are likely to be both more efficient and equitable if they are at least partly developed and implemented locally.

The programmes that UNICEF developed from the situation analyses, substantially builds on their historic experience and strengths in the health sector, particularly around MNH and EPI (Government of Bangladesh and UNICEF, 2016). It also includes support to DHIS2 and birth registration which was started previously. The focus on adolescents appears to be a natural progression of their support for children as well as fitting with the changing international emphasis of UNICEF and responding to changing demographics. It is a little less clear in the strategy documents why they chose to focus on other areas such as quality improvement and DEPB.

One thing we found missing in strategy development documents was much mention of the contribution of other partners and how UNICEF complements this support. As a result, although the needs are very well spelt out, it is not always clear from the documents why UNICEF is choosing to engage instead-of or together-with other partners.

⁴² IDI_SP_Child Health3

Effectiveness

Summary: With a few exceptions, output monitoring indicators and spending suggest activities are on track against the targets. Where they are not, there are indications that outputs will be delivered during the last two years of the programme.

Programme effectiveness could be enhanced in several areas: i) greater linkage of community/communication for development (C4D) interventions with supply-side programme components; ii) a more consistent approach to development, synthesis and communication of evidence, including comparisons with similar programmes; iii) increasing focus on quality as well as quantity of data collected through the HMIS. Although it is unsurprising that much monitoring has focused on quantity of service roll-out, it will be important to start monitoring the content and quality of services if the envisaged gains in health outcomes are to be achieved. Human resource availability remains a severe constraint to delivery of quality services.

In this section we look at the evidence for the effective implementation of interventions. In particular we address research questions 13 to 23 that focus on how likely the programme is to achieve desired results by 2020 across a series of related areas.

The progress achieved is monitored through assessment of output indicators listed in the RWP and results framework and reported through the RAM. For each indicator, a baseline was set together with targets for the end of the programme (2020) and intermediate targets. For the purposes of the assessment, we have listed the indicator next to the most closely linked activity although we recognise that some indicators will be affected by more than one activity (Table 5). Listing indicators in this way also helps to identify those activities that do not appear to be linked to a monitoring indicator.

Table 5 RWP activities and indicators

Activity	Indicator	Means of verification	Baseline	Target in 2018	2018 Quarter 3&4 Achieved	Cumulative Target in 2020	% of target achieved	Comments
Activity 1.1.1: Develop Health policy and Strategies on Maternal, Newborn, Child and Adolescent Health	Number of health policies and strategies developed and operationalised (child health, urban immunization, and adolescent health)	Documents developed, endorsed and available	0	3	2	3	67%	On track



Activity	Indicator	Means of verification	Baseline	Target in 2018	2018 Quarter 3&4 Achieved	Cumulative Target in 2020	% of target achieved	Comments
Activity 1.1.2: Strengthening health systems for improving effective MNCAH services with equity	Number of districts implementing district-level evidence-based health plans (B-14, T-30)				14	20	70%	On track
Activity 1.1.3: Developing strategies and technical guideline for eHealth standards, Leadership management course and evidence-based planning for health managers in Bangladesh								No Indicator - this activity is linked to DEPB
Activity 1.1.4: Support to improve cold and supply chain management system performance to achieve the impact through the immunisation outcomes	Number and proportion of districts with functional Cold Chain and logistics System	HMIS Report, DGHS	8 (26%)	20	6	29	21%	Lower than expected achievement
Activity 1.1.5: Strengthen web based DHIS2 for planning, implementation and reporting of vaccine management, EmOC, IMCI, nutritional and newborn HMIS	Proportion of districts utilizing web based DHIS2 for reporting of vaccine management, EmONC, IMCI and newborn HMIS	DHIS 2	40%	60%	EMOC-95.7% IMCI-95.7% EPI-100% SCANU-97.6%	70%	>100%	On track
Activity 1.1.6: Ensure effective coverage of maternal health services	Number and Proportion of designated CEmONC facilities that are operational on a 24/7 basis in UNICEF priority districts	HMIS report from DHIS 2, DGHS	12 District Hosp (60%)	17	16	20	80%	On track

Activity	Indicator	Means of verification	Baseline	Target in 2018	2018 Quarter 3&4 Achieved	Cumulative Target in 2020	% of target achieved	Comments
Activity 1.1.7: Mainstream gender for delivery of gender sensitive and women friendly MNH services								No indicator
Activity 1.1.8: Promote and ensure priority newborn interventions including essential newborn care package and sick newborn management at facility	Number and proportion of facilities upgraded with functional Special Care Newborn Unit (SCANU)	HMIS Report from DHIS 2, DGHS	26 (41%)	35	36	40	90%	On track
	Number of districts delivering five new newborn health interventions (chlorhexidine; KMC; antenatal corticosteroids; neonatal sepsis management) [1];	HMIS report from DHIS 2, DGHS	0	15	11	20	55%	On track
Activity 1.1.9: Implement Integrated Child Health (EPI, IMCI, ECCD, BR, Disability, drowning, WASH) Package (IHP)	Percentage of service providers in selected districts trained on revised SOP of vaccine and cold chain management (B-0; T-90%)					90%		On track
	Number of health workers trained on birth registration	Programme/ Training Reports	3000	4000	850	5000	17%	Lower than expected achievement
Activity 1.1.10: Implement Quality Improvement interventions at national and in selected facilities	Number and proportion of facilities implemented quality improvement of MNCH service	HMIS report from DHIS 2, DGHS	33 (47%)	40	60	50	120%	On track



Activity	Indicator	Means of verification	Baseline	Target in 2018	2018 Quarter 3&4 Achieved	Cumulative Target in 2020	% of target achieved	Comments
Activity 1.1.11: Upgrade facility for provision of disability friendly MNCH services	Number and proportion of health facilities with provision of disability friendly health services in selected districts	HMIS Report, DGHS	0 (0%)	10	0	20	0%	On track
Activity 1.1.12: Mainstream Climate Change in health programme and implement climate resilient and child centred adaptation interventions in selected districts								No indicator
Activity 1.1.13: Program evaluation and research of implemented programs through external agencies								No indicator
Activity 1.1.14: Strengthen co-ordination and management for improved delivery of Urban MNCAH services								No indicator
Activity 1.6.1: Implement integrated Communication for Development plan for MNCH services	Proportion of caretakers of new-borns (mother, father, in-laws) who know at least three danger signs of new-borns	Survey Data and Real Time Monitoring Reports (UNICEF- BBS/ GOB)	0	7%	80%	25%	320%	On track
	Proportion of mothers and caregivers with knowledge of at least five essential family practices in UNICEF focus / select districts	Survey Data and Real Time Monitoring Reports (UNICEF- BBS/ GOB)	0	7%	Reached 10.5 million population repeatedly through TV plus 500,000 through district information offices.	30%		On track

Activity	Indicator	Means of verification	Baseline	Target in 2018	2018 Quarter 3&4 Achieved	Cumulative Target in 2020	% of target achieved	Comments
Activity 3.1.1: Promote & establish gender responsive adolescent friendly health service (AFHS)	Number and proportion of health facilities delivering adolescent friendly services in UNICEF priority districts	HMIS report, DGHS	0 (0%)	15	141	20	705%	On track
Activity 3.1.2: Implement cost-effective model of adolescent friendly health service (AFHS) for evidence generation	Number of service providers trained on adolescent friendly health services							On track
Activity 3.6.1: Strengthen capacity to families and communities to support and demand for adolescent health service	Targeted unions that have publicly committed to end harmful practices of child marriage							On track

Source: Rolling Work Plan 2017-2018, UNICEF Excel Sheet

For the majority of indicators, achievement against the intermediate and final targets are on track, with at least 50% of the 2020 target achieved by the end of the second year of the programme. Three main comments on this include:

Lower than expected achievement: There are a few indicators where progress is showing less than 50% achievement by the end of the second year. This is not necessarily a concern, and it is to be expected that progress will build up more slowly in early years as the necessary investment is established. This appears to be the case for ensuring a functional cold chain (1.1.4) for vaccine delivery where it was explained that procurement delays lead to lags in spending an achievement.

A background assessment to review the progress has been undertaken by UNICEF. Activities are due to be rolled out from 2019. Close monitoring of this activity will be required to ensure achievements by end of the programme. Although training on birth registration is ongoing, achievement is below the target for 2018 – 50% of the target for 2020.

No indicators: A number of activities could not be linked to an indicator. These include mainstreaming of disability friendly services (1.1.7), mainstreaming climate change (1.1.12) and service providers training



in adolescent services (3.1.2). There is also no separate indicator for the urban MNCAH services (1.1.14) although we recognise that these services are monitored as part of the overall support for MNCAH, including disaggregation by urban and rural areas.

Indicators in need of review: In a few cases, the indicators have already exceeded the targets. In general, this is the case for the knowledge indicators lined to the C4D activities (1.6.1). It is also the case for the establishment of gender responsive services. This reflects positive achievement. Exceeding the targets can happen for multiple reasons including problems with the indicators or setting the targets too low. Reviewing the indicators, our assessment is it is the latter. This is an opportunity to refine the indicators (if needed) or review the targets. In the case of adolescent services more focus might be given to the content of the care offered (RQ24). In case of the C4D services greater consideration might be given to whether the knowledge exhibited by the target population translates into changes in behaviour (see RQ20).

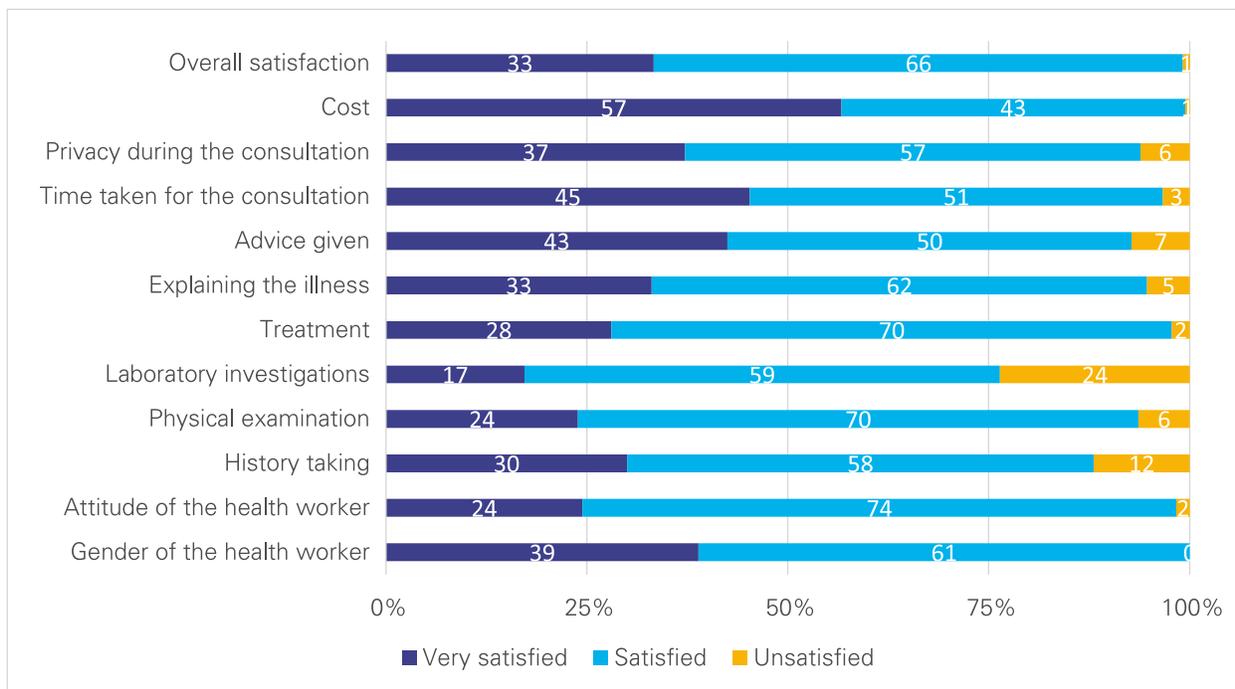
As the programme develops, it will also be important to focus on service quality both from a clinical perspective, and from the point of view of service users. The assessments undertaken for this evaluation suggest that while patients take a generally positive view of the services they receive, from a technical perspective they are often of inadequate quality (Table 6, Figure 3, Figure 4). This is however important to mention here that the assessments on quality of care were carried out by the medical doctors recruited by the evaluation team, and they have done their assessment on adequacy of the treatment during the observation. Although the medical doctors were trained and briefed during the training to be unbiased and objective, there is likely to be some degree of subjectivity in some assessment questions

Table 6 Quality of care and satisfaction with services

Type of patient	Quality of care (technical assessment)				
	Adequate	Somewhat adequate	Inadequate	Total	N
Adolescent	15.5	31.0	53.5	100	58
Child	7.3	46.4	46.4	100	69
Infant	5.7	50.0	44.4	100	124
Neonatal	14.6	46.3	39.0	100	41
Maternal	42.7	25.0	32.4	100	68
Total	15.6	41.1	43.3	100	360
	Overall satisfaction of patients				
	Very satisfied	satisfied	Unsatisfied	Total	
Total	33.3	65.8	0.8	100	360

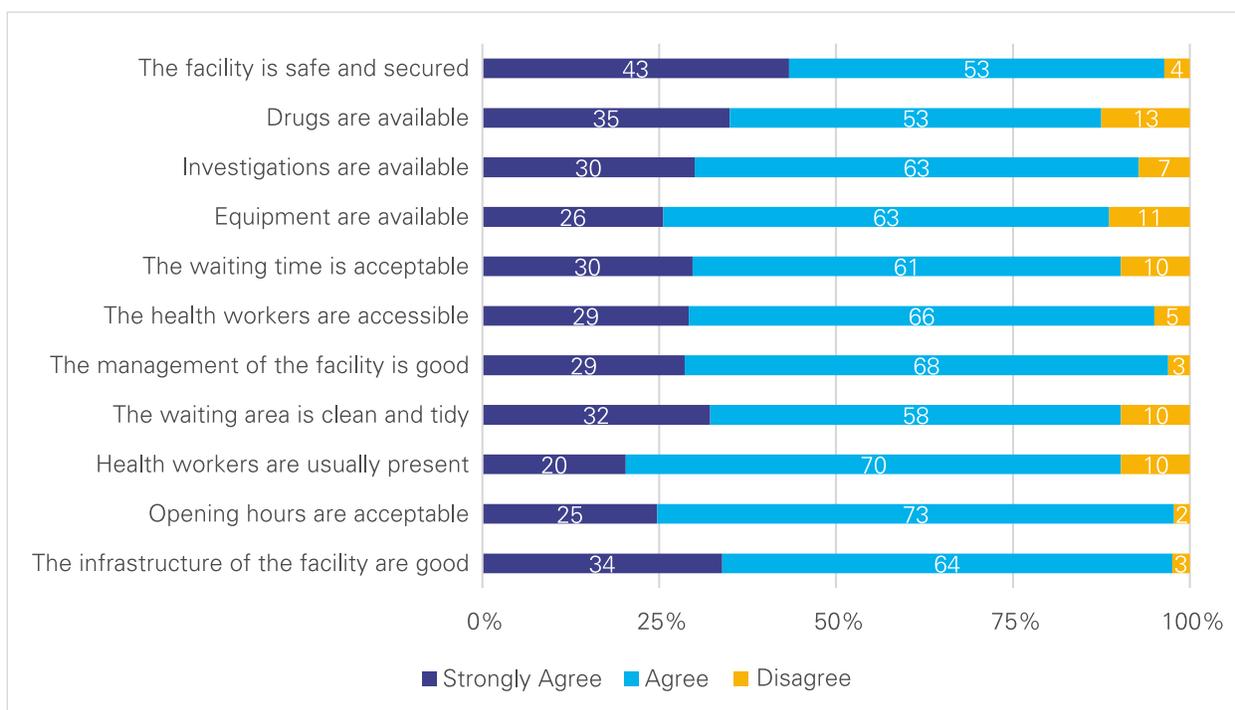
Source: Health facility survey

Figure 3 Patients' satisfaction by different aspect of the service



Source: Patient exit survey

Figure 4 Patients' agreement on key service standards

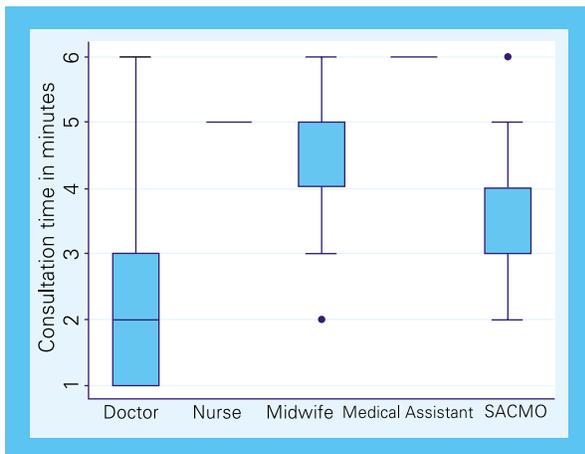


Source: Patient exit survey



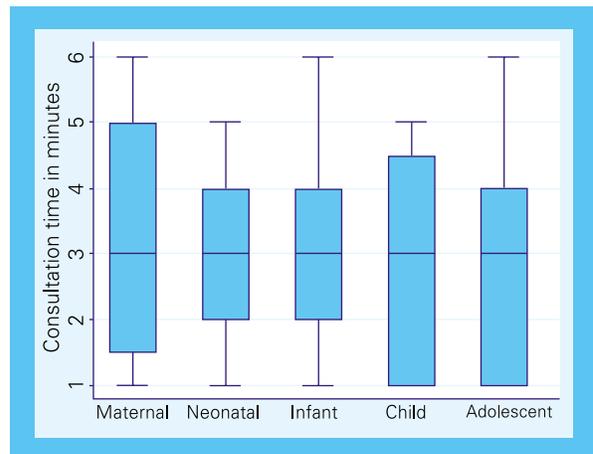
Similarly, despite high patient satisfaction with the content of services, the direct observation of the consultations revealed that the duration of the consultations, especially by the medical doctors were often rather short (Figure 5). This could be because of high patient load, but the vacant positions, absenteeism and reduced working hours of the outpatient departments can also have impact on the short duration of consultation. Across all type of patients, half received at least three minutes of consultation from the healthcare provider but maternal patients show a relatively wider spread signifying that long consultation sessions occur mostly with them. This is perhaps because this category involves both pregnant women and mothers that delivered in the last forty days, hence covering a wide range of health issues.

Figure 5 Duration of consultation, by types of health worker



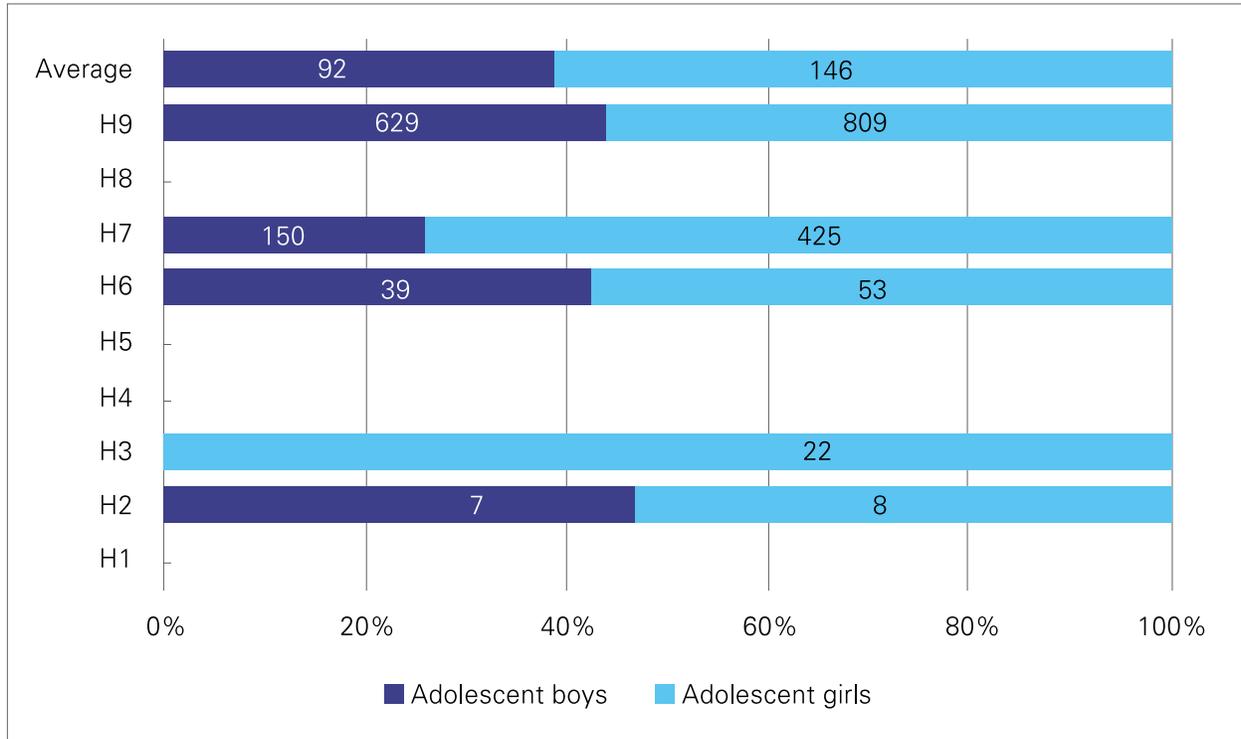
Source: Service provision, direct observation

Figure 6 Duration of consultation, by types of patients



Source: Service provision, direct observation

Adolescent services are relatively new to the system and many facilities are still gearing up to deliver the function. The facility survey suggests that while adolescent services are often physically present, what, and how much, is offered varies substantially. Girls appear to make consistently greater use (60%) of services than boys and in one facility only girls were reported using the service. In four out of nine facilities visited, no services were offered in the last month, despite a corner being available.

Figure 7 Use of adolescent services by gender, by facility

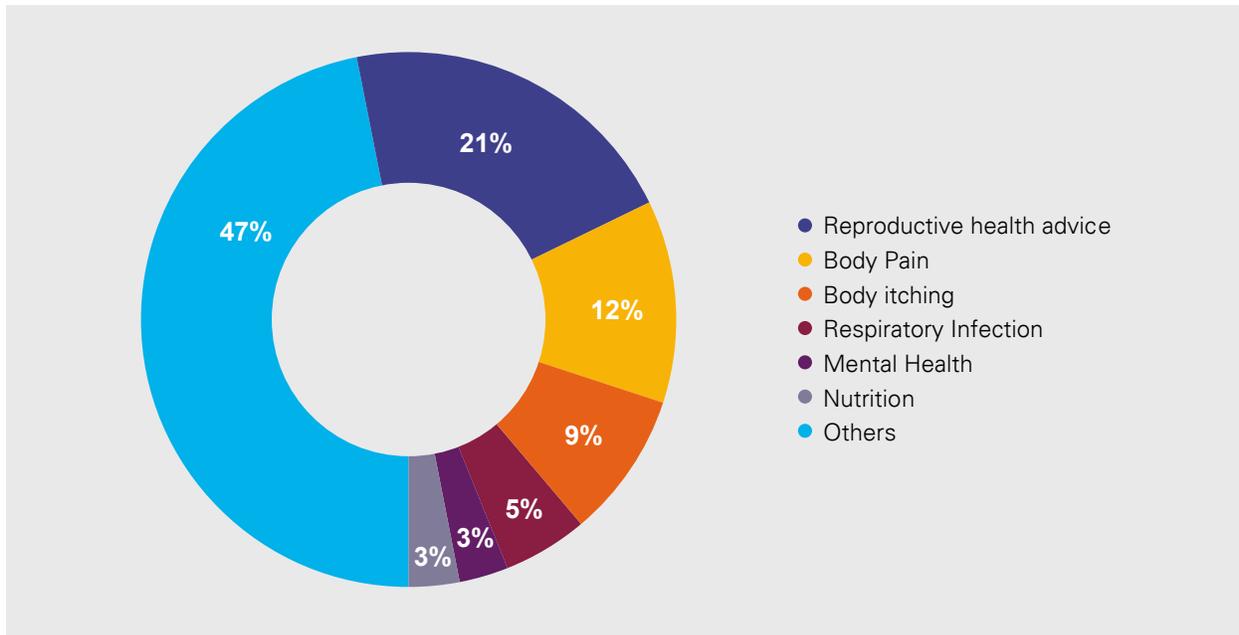
Source: Health facility, direct observation

Based on direct observations, reproductive health concerns (including pregnancy, menstruation and STIs) were the most common cause of consultation where a condition was clearly defined (Figure 8). Data also suggests that adolescents are frequently seeking care for various types of illnesses that are not specific to adolescent health at the adolescent corners indicating a high proportion of “others” in Figure 8. Most services were by a doctor (63%) or SACMO (32%). Although services for addiction referral and psychiatric counselling were reported as available in many facilities there were no referrals reported for any of these facilities. This is despite the qualitative interviews that suggest addiction problems are common in the areas where the surveys were carried out.⁴³ Informal discussions suggest that the reason for lack of use may relate to shyness of adolescents and the presence of a relative or carer. Further exploration of this issue is required.

⁴³ IDI_Ado_Girl1, IDI_Ado_Boy1



Figure 8 Use of adolescent corner and reason for consultation



Source: Health facility, direct observation

The quality and availability of maternal services remains an important factor determining service use. A respondent from a UNICEF equipped SCANU unit mentioned that the unit is run with just one doctor, so reducing their potential impact.⁴⁴ A similar issue was raised about other staff such as technicians and nurses by a service provider in another district.⁴⁵ The facility survey looked at six facilities with SCANU units. All of the units visited had at least one paediatrician and some had two, but staff ratios often seemed low. Notably, one unit that had more than 50 newborns on the day of the visit, and it was reported as having only one paediatrician. General staff vacancy rates in many of these facilities are also high with 53% and 15% vacancies of doctors and nurses respectively at these facilities, supporting the observations of many respondents on the difficulty of running services in many areas.

SCANU units were broadly well equipped and functional. Table 7 outlines the mean number of key equipment at the SCANU in the sampled district hospitals and the proportion that were functional. Based on direct observation of facilities, most of the equipment are available and a high proportion of them are functioning, except the Continuous Positive Airway Pressure (CPAP) machines. All six SCANU also had handwashing stations, water supply and back-up electricity.

⁴⁴ IDI_SP_SCANU_1

⁴⁵ IDI_SP_Maternal Health_1

Table 7 Mean number of equipment at SCANU per facility and proportion of functionality

Equipment	Mean number per facility	Functionality %
Baby Cot	18.5	98%
Incubator	6.0	67%
Warmer	9.67	78%
Phototherapy	6	100%
Room heater/ air conditioner	2	92%
Sucker machine	8.17	88%
Oxygen	4.67	93%
Weighing scale for infants	1.33	88%
CPAP machine	1.17	0%
Ambo Bag	8	94%
Pulse oximetry	2.1	56%
Intubation set	2	67%
N	6	-

Source: Health facility, direct observation

An index of SCANU functionality was constructed based on 12 dimensions: functioning baby cot, incubator, warmer, phototherapy, room heater, sucker machine, oxygen available, weighing scale positive airway, ambo bag and pulse oximetry and intubation tube. None of the SCANU units had all functions available on the day of visit, two had 11 items and the rest eight or nine (Table 8).

Table 8 Use of SCANU, functionality and staff availability

Facility	SCANU patients	Functionality	Paediatricians	staff vacancy rate at the facility
H1	58	9	1	37.82
H2	6	8	1	11.35
H3	23	9	2	23.85
H4	22	8	2	25.00
H5	20	11	1	30.57
H6	19	11	2	10.24

Source: Health facility, direct observation



RQ13: How efficient has the programme been in development and implementation of health and multisector policies, strategies, and costed action plans, (special focus, though not limited only to MNCAH and HSS sectors)?

UNICEF-GoB Health Programme was instrumental in designing and developing some of the crucial HNP sector policies and plans. UNICEF participated in the multi-stakeholder development of the Strategic Investment Plan (SIP) of both 3rd and 4th SWAp.⁴⁶ There was substantial involvement in the development of the Programme Implementation Plan (PIP) as well for both these SWAps. UNICEF was also involved in the development of at least 14 Operational Plans (OP) in the 4th HNPSp relevant to improving stewardship, strengthening health systems, and improving quality and extent of health services. Technical Assistance was provided from the health programme to the development of a costed Essential Service Package (ESP). From the health programme, technical assistance was provided to the World Bank and partners for strengthening disbursement-linked indicators and SDG health indicators (UNICEF, 2015b).

Apart from the SWAps, UNICEF supported MoHFW and other stakeholders in development and implementation of a number of strategies, policies and guidelines including:

Table 9 UNICEF supported policies and UNICEF programmes supporting implementation

Development of policy	Implementation
Comprehensive Social and Behavioural Change Communication (SBCC) Strategy	C4D activities in health programme and through C4D section in UNICEF
National Strategy for Adolescent Health, 2017-2030	AFHS services in facilities and the community.
Bangladesh National Strategy for Maternal Health 2017-2030	CEmONC, MNCAH services
Gender Equity Strategy, 2014	QI, WFHI
Bangladesh Every Newborn Action Plan (BENAP)	Newborn health programme, SCANU
National Guideline on Maternal and Perinatal Death Surveillance and Response (MPDSR)	Yes, part of QI initiative in 13 districts
National Strategic Plan on Quality of Care	Part of QI initiative
National Immunisation Policy, 2014	Support to national EPI programme

⁴⁶ DP3

A number of challenges remain for the rest of the programme. UNICEF has been supporting a number of programme areas that are relatively novel, or considered as pilots including: adolescent health, SCANU and KMC care, DEPB and Quality Improvement initiatives. The evidence on effectiveness and sustainability of all these interventions were raised during various stakeholder meetings.⁴⁷ UNICEF is creating evidence through monitoring and evaluating of these programmes (e.g. KMC, DEPB, Quality Improvement) and it will be important that the experience of implementation and evidence of effectiveness is communicated to sector stakeholders. Where evidence suggests that the interventions are cost-effective and scalable, UNICEF is well positioned to be involved in helping the government to integrate these interventions into their core programmes. Of course, in some cases it may turn out that the interventions are not scalable, but this in itself is important information for the sector and needs to be shared widely.

RQ14: How efficient has the programme been in strengthening sector coordination and governance?

UNICEF has had a significant role in all the mechanisms for strengthening health sector coordination and governance. The Local Consultative Group (LCG) was set up in Bangladesh to institutionalise a cooperation strategy of GoB and Development Partners (DPs). The LCG sub-group on MoHFW, also known as LCG-health was formed during the 2nd SWAp to ensure effective GoB-DP coordination in the HNP sector. UNICEF was always a part of LCG-health and has also been the Co-chair.⁴⁸

In general, UNICEF supported interventions are well embedded in government programmes. This is particularly evident for EPI, maternal health, and HMIS at DGHS, quality improvement and adolescent health. One local manager highlighted the importance of the coordination as part of the QI secretariat in MOHFW (HEU) for quality improvement.⁴⁹ Strong coordination across UN agencies is also acknowledged.⁵⁰

To coordinate the activities and ensure good governance at OP level, Task Groups (TG) were formed, during the 2nd SWAp (Ministry of Health & Family Welfare, 2013). TG modality was designed as a key mechanism for consultation on important thematic areas, and the forum for discussion on sector management and technical issues between stakeholders, and especially government and development partners. TGs were supposed to monitor the implementation of the actual compared to planned OP activities, set priority actions, coordinate within agencies and ministries to support effective implementation of the priority actions, and work as a stewarding entity. From the very beginning UNICEF was a member of all the TGs. Currently, UNICEF is the Co-chair in the biggest TG, i.e. MNCAH.⁵¹ UNICEF is also the co-chair in the M&E task group.

⁴⁷ NAT_KII_7, GOV2, NAT_KII_4

⁴⁸ Nat_FGD_3

⁴⁹ FGD_CC_2

⁵⁰ NAT_KII_6, NAT_KII_7

⁵¹ Nat_FGD_22



The effectiveness of the LCG and TGs themselves is impaired due to the irregularities in meetings. The recently completed Annual Programme Review (APR) 2018, found no LCG meetings being held during January 2017 to June 2018. There were no TG meetings held during this period as well. The TG meetings were held for the first time in 4th SWAp, only at the end of 2018 (MoHFW, 2019). To strengthen sector coordination and ensure good governance, these mechanisms should be regularised.

MoHFW has developed the “National Strategic Planning for Quality of Care on Health Service in Bangladesh” for Universal Health Coverage. The idea was to achieve an effective health system that can provide the highest quality of care through the quality improvement approach. The National Quality Improvement Committee (N-QIC) functions to co-ordinate among national committees, monitor and review activities of organisation and facility level committees. QI Secretariat (QIS) is a formal management body of the N-QIC. UNICEF, though the health programme has supported the N-QIC and QIS from the very beginning. There is joint planning meetings held every month at the QIS, as well as in the facilities, which helps avoid duplication and ensures quality of care in the facilities in which it is being implemented.⁵²

Weaknesses in coordination are perceived by some other development partners (see RQ30). More might be done to foster cooperation across development partners that are undertaking similar work in different areas, for example quality improvement.⁵³ Partly this issue surrounds the communication of evidence, but also may be a response to the deadlines and pressures to hit targets imposed on various agencies, which lead to partners (not only UNICEF) ‘getting on with it’ rather than planning together.

RQ15: How efficient has the programme been in creating an evidence base and building capacity at national and sub-national levels for evidence and equity-based planning and budgeting?

The three evidence functions – research, monitoring & evaluation, and data & analytics – are gaining prominence on UNICEF’s strategic agenda. They comprise an increasingly critical area of technical support sought by governments who are gradually taking over the service delivery role traditionally supported by UNICEF, and need evidence on how and where to make the most effective investments for children. The evidence function is also pivotal to the change theory behind the programme, which is partly based on “the generation and use of rigorous evidence with partners capacitated to advocate for sound policy change as a result” (Government of Bangladesh and UNICEF, 2016). This has been achieved through fostering partnership internally within other departments of UNICEF, and externally with GoB research entities (e.g. Bangladesh Bureau of Statistics (BBS) and National Institute for Population Research and Training (NIPORT)), universities and other development partners and agencies.

UNICEF has made commendable efforts to underpin interventions with evidence including baseline surveys and literature reviews. Evidence commissioned and developed with the assistance of UNICEF

⁵² KII with Superintendent, Moulvibazar; FGD with UNICEF Health Team; KII with Joby George, Save the Children

⁵³ IDI_SP_Child Health3

includes the EPI coverage survey which is an important tool to assess performance, achievements and progress of EPI in Bangladesh. Strategic decisions regarding expanding coverage of EPI and subsequent budgeting and allocations are completed based on the CES findings (DGHS, 2017). Evidence of SCANUs' effectiveness for improving the management of sick newborns, and correspondingly reducing case fatalities, influenced policy makers to scale-up the programme to cover all districts in the 4th HNPS. The Bangladesh Multiple Indicator Cluster Survey (MICS 2012-13) report was launched in 2015 (BBS and UNICEF, 2014). This survey was particularly important for MoHFW in designing the PIP, as well as relevant OPs of 4th HNPS. More recently, UNICEF has supported studies to underpin its current programme including emerging evidence on Kangaroo Mother Care, disability friendly services, and development of district level planning (Jahan et al., 2018, DGHS, 2017, BRAC School of Public Health, 2019, Rahman et al., 2018). A series of baseline reports were also commissioned by UNICEF to inform the development of the adolescent (Haseen et al., 2018a, Haseen et al., 2018b).

Respondents were asked to identify the evidence products they felt were most visible and/or used. A variety of different types of evidence was mentioned including: district plans (DEPB) and strengthening of training institutions;⁵⁴ SCANU;⁵⁵ Adohearts;⁵⁶ WFHI;⁵⁷ disability;⁵⁸ quality of care,⁵⁹ and management of sick newborns.⁶⁰ The evidence produced is in a variety of forms including reports, surveys, and workshop presentations.

While the above list of products is encouraging, respondents have noted that UNICEF could do more to communicate their results.⁶¹ This might include clearer guidelines on how to transfer knowledge, and a focus on the types of materials that are suitable to different audiences. For many, long reports are not the best way to engage with evidence. Knowledge organisations, including university research programmes and NGOs increasingly make use of variety of information products to communicate their messages. The COMDIS-HSD project, for example, which focuses on development and evaluation of primary care led interventions in Asia and Africa, as well as publishing the original research in reports and academic journals, communicates research briefs that provide condensed versions of evidence aimed at the professional community, policy briefs aimed at in-country policy makers and tools that communicate overall approaches to the development of interventions.⁶² Similarly, the Overseas Development Institute (ODI), a development think tank, has a range of outputs, which as well as standard research reports, include a much shorter synthesis papers for various audiences that place an emphasis on direct communication of results in the context of evidence from previous evaluations.⁶³ Placing evidence generated in the context of previous experience in-country or internationally can help readers to understand the novelty of the evidence generated.

⁵⁴ NAT_KII_1

⁵⁵ NAT_KII_5, NAT_KII_6

⁵⁶ NAT_KII_1

⁵⁷ NAT_KII_1

⁵⁸ Nat_KII_21

⁵⁹ NAT_KII_2

⁶⁰ NAT_KII_4

⁶¹ NAT_KII_6

⁶² <https://comdis-hsd.leeds.ac.uk/>

⁶³ <https://www.odi.org/publications>



One further issue that was raised here was the GoB's own ability to generate evidence. Over the last 25 years, the Health Economics Unit of the MoHFW has often been relied upon to generate and/or disseminate evidence. The strength of this function has often depended on the staff in-post, and support from development partners. UNICEF is already working with the HEU on quality improvement and thought might be given to how to collaborate more consistently on the generation and communication of evidence with them. For example: Joint publication of reports and policy briefs; development of an archive of data sets from programme monitoring that can be used to answer policy-research questions; collaboration on ways to integrate a primary care led approach, a major strength of UNICEF, into UHC initiatives (e.g. SSK); joint initiatives to better understand the limitations and the processes of the government departments to implement policies.

RQ16: How efficient has the programme been up to now in identifying successful interventions for scale up and scaling them up through government systems?

The health programme has identified a number interventions for scale-up through government systems, namely: a) improve coverage of essential newborn care; (b) establish SCANUs in 24 new districts for sick newborn care; c) ensure functioning of comprehensive and basic emergency obstetric care in all district hospitals and selected UHCs; and, d) scale-up case management of pneumonia and diarrhoea (UNICEF Bangladesh, 2017).

Through the health programme, UNICEF introduced the “newborn bundle,” containing four essential elements – skills development of health workers on maternal and newborn care, improved facilities for giving birth, special care newborn units with lifesaving equipment and community empowerment for taking the correct action for newborns and mothers. To improve newborn and child survival, MoHFW took the initiatives into the National Newborn Health Programme (NNHP), which was first introduced in the MNCAH OP under 4th HPNSP. The NNHP is focused on achieving equitable and effective coverage of high impact newborn services and practices at scale, through quality implementation of a comprehensive newborn health care package by the public health system (DGHS, 2017). UNICEF, through the health programme, is still supporting the NNHP in 25 districts through capacity development of health workers (doctors and nurses).⁶⁴ It is also supporting the introduction of Kangaroo Mother Care (KMC) for sick and low-birth weight babies in medical colleges, district hospitals and upazila health complexes. Phase wise, implementation of 24/7 EmOC services in District Hospitals and UHCs and Basic EmOC services at UHC and UH&FWCs are within the plan of MoHFW. Currently, all medical college hospitals, 59 district hospitals, three general hospitals, 132 upazila health complexes, and 71 MCWCs provide CEmOC, and 284 UHCs provide Basic EmOC services (MIS, DGHS, 2018).

The issue of ensuring that interventions and practices are scaled-up and sustained is a theme running across many of the interviews undertaken during the assessment. Some of the interventions seem more embedded in government programmes and amenable to scale-up than others.⁶⁵ Programme on

⁶⁴ Nat_KII_23

⁶⁵ NAT_KII_8

EPI, some maternal health interventions and DHIS2 already have wide or national reach. The roll out of SCANU is described as a successful example of scaling up of UNICEF interventions through government system.⁶⁶ Starting with the pilot in 2011 in one district, under the NNHP of 4th HPNSP, SCANU is now being implemented in 25 districts. However, some of the key informants questioned whether the government health workers are properly trained in managing SCANU, particularly after the withdrawal of UNICEF support.⁶⁷ A government health manager mentioned that withdrawal of health workers (for those UNICEF used to pay salary) is causing problems in managing the SCANU, since the Government's own staff have not been fully trained.⁶⁸ For some, SCANU is a controversial intervention with some respondents recording strong support and demanding scale up⁶⁹ while others are more critical (See RQ5). The need here is to deliver evidence on cost-effectiveness and equity in the context of a system that has substantial skills shortages and help plan for scale-up. These findings may be modified by the SCANU evaluation recently undertaken by UNICEF but not available to the assessment team.

DEPB plans have now been developed in 14 out of the 20 districts to the end of the programme. The issue here is that it is relatively easy to develop a plan but the more important issue is whether these plans have finance attached and are actively used to manage services; one the former issue one respondent mentioned that this time plans are properly funded.⁷⁰ An evaluation of DEPB experience suggested that MNCH services increased between baseline and endline, while costs per patient fell (Jahan et al., 2018). The DEPB initiative is hugely important for the future of services, including as a way of ensuring that services are sustainable at the local level. Building on the progress so far, to help localities develop more comprehensive plans, which include an increasing proportion of resources and programmes in their areas, is an important area for further investment.

The adolescent programme is already well embedded within the Government programme and currently being scaled up across the system. The services involved are broad. Although currently services encompass communicable, reproductive, and non-communicable diseases most reported use is for reproductive health care. According to the exit and facility survey there is also much variation in the quality and quantity of services provided across facilities. UNICEF has been active in developing the package of care. We know there is an intention to 'test feasible cost-effective service delivery models' for the adolescent health package but are not aware this actually taken place yet (MOHFW and UNICEF, 2016). There is likely to be substantial international interest in the effectiveness and cost-effectiveness of these services.

The quality improvement programme is well embedded in the Ministry (HEU) and is beginning to be replicated across the sector. We think there is considerable potential to develop effective guidelines and regulations on quality management from this experience, and use it to influence the quality across

⁶⁶ Nat_KII_6; Nat_KII_7

⁶⁷ Nat_KII_7; Nat_KII_4, Nat_KII_4; Nat_KII_23; Nat_KII_5

⁶⁸ KII_manager3

⁶⁹ KII_manager2

⁷⁰ NAT_KII_5



the sector; both public and private. There is a good opportunity as part of UHC particularly given HEU's responsibility both for QI and social health insurance.

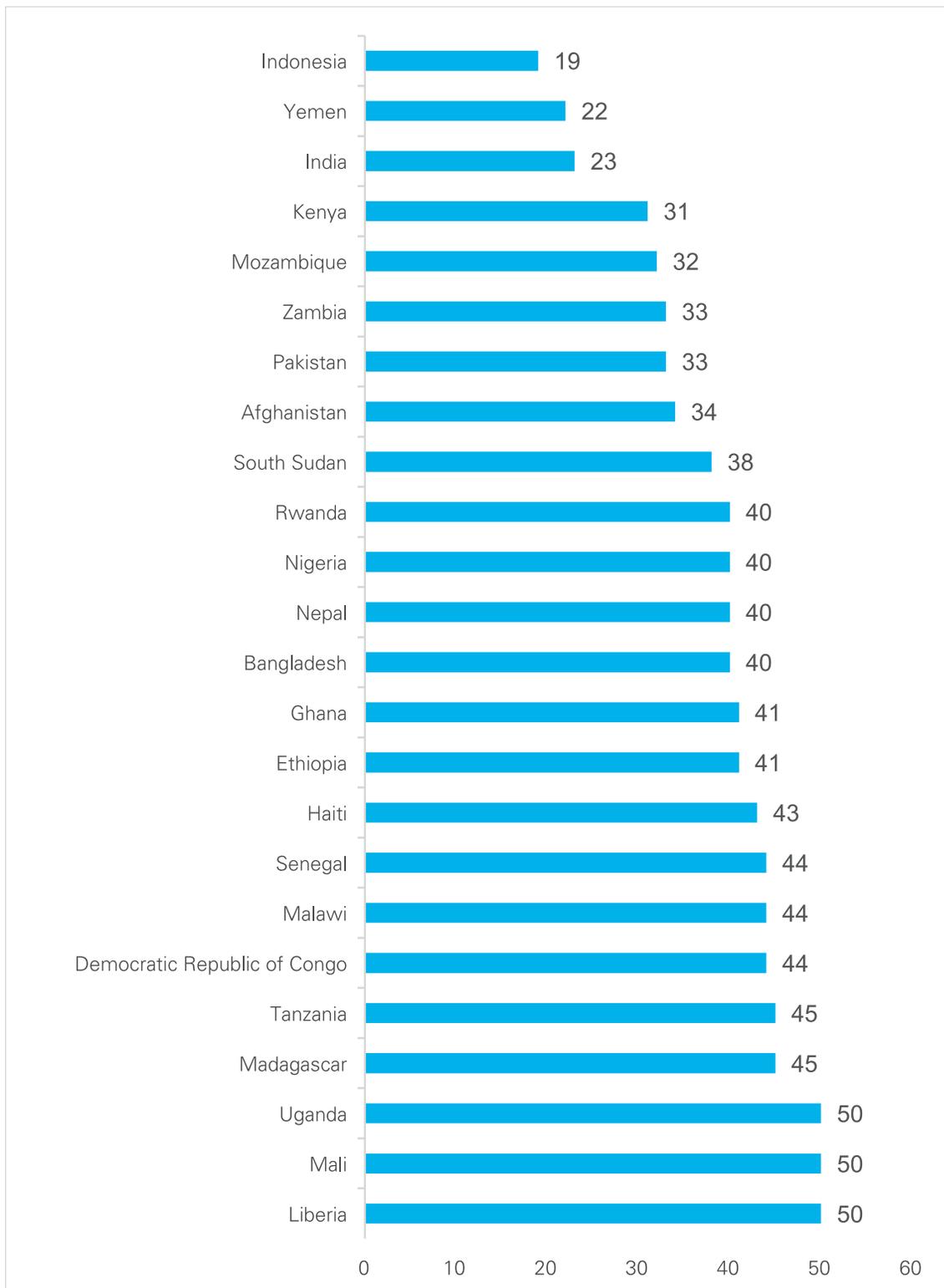
RQ17: How efficient has the programme been up to now in strengthening management information systems and institutionalising quality improvements?

UNICEF supports the MIS-DGHS by providing technical assistance to upgrade the District Health Information System 2 (DHIS2) software and providing training on the latest version. UNICEF also supported introducing an open-source digital registry platform to improve services provided by frontline health workers. The platform runs on health workers' tablets and shifts registration, reporting and tracking of RMNCH from paper to a mobile-based application powered by RapidPro. Linked with the District Health Information Software 2 (DHIS2), the application enables health workers to maintain records more effectively, send out automated reminders to beneficiaries, and track compliance to improve vaccination rates and coverage of antenatal care services and increases M&E capacity and capabilities (UNICEF, 2017). All divisional HMIS teams and district health managers have been trained on the real-time Health Information Dashboard to inform evidence-based decision making.

Support to the information systems envisage a gradual increase in the number of districts using web based DHIS2. A target of 70% of districts by 2020 was set, and by the end of 2018 this target had been exceeded with over 90% of districts using the system for EmOC, IMCI, EPI and SCANU.

Measure Evaluation has recently published a report analysing the health information systems of various countries including profile indicator scores on the quality of HIS performance (Measure Evaluation, 2019). The evaluation used 30 indicators to construct to score. The indicators were grouped into various areas including governance and leadership, Health Information System (HIS) management, data management, data sources, information products and dissemination, data quality, data use and HIS performance. The indicators were scored in a three-point scale by countries using the following characteristics: "available and current", "available and not current", "partially available", "available and undated", "not available" and "unknown". The results of the country profile on preventing child and maternal deaths are shown in Figure 5, which indicates that Bangladesh has a decent health information system with 40 points on a 60-point scale.⁷¹

⁷¹ The score of Pakistan was presented separately by regions (Balochistan: 26, Khyber Pakhtunkhwa: 34, Punjab: 34 and Sindh: 38) and we have averaged them for the entire country by dividing the total by 4.

Figure 9 Indicator scores of country profile of health information system


Source: Measure Evaluation, 2019



The support to HMIS appears to have been responsive to the needs of government including incorporating a requirement by the Minister to monitor real-time doctor attendance in facilities.⁷² To build on the achievements in supporting the information systems, emphasis should perhaps now be on the content and comprehensiveness of data. This observation is supported by UNICEF monitoring reports, which suggest the targets now need revising and should focus on data quality and completeness. Currently DHIS2 is largely focused on public facilities. During 2018, the DHIS reports 363,899 deliveries (normal and c-section), which equates to a public facility delivery rate of just under 12%.⁷³ The most recent DHS suggests that delivery in public facilities is around 14%, although this is a survey and so accompanied by a margin of error (NIPORT et al., Unpublished). This suggests the DHIS2 is recording most of the births at public facilities. Recording of births and other activities in non-government facilities is, however, an obvious gap and one that could increase if urbanisation means that even more services are delivered through non-government outlets.

One service provider in a SCANU hospital suggested that although the information from DHIS2 is useful, the information on patients' needs to be more detailed to identify problems.⁷⁴ Another, commenting on the training provided, mentioned that while it is useful it cannot just be a one-off; as more people will require training as new colleagues are recruited and systems change.⁷⁵ A further point was the need for staffing of data clerks and statisticians to maintain the system.⁷⁶ Similarly, the sustainability of DHIS2 within the Government's system was raised by both government and non-government respondents.⁷⁷ Equipment functionality for DHIS2 appears to be generally good. Facility observation found that all facilities (18) had the capability to record and send DHIS2 data.⁷⁸ On average, facilities had two computers available, and at least one of which was functioning on the date of the visit. Only three quarters of the facilities had working backup power supplies, affecting the functionality of the system.

The quality improvement programme aims to implement quality improvement in 50 facilities across nine districts. By 2018, interventions had been implemented in 60 facilities while 22 facilities received training on PDCA (Plan-Do-Check-Act) and 18 have initiated a programme of total quality management. The quality improvement initiative, particularly the model developed in Kurigram, is widely talked about, and is considered well embedded in the Ministry.⁷⁹ As suggested in RQ11, RQ16 and RQ8, the initiative has a potentially important function to play in the roll out of UHC. The main concern is that the initiatives in individual districts supported by UNICEF and other development partners (e.g. SCF), have not been particularly well communicated and the experiences synthesised. We have not seen an evaluation report, although there are monitoring reports indicating progress with targets (UNICEF and GOB, 2017). The experience so far should provide a huge amount of evidence to inform policy and scale-up of services.

⁷² NAT_KII_10

⁷³ See http://103.247.238.81/webportal/pages/dashboard_maternal_delivery.php. Based on the current crude birth estimate of 18.3/1000.

⁷⁴ IDI_SP_EPI_1

⁷⁵ IDI_SP_DHIS2_2

⁷⁶ IDI_SP_DHIS2_2

⁷⁷ GOV1, NAT_KII_6

⁷⁸ Health Facility Survey, 2019

⁷⁹ NAT_KII_14

Given the satisfactory progress in implementing activities, the production of this evidence could become a priority for the next two years of the programme.

RQ18: How efficient has the programme been up now to in delivering quality MNCAH services that are inclusive, equitable, sustainable, cost-effective, gender responsive and climate-resilient?

Central to the vision of the UNICEF country strategy in Bangladesh is that infants, young children and their mothers and families will use high-quality social services in a safe environment, and will be empowered to practise positive behaviours (UNICEF, 2016a).

MNCAH services represent a large proportion of the UNICEF programme activity, both in physical and financing terms; spending in 2017-18 represented 46% of total funds committed to UNICEF programmes (Figure 2). The indicators to the end of 2018 (Table 5) indicate most are on track: 16 out of 20 24/7 CEmONC facilities are operational, 36 out of 40 SCANU units and 11 out of 20 districts delivering essential new-born interventions. SCANU services in particular can be seen to be highly appreciated by communities.⁸⁰ UNICEF, along with partners, are supporting MoHFW to increase the number of newborns registered as soon as possible following birth. UNICEF is supporting MoHFW in maternal and perinatal death surveillance and response. Twenty-two districts are currently implementing the new maternal and perinatal death surveillance and response (MPDSR) system with UNICEF supporting 13 districts until 2017 and 22 districts from 2018, UNFPA five and Save the Children four (Secretariat, 2016).

Since 2014, UNICEF Bangladesh's efforts to address these inequalities have focused on strengthening engagement with the private sector; generating evidence to scale up successful models and cover service delivery gaps; and build systems to address gender issues and poverty. Although an example from another programme (Nutrition) the Mothers@Work programme to improve breastfeeding among working mothers provides a good example of such collaboration. Equity analysis conducted for maternal, newborn and child health (MNCH) programming, including immunisation using the Equitable Impact Sensitive Tool (EQUIST), suggests that children from less educated mothers, and living in remote areas, benefit less from immunisation services than children of well-educated and urban families. These findings influenced the focus of GAVI's Third Health System Strengthening support on deprived communities and areas in Sylhet, Chittagong and the City Corporations (UNICEF, 2017).

Inclusive: The programme clearly embodies a desire to make services inclusive. One aspect is ensuring services are inclusive of people with disabilities, which is being pursued. Another example is WFHI focusing on facilities that are more responsive to the needs of women. through upgrading of services (1.1.11) as recommended by a commissioned report (Rahman et al., 2018). Although some budget is recorded as spent the indicator (Number and proportion of health facilities with provision of disability friendly health services in selected districts) is currently recorded as zero. We are informed that activities will be rolled out in 2019.

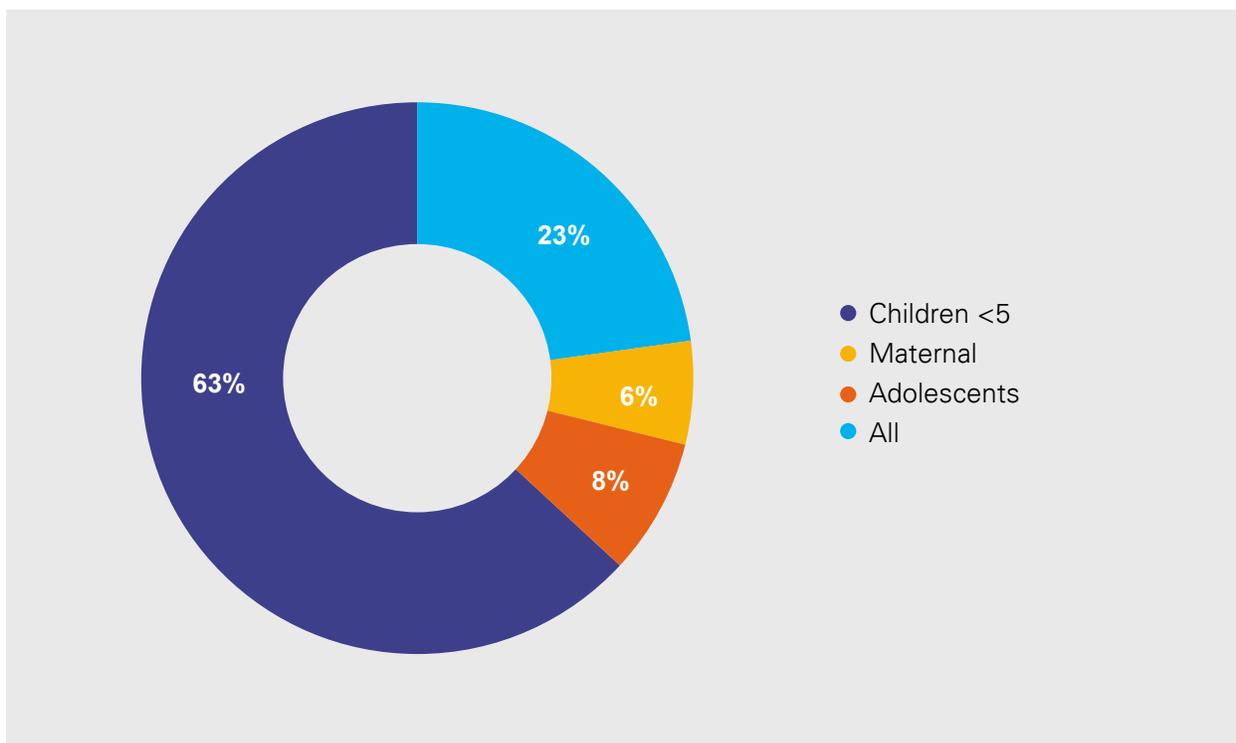
⁸⁰ IDI_SCANU Mother3, IDI_SCANU Mother4, FGD_CC_1



UNICEF is working with the MoHFW to promote the shift of health systems based on vertical, disease-specific interventions towards UHC, namely, a more comprehensive health-systems approach that incorporates a holistic consideration of children’s right to health at all stages of the life cycle.⁸¹ Key interventions in health programmes, such as emergency obstetric care, special newborn-care units, and services for the prevention of mother-to-child transmission of HIV, and for early infant diagnosis and treatment of HIV, have been scaled up through MoHFW interventions in low performing districts.

Equitable: Spending by UNICEF primarily benefits children, mothers, and adolescents. Assuming that EPI is considered to benefit children, while MNH activities benefit infants/children and women around childbirth equally, around 63% of spending during 2017-2018 was on children/infants, 23% women around the time of childbirth and 6% on adolescents. These apportionments are approximations only, and tell us nothing about whether the funding reaches the final intended beneficiary with impact on outcomes.

Figure 10 Crude benefits-incidence of programme spending, 2017-2018



Source: spending reports for 2017 & 2018

⁸¹ IDI_SCANU Mother3, IDI_SCANU Mother4, FGD_CC_1

Cost-effectiveness: There is a strong international evidence base, including a number of studies undertaken in Bangladesh, supporting the cost-effectiveness of many of the maternal and child health interventions including KMC and thermal care, EPI, PNC care including treatment of infection, prevention of HIV transmission (Cattaneo et al., 1998, Mangham-Jefferies et al., 2014, Black et al., 2015). The cost-effectiveness of special care newborn units (SCANU) is more complicated. These are costly to sustain (particularly equipment maintenance and ensuring human resources) but if used selectively as part of a broader package of care can be highly effective (Neogi et al., 2011, Darmstadt et al., 2005).

Sustainable: Sustainability of interventions depends substantially on how far government integrate the interventions into their own programmes and ensure resources are available to provide services. There is good evidence that the first has happened, or is happening for most of the programmes running. UNICEF has emphasised strategic advocacy for policy implementation, including strategies and guidelines to facilitate the operationalisation of the comprehensive Early Childhood Care and Development Programme.⁸² MoHFW have assisted the programme to develop integrated, costed action plans and to advocate for increased resource allocations to reach the most deprived children and areas. Ensuring resources, is more difficult to guarantee, although the Government is now funding a larger proportion of the sector, overall. UNICEF are also tapering support for equipment maintenance, providing funding initially but then helping to plan to transition government support. Staffing, particularly of services that require high level technical skills, remains a potential weakness that requires monitoring.

Gender responsive: UNICEF programmes are guided by the 'Gender equity strategy 2014' and 'Gender Action Plan 2018-2021' which together provide a roadmap for promoting gender equity⁸³. The programme is addressing gender in a number of ways. This includes development of gender sensitive and women friendly MNH hospitals (1.1.7) and gender sensitive adolescent services (3.1.1). UNICEF supported the MoHFW to model and scale-up the Women Friendly Hospital Initiative (WFHI) to provide quality maternal and newborn care for women, along with legal support for those affected by gender-based violence. The approach aims to enhance availability of quality services for women in a congenial environment that ensures dignity, respect, and privacy, and builds women's confidence to avail themselves of quality health services in the formal health system. Through the Initiative, violence against women has been recognised, diagnosed, treated, and linked with legal-aid agencies. Since 2007, WFHI has been scaled-up to 26 hospitals, out of which 19 hospitals have been accredited. 4th HPNSP has operationalized the model for scaling-up through revenue funding (MOHFW, 2017).

WFHI has no monitoring indicator attached. Although RWP spending 76% against budget is recorded, there are few mentions of the work in the reports of the four divisions that are implementing the interventions. Both Khulna and Mymensingh mention slow progress and a lack of a full assessment. Gender responsive adolescent services are well integrated into GoB operational plans and reported during the APR. Monitoring reports good progress in implementing services across six divisions.⁸⁴

⁸² Nat_FGD_3

⁸³ <https://www.unicef.org/gender-equality/gender-action-plan-2018-2021>

⁸⁴ The monitoring indicator appears to be written as a proportion of facilities (20 is the cumulative target) while the 2018 outcome is in numbers of centres (140). This requires clarification.



Climate resilient: One of the programme activities (1.1.12) focuses on mainstreaming climate change in health programmes, including training for health professionals.⁸⁵ Efforts to address the impact of climate change on children were mainstreamed in UNICEF Bangladesh programmes and operations. In 2017, a policy review and institutional mapping of all stakeholders implementing climate change-related interventions in the country was supported as the first step toward identifying the gap in policies and capacity to deliver climate resilient social services. UNICEF supported the development of the Bangladesh Action Plan to operationalise the South Asian Association for Regional Cooperation (SAARC) policy framework on Child-Centred Disaster Risk Reduction and Adaptation. The plan aims to ensure effective engagement and leadership by state and non-state actors toward reducing children's disaster and climate change-related risks and vulnerabilities. It also aims to ensure children's participation and their voice in Disaster Risk Reduction and Climate Change Adaptation related plans and programmes. As part of UNICEF's strategy to create a critical mass of knowledgeable youth in Bangladesh, who can promote climate change-related issues, and act as change agents to promote appropriate mitigation and adaptation, UNICEF supported the first Youth Conference on Climate Change in Bangladesh⁸⁶ in 2017. As yet, no indicator of achievement for this aspect of the programme has been identified so that divisional reports give little attention to progress with this activity; none of the 2018 end of year reports mentioned climate. Spending amounts to 18% of the RWP budget allocated for the two-year period.

RQ19: How efficient has the programme been up to now in adopting a health system strengthening approach for achieving effective coverage of MNCAH services?

UNICEF's mandate is to advocate for and protect children's rights, to help meet children's basic needs, and to expand on opportunities to help them reach their full potential; with a particular focus on the most disadvantaged. UNICEF has a long history of initiatives with a specific focus on child survival and development but acknowledges that a health systems strengthening (HSS) focus is also imperative in the post-2015 context. With this background, and in support of the SDGs, UNICEF has developed a new, agency-wide Strategy for Health, 2016-2030. The strategy envisions a world where no child dies from a preventable cause, and all children reach their full potential in health and well-being. To achieve this, all programmes supported by UNICEF aim to address inequities in health outcomes; promote integrated, multi-sectoral policies and action; and, strengthen health systems, with a particular focus on emergency preparedness, response and resilience.

UNICEF's international health system strengthening approach is grounded in the knowledge that many of the bottlenecks to achieving better reproductive, maternal, newborn, child and adolescent and nutrition service coverage are shared across services and linked to health system building blocks (UNICEF, 2016c). Addressing these bottlenecks requires cross-system action, particularly focused on improved information systems, supply chain management, social protection and welfare mechanisms, private sector engagement and regulation and quality of care at community and facility level working at the

⁸⁵ NAT_KII_16

⁸⁶ https://www.preventionweb.net/files/51692_youthdeclaration.pdf

national, local and community level. Local respondents did not explicitly refer to HSS support. However, they did recognise the system nature of maternal health, and that good services require that core functions, including blood, transport, and training, are in place and of high quality.⁸⁷ Lack of blood banking in particular was highlighted as a systems failure, although this is outside the scope of current UNICEF's mandate and is supported by another development partner.

HSS is a dedicated unit in UNICEF Bangladesh, something absent in other country offices.⁸⁸ During 2014, UNICEF enhanced its support to HSS capacity building to include local level planning, budgeting, implementation and monitoring towards the achievements of effective coverage (Goss Gilroy Inc., 2016). UNICEF established an Equity Profile of the low performing districts, which served as the baseline for the effectiveness of coverage of MNCH services. The Equity Profile was used to advocate for equitable health and other services, and in the strengthening of health systems in the 20 districts through DEPB.

The emphasis on health systems is a powerful feature of the changing UNICEF programme. The main HSS interventions identified by the programme are the support to HMIS/DHIS2, DEPB and the leadership development programme. The support to the health system goes much wider than this since various maternal health interventions, quality improvement, improving the cold chain for EPI and developing demand in the community have potential to have broad impact that goes beyond the specific intervention focus. In this context, we wonder whether more could be made of the opportunities for system linkages by more connections across the programme.

RQ20: How efficient has the programme been in mobilising and engaging families, communities, local government bodies and key influencers through C4D strategies to address socio-cultural barriers and bottlenecks, increase demand for utilisation of health services and promote practice of desired behaviours?

Following the global HSS report, community demand for effective interventions is emphasised in the country programme (RWP activity 1.6.1). This builds on considerable evidence that the demand-side is at least as important in ensuring access to quality services as strong supply (Ensor and Cooper, 2004). The UNICEF Communication for Development (C4D) approach is a cross-cutting programming strategy based on human-rights and amplifies the voices of communities and marginalised groups to demand their rights, connecting them to upstream policy and legislation. The goal is to increase knowledge on key lifesaving behaviours, and create awareness amongst communities about basic social services; change individual, harmful traditional beliefs and perceptions; influence attitudes and behaviours and consequently social norms and social practices. Approaches used are: (1) advocacy; (2) social mobilisation; (3) communication for social change (CfSC); and, (4) behaviour change communication (BCC). C4D is deeply seated in UNICEF's overall institutional framework and not just restricted to country office programming. UNICEF's strategic plans are strongly dependent on behavioural and social

⁸⁷ IDI_SP_Maternal Health_1

⁸⁸ Nat_FGD_3



change targets (UNICEF, 2016a). C4D in Bangladesh has a strong association with health, and over the years there has been support to different interventions, including demand creation of mass vaccination campaigns, family practices for maternal and newborn health, health education and promotion, and SBCC for immunisation and polio eradication.⁸⁹ MoHFW and partners of the Behaviour Change Communication (BCC) Working Group, developed a Social and Behaviour Change Communication (SBCC) Strategy on Health, Nutrition and Population – to which UNICEF was one of the partners.

C4D programme utilise a mix of communication channels and techniques to convey and discuss essential information. These include household visits four times a year, community dialogue sessions, courtyard meetings, school sessions and interactive meetings through adolescent radio listeners' groups, interactive popular theatre, folk songs, and film shows. Significant positive changes were reported as a result of C4D interventions, particularly in knowledge and practice levels among mothers, fathers and adolescents in relation to maternal and child health care seeking behaviour, iron folic acid tablet consumption, handwashing with soap, birth registration in 45 days, and ending child marriage, child labour and corporal punishment (Manitou Inc, 2017). Amongst mothers of children under six months old, 78 per cent reported washing hands with soap at critical times as compared to 45% reported in the baseline. Similarly, there was an approximately a 30 percentage point improvement in handwashing practices reported amongst mothers of children under five, adult males and adolescents. Increased awareness and demand for SCANU was therefore visible.

The main intervention in the health RWP is a communication plan to educate the community on the need for MNH services. There is also support to community-based organisations to develop community MNCAH services. Spending on this area, as a proportion of the health programme budget, has so far been low (7% of the two-year budget). However, we are told that spending is under-recorded as some is reported under a different activity (1.1.2: Strengthening health systems for improving effective MNCAH services with equity). Community engagement appears to have been well received and considered important (RQ 4,9). Engagement operates through direct communication with households (courtyard sessions) and community wide meetings at the community clinic.⁹⁰ Information to pregnant women about choices is seen as a core function of government and partners like UNICEF⁹¹.

The main indicator of achievement relates to the proportion of caregivers that know about newborn danger signs. Achievement is high with 80% awareness against a 2020 target of such 25%. The data for this report was drawn from a baseline study carried out in the middle of 2018, suggesting that awareness was high, even at the outset of the programme (UNICEF, 2018a). This begs the question of whether the target for the indicator is adequate given that the target was probably exceeded before the programme began. The indicator may also not be appropriate, since awareness of danger signs may not be a sufficient motivation to induce behaviour change, which presumably is the ultimate goal of the intervention. There is copious evidence that for awareness to be converted to effective demand, other barriers, including transport and service awareness, need to be addressed.

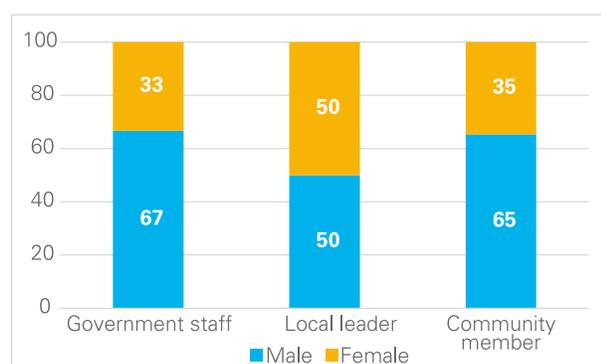
⁸⁹ Nat_KII_9

⁹⁰ FGD_CC_1

⁹¹ IDI_SCANU Mother4

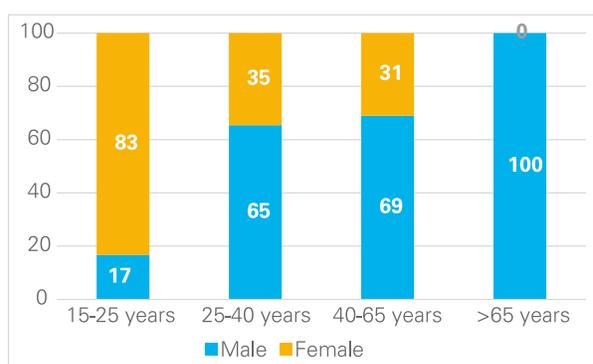
In our surveys, we have observed six community group and community support group meetings that had in total 65 members including government staffs, local leaders, and community members. Figure 11 shows the distribution of the members by their affiliation and gender and Source: Community group meeting, direct observation Figure 12 shows the distribution of the members by age groups and gender.

Figure 11 Proportion of community group members, by affiliation and gender



Source: Community group meeting, direct observation

Figure 12 Distribution of community group members by age group and gender



Source: Community group meeting, direct observation

Both Figure 11 and Source: Community group meeting, direct observation

Figure 12 indicate there is significant involvement of women in these groups. However, having a higher proportion of men amongst the Government staff and the elder people suggests that women might have less of a voice in these groups. This assumption was further backed up by the observation of our enumerators, which suggested that in five out of six (83%) of the meetings the discussion was mostly dominated by men. There was also lack of participation by adolescents: three (50%) community groups did not have any adolescent members and the remaining three (50%) had adolescent members that who were not actively participating in the discussion.

Table 10 provides details of the agenda, moderation, topics discussed and other elements of these community meetings.

Table 10 Details of the community group meeting

Meeting details	%	N
Agenda		
Agenda prepared and circulated	33.3	2
Agenda discussed and agreed at the beginning	66.7	4
Moderation		



Government officials	100.0	6
Local leader	0.0	0
Community member	0.0	0
Confidence of the moderator*		
Confident	83.3	5
Not confident	16.7	1
Topics discussed		
Facility management and governance	33.3	2
Problems with the facilities	100.0	6
Financial issue	50.0	3
Others	50.0	3
Notes taken during meeting	66.7	4
Action points, Identified and noted	50.0	3
No disagreements	100.0	6
Next meeting		
Date agreed	83.3	5
Not discussed	16.7	1
Total	100.0	6

* As perceived by the observer

Source: Community group, direct observation

The evidence suggests that although community groups are functioning, more support might be needed to ensure their effectiveness, particularly in ensuring the voice of members that are most likely to benefit from UNICEF supported services.

RQ21: How efficient has the programme been up to now in supporting the Government to reach the global goals set by the World Health Assembly and SEARO?

The World Health Assembly considers a large number of resolutions each year. Of particular relevance, from the 2018 session, were strategies on early childhood development (including adolescence) and access to vaccines; both of which are a core part of the current work-programme (WHA, 2018a, WHA, 2018b). The former reference's UNICEF's global strategy to focus on interventions up to 18 years, and links well to Adohealth programme as well as other government MNH programmes.

SEARO currently has four main goals: Addressing the persistent and emerging epidemiological and demographic challenges; advancing universal health coverage and robust health systems; strengthening

emergency risk management for sustainable development; and articulating a strong regional voice in the global health agenda (WHO, 2016). The health programme is directly contributing to the first two of these goals and, through the support to the Rohingya and emerging work on climate change, to the third.

RQ22: What unintended outcomes, positive as well as negative, have resulted from the programme?

The main unintended consequences mentioned by respondents was the potential negative effect of managing the Rohingya humanitarian crisis on the regular programme.⁹² Respondents who spoke about this, mentioned only that it may have had an impact on the speed of roll-out, and felt compelled to say that the office is very well organised to cope with such eventualities.

A positive impact of the programme was suggested through the knock-on effect of developing services for maternal and child groups for the rest of the health system.⁹³ This is really a system effect arising from the general improvement in the ability to deliver services. Similar impacts on groups that are not targeted by UNICEF might be expected from the system level interventions.

The issue of sustainability [RQ 33] is relevant here. In particular, equipping districts with the ability to provide sophisticated services that either cannot be maintained or that cannot be staffed properly runs the risk of raising expectations about what the public system can do that cannot be fully delivered in the medium term. The programme team are taking action to address these sustainability issues including, for example, providing initial assistance for the maintenance of equipment and then working with the MoHFW equipment maintenance unit for them to take over.

RQ23: Is the new country programme a structure of a life cycle approach where different sections work jointly within outcomes (life phases) conducive to achieving the results of the health programme?

The country programme uses a life cycle approach to understand problems across sectors (Government of Bangladesh and UNICEF, 2016). This aims to cover the main periods of life that are focal to UNICEF's mandate: infants, children, adolescents and women of child bearing age. Crucially, the approach seeks to join up UNICEF's input at each stage across sectors.

The nature of interventions to improve the welfare of different groups make the life cycle approaches a potentially effective approach. Health issues relating to children and adolescents in particular cross-cut education, nutrition and WASH sectors. Maternal education is key to the uptake of effective health services by a household. A focus on age-groups across the life cycle can help break down barriers between sectors and potentially lead to more efficient delivery of services with opportunity to reduce duplication and combine expertise.

⁹² NAT_KII_5, NAT_KII_2, NAT_KII_9

⁹³ KII_manager2



Members from other teams within UNICEF have a good understanding of the importance of linking efforts across sectors to support different groups. We generally found good articulation of the importance and benefits of this cross-working. Strong links have been forged between teams. The interventions of the health programme are particularly linked with the C4D programme where activities are jointly planned and financed. In general, it appears that MoHFW understands that this approach requires cross-sector collaboration. This may be less true in other government departments. Respondents from non-health teams were critical of the extent to which their government counterparts really understand the importance of cross-sector working.⁹⁴

We do not see any substantial negative aspects of this approach. We do feel there is potential to extend this approach even further to encourage a stronger linked policy and interventions across sectors. One example that arose during discussions with respondents, is to link school and health services more closely at a village/community level. This includes incorporating health-related content into the school curriculum for example on reproductive rights and mental health. Some of this in fact is already underway with the development training modules for teachers on adolescent health.⁹⁵

Impact

Summary: Trends in key outcome indicators across the time period of the programme are broadly positive suggesting evidence of early impact as assessed by available outcome indicators. These early indications cannot necessarily be attributed to programme support given other changes across districts. Efforts to continue to improve the accuracy and completeness of data collection at the district level should be made to impact the assessment more accurately at programme end.

After two years of implementation it remains too early to assess the impact of the programme on health outcomes and health seeking behaviour. Rather, the evaluation attempted to assess whether the way in which funding has been allocated and activities undertaken is likely to impact on crucial health outcomes beyond the current four-year programme.

RQ24: How successful has the programme been to date in reducing neonatal mortality, improving coverage of EPI in low-performing districts, ensuring adolescent friendly health services, and improving the quality of MNCAH services? Are there signs of early/short term impacts?

We sought to examine how health outcomes and outputs are changing in UNICEF and non-UNICEF districts across the course of the programme. This exercise helps to reveal general trends and aids in our understanding of the strengths and weaknesses of available data sources.

⁹⁴ Nat_KII_13

⁹⁵ DP13

Provisional results from the 2017-18 DHS have just been released, and suggest that outcomes have improved across three of the outcome 1 indicators between 2014 and 17/18 across all divisions (Table 11). Post-natal care within 48 hours also improved across the country, from 36% to 52%; division details have not yet been released in the latest DHS. These trends are encouraging but are of course a product of a variety of changes across the country and will not only be attributable to development partner or MOHFW action.

Table 11 Outcome indicators derived from the DHS

Region	Indicator 1: ANC from a medical trained provider			Indicator 2: Delivery with SBA			Indicator 4: Proportion of births delivered in a health facility		
	2014	2017-18	Change	2014	2017-18	Change	2014	2017-18	Change
National	63.9%	81.9%	18.0%	42.1%	52.7%	10.6%	37.4%	49.6%	12.2%
Dhaka	64.3%	87.0%	22.7%	43.9%	60.5%	16.6%	40.5%	57.4%	16.9%
Rajshahi	75.5%	84.5%	9.0%	41.6%	54.7%	13.1%	39.2%	52.8%	13.6%
Barishal	58.0%	76.5%	18.5%	36.7%	47.1%	10.4%	29.9%	39.2%	9.3%
Chittagong	66.3%	83.2%	16.9%	43.9%	50.2%	6.3%	35.2%	46.1%	10.9%
Khulna	73.9%	90.7%	16.8%	58.2%	63.6%	5.4%	54.6%	61.0%	6.4%
Mymensingh		72.2%			41.8%			39.0%	
Sylhet	53.1%	71.4%	18.3%	27.1%	39.3%	12.2%	22.6%	38.4%	15.8%
Rangpur	62.4%	74.6%	12.2%	37.9%	49.1%	11.2%	34.3%	47.5%	13.2%

Source: DHS 2014 & DHS 2017/18

To refine the analysis, we obtained district level HMIS/DHIS2 data on outcomes relating to key components of the programmes: delivery with a skilled birth attendant (maternal health), neonatal deaths (newborn care) and full vaccination (EPI). Data at HMIS were available for 2017 and 2018 only.

Table 12 Changes in health outcomes 2017-2018

UNICEF activity	Number of districts	Outcome 1: ANC4			Outcome 2: Delivery with SBA		
		2017	2018	Change	2017	2018	Change
CEMONC/KMC	9	27.1%	41.5%	14.4%	50.7%	63.7%	13.0%
Priority	24	23.8%	35.1%	11.3%	44.5%	58.8%	14.3%
Any UNICEF maternal programme	34	30.9%	39.7%	8.8%	49.1%	60.0%	10.9%
No programmes	36	30.3%	37.0%	6.7%	50.8%	56.7%	5.9%
Total	70	27.9%	36.3%	8.4%	48.6%	58.0%	9.5%



		Outcome 3: PNC 48 hours			Outcome 5: Full vaccination		
		2017	2018	Change	2017	2018	Change
CEMONC/KMC	9	32.6%	46.6%	14.0%			
Priority	24	27.3%	36.6%	9.3%			
Any UNICEF maternal programme	34	30.3%	40.5%	10.2%			
No programmes	36	28.5%	37.2%	8.7%			
Total	70	27.8%	37.5%	9.7%	98.1%	97.6%	-0.5%

Source: DHIS2

Four of the RWP outcome indicators are reported in HMIS: ANC4, birth with a skilled health worker, PNC within 48 hours and full vaccination rates. The third indicator, proportion of births in a health facility is only available for public facilities which accounts for around 12% of deliveries (see RQ 17). In Table 11, averages are computed for districts where UNICEF is supporting any MNH-related programme (KMC, MPDSR, CEOMC, SCANU, WFHI), districts where support includes CEOMNC and KMC services and where UNICEF is not providing direct support. The emerging picture is that output indicators are improving in all districts, but that the improvement appears to be higher in districts where UNICEF concentrates its support. Vaccination rates were already high in all districts in 2017, and small fluctuation in 2018 is probably not programmatically significant. Of more interest are the number of dropouts and the resulting full vaccination rates. These are not available for both years in HMIS.

This is a necessarily crude analysis and a number of caveats are required. First, we cannot attribute the changes to the effect of the programme; these are associations and other factors may contribute to this. Specifically, we would need to control for the effect of other programmes and therefore need intelligence on what other specific support is provided by government and other partners. Secondly, no data was available from HMIS on the outcomes by district prior to the start of the programme. We are also aware that, while the HMIS data is mostly complete for public sector health facilities, it does not always include the data from the community and from the private health facilities. Thirdly, although the average across the districts supported by UNICEF indicates a positive trend, there are some districts where the trend is negative. Some of the changes are large and are likely to reflect improvements in recording as much as positive trends in health seeking behaviour.

Table 13 AFHS services as reported in the HMIS

	Reporting districts	Received services	Counselling for RTI/STI	Using sanitary napkins
2017	2	9,091	5,776	4,765
2018	6	37,671	19,355	10,914

Source: DHIS2

Indicators on the adolescent programme are available in the DHIS2 system for total services received (number of contacts), counselling for RTIs/HIV and counselling for use of sanitary napkins. In 2017, only services are reported for two districts but in 2018 all six AFHS districts reported and services provided had increased substantially (Table 13).

The relatively new adolescent programme has been well integrated into government strategy and local facilities and communities. The more complex question is whether these services, once in place, have an impact on adolescent health. It remains too early to tell, but a couple of issues would increase the likely impact and the ability to assess this impact. Firstly, greater attention might be given to what services are offered and to whom and what constitutes the package. Adolescent services are complex to deliver, covering, in principle, all the physical and mental health needs of young adults. The complex needs relating to drugs misuse was also mentioned.⁹⁶ One respondent suggested that more attention must be paid the quality of adolescent services.⁹⁷ The need to make services age-specific was also mentioned.⁹⁸ A further group suggested that communication with the community should be clearer; for example, to rule out marriage before a certain age rather than to warn vaguely about the perils of child marriage.⁹⁹ Some variation across communities is likely to be necessary, and indeed, could have a research benefit if the impact of different services on adolescent health are to be examined.

RQ25: To what extent are these (early) gains directly attributable to the programme's interventions?

We believe that it is too early to attempt to attribute the impact in different areas of the country to the programme. Our main concern, at this stage, is ensuring that data will be available to allow this attribution at, or just after, the end of the programme. Rigorous impact evaluations generally require either a cluster randomised control (cRCT) design from the start, or the ability to undertake well controlled quasi-experimental analysis. A cRCT design was not established from the start. Indeed, such a design almost certainly would not have been possible, or even desirable, given that other factors are involved in deciding whether to roll out interventions; such as where government and other DPs are working, and previous experience of these areas.

The data required for a quasi-experimental design are still substantial. Some thought should be given to whether this data will be available at the end of the programme for different programme components. Given the diversity of the UNICEF programme, it is not possible to investigate the impact of all elements. Instead, it is best to focus on four or five key components and indicators, preferably those that are already included as programme outcomes.

⁹⁶ IDI_Ado_Boy1

⁹⁷ KII_manager2

⁹⁸ IDI_Ado_Girl2, IDI_Ado_Boy1

⁹⁹ IDI_Ado_Girl1



For example (programme area, key indicator):

- EPI, valid vaccination rates.
- Neonatal outcomes – neonatal care is a major component of UNICEF support but there is no specific outcome. It might be useful to measure neonatal admissions and neonatal death rate although their interpretation can be complex.
- Maternal health – delivery with trained birth attendant (chosen because maternal mortality is too rare an outcome to assess a significant difference).
- Adolescent health - a suitable outcome indicator is required.

Our exploration of the DHIS2 data suggests that much of this data is available through the DHIS2, although the lack of baseline data (2016 and before) needs rectifying; perhaps from data from other sources. Ideally, we would recommend an interrupted time series; a panel design that tracks each outcome indicator over time in all districts, adjusting for secular trends and differential start of the intervention (quarterly or monthly data might be useful). Alternatively, a difference-in-difference approach could be adopted, which incorporates all change in outcome into a before-after change. In both cases, the changes are adjusted for what goes on in other (non-UNICEF) areas. Indicators on impact are in principle available through the DHIS2, although it will be important to ensure that quality numbers for the period before, during and after execution are available. The intervention is conventionally represented by a binary variable, but it might also be interesting to look at the intensity of the intervention by including the level of financial input to a programme/area. For this to be possible, improved tracking of resources by programme and programme area (down to district) will be required, which goes well beyond what is currently undertaken. The UNICEF office is currently working to improve the specificity of funding recording.

As discussed in RQ24, both output and outcome indicators often have ambiguous interpretations, even when measured accurately with account taken of important confounding factors. It is therefore desirable that alongside the analysis of quantitative data, a process and quality evaluation is undertaken to investigate the reasons for the programme success (or failure), and help understand ambiguous indicators (e.g. does a change in the c-section rate imply improvement in life saving care, or a change in elective surgical delivery).

There remain several complexities with a rigorous evaluation approach. One is adjusting for the impact of other similar programmes in other areas. Work will be required to establish whether some areas can be used as without-intervention controls or whether other adjustment will be required for these programmes. A second issue is that in some cases, outcomes may deteriorate as a result of a successful programme as more complex cases are admitted. This may be the case with neonatal deaths; hence the suggestion to also include general neonatal admissions as an output measure.

Efficiency

Summary: Although we cannot yet establish the programme value for money or cost-effectiveness, evidence that resources are being well utilised can be assessed by examining how funds have been disbursed by programme. The budget is mostly being spent evenly across the programme, with concomitant achievements in outputs as assessed by the measured indicators. The focus on vulnerable areas and groups has potential for substantial gain for resources expended. However, issues of human resource availability and other access barriers could undermine overall achievement.

RQ26: How efficiently has UNICEF used the resources dedicated to the programme to deliver high-quality outputs in a timely fashion, and to achieve targeted objectives [i.e., is UNICEF expending the least amount of resources to achieve programme effects)?

Ensuring that the least resources are spent to achieve programme results has a number of pre-requisites including: i) choice of interventions needed to be supported by evidence; ii) results needed to be delivered on time and in proportion to resources expended; and, iii) the combination of interventions needed to be applied appropriately (to the right patients).¹⁰⁰

Choice of interventions and their cost-effectiveness.¹⁰¹ The individual interventions are known to be generally cost-effective internationally (see RQ 18). The package of maternal and neonatal interventions closely aligns with the DCP recommended interventions for evidence-based antenatal, intrapartum and neonatal package of care (with moderate to high grade evidence, tables 7.3 & 7.4 in (Black et al., 2015)). It is also acknowledged that other partners are supporting other aspects of these basic packages. The cost-effectiveness of components of the overall programme need now to be embedded within the system and treated as a complex intervention that can be jointly assessed at end-line. The programme components, together with contributions from other partners, are incorporated into the Government PIP for the sector programme which helps to minimise duplication of support from other partners (Ministry of Health & Family Welfare, 2016).

Timeliness of outputs: The analysis of activities (section 3.4) suggest that across most activities outputs are being delivered according to plan, with the exception of a couple of programmes that have taken longer to develop and implement (disability friendly hospitals, climate activities). We attempted to link funding flows to activities to compare with those stated in the RWP. Where this was possible, the figures suggest that spending is mostly reflect the level of activities in outputs.

¹⁰⁰ See <https://www.oecd.org/development/evaluation/dcdndep/47069197.pdf>

¹⁰¹ DAC criteria refer to the similar concept of cost-efficiency



With the exception of activity 1.6.1 and 1.1.6 (Ensure effective coverage of maternal health services) where spending is less than 10% of what is planned most activities have been funding at close to 50% of the full programme budget at the mid-way mark. In the case of 1.1.6 we have been informed that some of the spending is reflected in 1.1.2 (Strengthening health systems for improving effective MNCAH services with equity) but we were unclear how much, so reallocation was not possible. In a few cases, achievements have far outpaced the funding provided through UNICEF. For example, promoting gender responsiveness AFHS (3.1.1) has received substantial additional funding for the Netherlands, which has meant the original target has been far exceeded. This target now needs revising. As noted under section 3.5, lower than expected activity given spending is recorded for support to the cold chain, although we are told that progress will speed up in 2019, and for health workers trained in birth registration.

Interventions delivered to the right patients: Whether the combination of (cost-effective) interventions is the best use of resources depends ultimately on whether they are delivered to the right people. For some interventions, that are provided more or less universally to all mothers or all children such as vaccination or basic antenatal care the main concern is that access to services is generally equal. In the case of services that are only intended for a relatively small number of the target group (e.g. newborn interventions targeted only at sick newborns) further efforts are required to ensure that only those that can benefit received services.

RQ27: A strength of most of the programmes is that they build on initiatives already supported by government, UNICEF, or other development partners. Support to HMIS is a one example here, where support seeks to strengthen an existing system within the public sector that has in the past received financed from other DPs. The general support to HSS is also an opportunity increases the efficiency of services. District plans, for example, can be used to track whether services are being received by the right target group of patients. RQ27: How successfully has UNICEF coordinated with other key actors (e.g., implementation partners, MoHFW and other line ministries, other entities conducting complementary interventions) to ensure non-duplication of efforts, a clear delineation of roles and responsibilities within joint programmes, and the overall success of the programme's implementation?

Much of the coordination work is with the MoHFW and responsible line and operational plan line directors. Respondents suggest good joint work and frequent communications,¹⁰² (see RQ1, 2 and 30). As well as EPI, Adohealth, and MNCAH, quality improvement is mentioned as an area where there is strong coordination across actors (RQ14). Good coordination between UNFPA and UNICEF is also mentioned by stakeholders.¹⁰³ UNICEF has become a focal point for adolescent health a role that one respondent felt leads to strong coherence and linkage.¹⁰⁴

RQ28: How has the focus on 22 districts, tea gardens, city corporations and enclaves and their type (i.e. poor performing, child marriage, and climate change) affected efficiency in service delivery interventions?

¹⁰² Nat_FGD_20

¹⁰³ KII_manager2

¹⁰⁴ NAT_KII_1

Summary: A focus on priority districts is appropriate given the wide disparity in outcomes across the country, and there is early evidence that indicators are improving in these areas. In some districts, notably in Sylhet division, local factors are impeding efficiency. These areas may need assistance to overcome bottlenecks to prevent them affecting overall programme impact.

The focus on vulnerable, and low performing areas, is a logical development of the health programme that has always sought to close gaps in health outcomes, and well in line with the international organisational vision. Poor infant health outcomes are well acknowledged in tea estate areas.¹⁰⁵ Many of these areas begin at a lower level and so the potential gains in terms of health outcomes are larger. The appropriateness of focusing on vulnerable groups for maternal care was mentioned by respondents, and there is strong support by government to focus on these areas.^{106 107}

Table 14 Priority districts by division

Division	Districts	Priority districts	Priority as % of total
Barisal	7	3	43%
Chittagong	12	4	33%
Dhaka	16	1	6%
Khulna	11	4	36%
Mymensingh	4	3	75%
Rajshahi	8	2	25%
Rangpur	8	3	38%
Sylhet	4	4	100%
Total	70	24	34%

Available data seems to support the inclusion of these districts in the programme. Early impact data based on HMIS data suggests that these areas did indeed have lower than average health outcomes, and they also report substantial improvement in indicators in the first two years (see RQ24, Table 12).¹⁰⁸

Efficiency in delivering services to priority districts may be reduced if the same factors that have led to poorer outcomes in the past also impact on completion of current activities. All divisions include one or more priority districts (Table 14) with the highest proportion in Sylhet and Mymensingh. Data on

¹⁰⁵ KII_manager2

¹⁰⁶ Nat_FGD_20

¹⁰⁷ IDI_SP_Child Health_Madhupur UHC_Tangail

¹⁰⁸ In the files we were given, 24 districts were listed as Tea garden/low performing/high child marriage/CC



activities and achievement of indicators suggest that Mymensingh's activities are mostly on track, with achievement at or above what was envisaged for 2018 (UNICEF Mymensingh Field Office, 2018). This is borne out by spending on activities in the division that make use of most of the budgeted amount in the RWP (the MTR report itself reports 80% spending against budget). The reported situation in Sylhet is a little different with maternal, neonatal, and adolescent (output) indicators mostly below the expected targets for the end of 2018. This includes the proportion of service providers receiving training on cold chain management (one of the lagging indicators identified in 3.5) and other newborn and children activities. Spending, at least activities attributed to the division, is substantially lower than the budget for the period. The mid-term review (PowerPoint) review observes that there have been bottlenecks/ challenges due to staff turnover (DEPB workshop delayed), delay in agreement with NGO partners and a delay of supplied equipment (UNICEF Sylhet Field Office, 2018). Measures were identified to mitigate these challenges in each case.

According to the data received, there appear to be a few districts (Sherpur, Chapainawabganj) identified as having child marriage and included in the UNICEF overall programme that do not yet participate in the adolescent (AFHS) programme which is one of the main routes for encouraging a reduction in child marriage. It may be that these districts are now included but if not, it would be worth investigating their inclusion.

Connectedness

RQ29: How effectively has the Health programme coordinated with other UNICEF sections (e.g. C4D, nutrition, WASH, SPEAR, CAP, Education) to ensure that further building blocks of child and women's health that lie outside the scope of the present programme are in place?

Meetings with other sections in UNICEF demonstrated there is good interaction between the health Programme and the other teams in UNICEF (various KIIs, codes suppressed). The UNICEF-GoB Health Programme is in close synchronisation with the UNICEF Strategic Plan 2018-21, i.e. the global strategy of UNICEF, leading to sector specific guidance linked to SDGs.¹⁰⁹ It is also linked to global priorities, including developing an MNCH package. In doing so, the health programme coordinates closely with other sections within UNICEF Bangladesh.

C4D of UNICEF Bangladesh has strong associations with the Health team and their activities in the health programme. Particular focus of the association is on maternal and neonatal health outcomes and immunisation.¹¹⁰ A successful example of the collaboration is the cartoon "Meena", which started as a meme to convey information and enhance awareness on girls' education, however, later focused on disseminating important health messages. The SBCC activities conducted from C4D in collaboration with the Health team is one of the reasons for the significant positive changes in the knowledge and

¹⁰⁹ Nat_KII_2

¹¹⁰ Nat_KII_9

awareness of caregivers of the children in relation to ANC/PNC visits, iron folic acid tablet consumption, handwashing with soap (Manitou Inc, 2017). C4D is also coordinating with the health programme in nutrition areas (IYCF, EBF, CF, etc.), in adolescent health (promotion of adolescent health and nutrition and menstrual hygiene practices) and demand creation of services (e.g. SCANU).

A strong link was noted between the community activities and the demand for the services being developed at facility level (e.g. SCANU). A system approach suggests that this linkage could be deepened further to ensure that the demand-side barriers to using services, particularly amongst the most vulnerable, are overcome. The nature of the life-cycle approach means that health and education specialists need to cooperate through, for example, school health. It is felt that there are opportunities for closer working relationships between the two-line ministries that the UNICEF programmes might facilitate.

Gender: Gender is a result in UNICEF Strategic Plan, not a cross-cutting area.¹¹¹ The gender action plan (GAP) was developed keeping alignment with UNICEF country strategic plan. Hence, there is strong alignment with the health programme. A key gender focus is on adolescents, which is thought by the gender team to be the most neglected group amongst women and children. In this regard, they work jointly with health team in adolescent health programming. The gender team also shares analysis in pregnancy care and nutrition areas. It works in collaboration with health programme on Women Friendly Hospital Initiative (WFHI) and ensuring health for Mothers at Work.

A number of health programme components necessitate a close working relationship with the gender adviser. Only the WFHI mentioned as a cross-sector activity in the overall UNICEF rolling work-plan but there is a desire to work more with other health programmes.¹¹² Amongst other activities, the adolescent services are already strongly gendered in the terms of needs and the way they are implemented. As observed elsewhere (RQ15, RQ16) there is a pressing need to develop evidence on the impact of different male and female adolescent packages with a significant role for the gender advisor. In practice, there is much working across sectors, facilitated by the UNICEF specialist. UNICEF is active in bringing other DPS and government together in cross-sector action; the National Action Plan on Ending Child Marriage was a much-cited example of this. Efforts are sometimes hampered by perceived weaknesses in the responsible line ministry (MoWCA) and UNICEF and other partners have taken the initiative to bring government and DP stakeholders together.

The education component of UNICEF works in collaboration with GoB in fulfilling relevant targets in 7th FYP in pre-primary, primary and secondary education and they work in collaboration with MoPMA, MoSCA and MoWCA. However, the Education team also works with the Health team, particularly in health and hygiene areas specific to the adolescents. The UNICEF country programme follows a life cycle approach – starting from 0 to five years. The outcome 1 group of UNICEF looks after the interventions in

¹¹¹ Nat_KII_11

¹¹² DP11



this area, which includes key members from health, nutrition, education, and WASH sections. The group members discuss, plan, and set priorities for the year on key areas. While the core intervention led by Health as 'survival' - including early pregnancy, SCANU, immunisation, maternal and child health - the Education team works, in coordination, in early learning interventions, and early childhood development of 0 to three and three to six years of age groups of children.¹¹³

RQ30: What is the perception of partners (e.g. GoB, Ministry of Health, WHO, Save the Children, UNFPA, WB) of the UNICEF health programme in terms of technical salience, comparative advantage, cooperativeness, and sectoral alignment with other stakeholders?

In general, partners have a good perception of the UNICEF health programme. This comes over most clearly for those programmes that are strongly embedded in government operational plans particularly MNH, Adolescent health, EPI and HMIS.¹¹⁴ At the field level, MoHFW officers are generally satisfied with the health programme interventions and think these are essential in delivering quality services, particularly in ensuring maternal, child and adolescent health.¹¹⁵ SCANU was mentioned as an essential life-saving system and acknowledged the role of UNICEF in scaling it up in different districts. Technical assistance provided by UNICEF also has been acknowledged to be important, particularly the capacity development support for GoB staff at district and upazila level health facilities. The Quality Improvement initiative, and EPI, also seems to be appreciated by the field level officials.^{116 117} UNICEF also provides financial support in terms of salary of some (non-government) health workers at UHC level, which the field level MoHFW officials think very important in ensuring quality and extent of health services. The senior officials from DGHS believe UNICEF is working with GoB in a coordinated manner.¹¹⁹ They specifically mentioned the advisory support from UNICEF Bangladesh office and the logistics support in arranging different strategic and advocacy meetings and workshops. However, senior level DGHS officials showed concerns about the sustainability of some interventions, and suggested examples of UNICEF interventions not being continued after external support is discontinued.¹²⁰

Partners acknowledge the good integration of UN agencies UNFPA, UNICEF and WHO, which play to each other's comparative advantage.¹²¹ Bilateral donors funding UNICEF in health programme interventions appreciate the modality in which UNICEF works with GoB, as they believe this gives government more ownership of the programs. They also think UNICEF, as the focal point for interventions, such as adolescent health, is an efficient, collaborative approach to implementation.¹²² There is acknowledgment of good cooperation on key areas where integration is needed such as

¹¹³ Nat_KII_13

¹¹⁴ Nat_FGD_20, Nat_KII_21

¹¹⁵ KII_manager4

¹¹⁶ KII_manager2

¹¹⁷ KII_manager5; KII, KII_manager1, KII_manager6, KII_manager3; KII, KII_manager7;

¹¹⁸ KII_manager7; KII_manager3; KII_manager2

¹¹⁹ Nat_FGD_22; KII, Nat_KII_24, Nat_FGD_20; Nat_KII_25; Nat_KII_26

¹²⁰ Nat_KII_21

¹²¹ NAT_KII_6, NAT_KII_7

¹²² Nat_KII_1

the newborn plan.¹²³ The approach of UNICEF and the historic approach of the MoHFW, avoids too much overlap in support from various partners. One partner acknowledged the willingness of UNICEF programme managers to incorporate the best practices of other development partners.¹²⁴ They feel there is good evidence and models developed from the interventions such as SCANU, WFHI and Adolescent Health, but question whether there has been sufficient dissemination of these examples across the sector.¹²⁵

Criticism of cooperation mostly relates to the need to further share practices across partners, particularly for common areas where different partners are delivering similar interventions in different areas of the country.¹²⁶ One respondent suggested that internal deadlines (e.g. end of programme) to achieve, sometimes hinders a collaborative approach to planning and lesson learning.¹²⁷ Although this criticism is directed at UNICEF, we suspect that it could apply equally to many other partners and it is a function of different internal budget cycles and the need to meet sometimes quite short deadlines (such as showing impact within a four year programme). A further perspective on this is that it is sometimes the third-party funders of UNICEF partners who have this rather short-term perspective rather than UNICEF.¹²⁸

Major implementers of MNCAH interventions in the country indicated, intervention development is generally well coordinated with UNICEF, but they also suggested that there are overlaps in Adolescent Health, Maternal Health and Neonatal Health.¹²⁹ UNICEF's role in supporting GoB in policy development was also appreciated by the implementers. At intervention level, UNICEF contribution in EPI was extensively respected by the other implementers. The SCANU intervention was also appreciated, however, was criticised for not providing ample capacity development of staff operating the SCANU and making it fully operational.¹³⁰ Implementers also believe there needs to be increased dissemination of the lessons learnt from successful and less successful interventions of the health programme. The view was also expressed, given limited resources and the strength of reputation, UNICEF should focus more on activities at the policy level with senior level officials of MoHFW, DGHS and DGFP, rather than being involved into micro level intervention implementation at district, upazila and below.¹³¹

In general, partners appeared to have a good impression of UNICEF, particularly those that provide funding for its programmes. Two negative issues were raised. One was that sometimes UNICEF is not good at identifying the source of their funding.¹³² In some ways this is the flipside of the observation (see RQ30) that UNICEF incorporates the ideas of other DPs into their own practices and programmes. When this is done seamlessly it is sometimes inevitable that those other partners will not be fully recognised or identified. The second issue raised is that UNICEF sometimes appears "hungry for attribution", which may lead to weaker collaboration and planning. We suspect this comment could be made of many partners particularly given the need to show value to funders.

¹²³ NAT_KII_7

¹²⁴ NAT_KII_1

¹²⁵ Nat_KII_5

¹²⁶ NAT_KII_4

¹²⁷ NAT_KII_4

¹²⁸ NAT_KII_2

¹²⁹ Nat_KII_6; Nat_KII_4

¹³⁰ Nat_KII_4

¹³¹ Nat_KII_4; Nat_KII_7

¹³² NAT_KII_5



RQ31: How successful has the programme been in setting up and strengthening key and innovative partnerships, such as the Health Sector Consortium and Government-NGO-private sector partnerships for promoting health service and delivery?

UNICEF mainly works with government and government services, although there is cooperation with NGOs such as SCF on planning and funding of programmes. UNICEF's partnerships with MoHFW, civil society organisations (such as CARE, PHD and WAVE), as well as academic institutions (Dhaka University, Bangabandhu Sheikh Mujib Medical University, John Hopkins University and University of Oslo) contributed to improving accountability and evidence for equitable and quality maternal, newborn, child and adolescent health service delivery. Technical assistance was provided to the World Bank and partners for strengthening disbursement-linked indicators and SDG health indicators. UNICEF partnered with OKUP to work on HIV prevention, including of mother-to-child transmission amongst migrant populations; and with Khulna Medical College Hospital to address the high concentration of people living with HIV in the division. The partnership with the James P. Grant School of Public Health (JPGSPH) of BRAC University enhanced the monitoring of behavioural changes in intervention and control sites. This showed that in selected districts with Communication for Development (C4D) interventions, 48% of pregnant women made at least four ANC visits (38% in non-intervention areas), and the consumption of at least 100 Iron-Folic Acid (IFA) tablets by pregnant women was 16% higher in intervention sites.

In urban areas, UNICEF works with the municipalities and local government division of MOLGRD¹³³ and supports their EPI programme, essential newborn care, and adolescent care. The EPI evening session for working mothers had been considered as an important initiative to cater the need of urban population.¹³⁴ Health care providers, including doctors, nurses and paramedics, had been trained on essential newborn care, and nutrition. However, concerns were raised about sustainability of the initiatives given the lack of ownership and leadership of City Corporation's to scale-up the programmes. Work is largely through public providers, although on adolescent health, the programme works with a local NGO (Bapsa). The programme also interacts with the private sector through its work with the garments sector on developing standards in a sector dominated by women and children workers (see RQ18). If the programme focuses more effort on urban areas in the future, then it is likely that it will need to work more closely with non-government NGO's and for-profit providers. Engagement with the private sector is also foreseen through climate change work (see RQ 18). There may be potential to roll-out the quality assurance initiative work to the non-government sector as part of improved regulation. Apart from Bapsa, it appears current engagement is largely about stewardship and standards, but there may also be a need for UNICEF to engage the for-profit sector as providers. This will require a greater understanding of the different ways in which UNICEF, as development partner, can engage effectively with the breadth of non-government actors.

RQ32: How well is the Bangladesh Country Office Health Programme supported by and effectively draws from UNICEF HQ Health teams and staff? Are the benefits of being in a multi-tiered organisation being maximized?

¹³³ NAT_KII_16

¹³⁴ NAT_KII_27

The central, and regional office view the Bangladesh office as relatively well resourced in the region with high staffing capacity compared to some other countries.¹³⁵ The regional office is involved in providing advice on planning of the programmes while the main inputs from headquarters revolve around special programmes, such as the support to the Rohingya. The country office run their own programme. The function of the Regional Office is to provide specialist inputs as required by the programme such as EPI advisor engagements.

There are opportunities to share practices across the region, including meetings every 18 months. The Bangladesh office has been active in using these opportunities; including sharing local best practice and new developments in particular the DHIS2 implementation. Because of good capacity and opportunities to be innovative, the Bangladesh programme is usually in the first wave of any intervention roll-out.

Two areas for further linkage development were suggested. One is that it was felt that more could be done to document and share positive and negative experiences of implementing programmes across the region and outside the regular regional meetings. There is a recognition that time constraints limit this, but such communication is in line with the country programme's goal to produce and use evidence. A second area mentioned, was that the unique experience of working with NGO's in Bangladesh could be shared more widely across UNICEF country and regional offices; it is thought there is much to learn from this experience.

Sustainability

Summary: Sustainability of programme components remains a core issue. Improving the evidence base on impact of interventions is a core component in planning for intervention incorporation and scale-up, particularly for interventions that are relatively new or implemented on a pilot basis. Evidence is at the heart of the UNICEF approach and theory of change, but our assessment suggests there is some way to go to build a convincing and well communicated evidence base. The extent to which programme components can be sustained is also substantially dependent on government systems, in particular the ability to deploy and motivate staff and the way in which financial rules allow programmes to be decentralised and developed locally.

RQ33: How successful has the programme been in equipping the Government and strengthening government systems to scale-up and sustain the successfully proven interventions once UNICEF support comes to an end?

¹³⁵ NAT_KII_2, NAT_KII_8



Sustainability of programme components remains a huge issue and one that goes well beyond UNICEF. Interlocutors at all levels expressed this in different ways. At a local level, UNICEF is frequently depended on to provide essential inputs such as supplies and training materials (cross ref RQ9). Help with items of equipment and training was often requested.¹³⁶ This is often because regular resources from government are not ensured.¹³⁷

There are a number of layers to the sustainability question, including integration of programmes in national plans; ensuring that programmes once integrated are properly resourced and direct efforts to help develop government systems.

From the perspective of plan integration, UNICEF has been very successful. All the programmes are clearly linked to line directors and operational plans. Earlier sections have emphasised the strong ownership that line directors feel for these activities. This embeddedness within government plans also permits capacity building through government counterparts and through the joint planning and management of programmes.

Ensuring that plans, once integrated, are properly resourced is a rather more challenging objective. The issue here is not about how to transfer the costs of what UNICEF funds to the Government budget. In funding terms, the UNICEF contribution, including from organisations that fund via UNICEF, is relatively modest. According to the APIR 2019, the direct contribution to donor funding was around 3% which rises to 9% if funds from other agencies are added (Independent Review Team, 2019). Some of these costs will be a one-off development of programmes, so not incurred again. Other costs are to service and replace equipment.

A more substantive issue relating to sustainability of UNICEF programmes are the availability of staff to ensure the smooth running of essential services caused by vacancies and staff absences. One local IDI suggested that lack of human resources was the main impediment to delivering services as mostly they have sufficient equipment and other items.¹³⁸ The Government is taking steps to mitigate the problem of staff absences, including through DHIS2 monitoring (see RQ17), but the issue remains chronic. Most respondents mentioned human resource issues as an impediment to the sustainability of UNICEF and most other sector interventions.¹³⁹ This is particularly true for services where skilled staff are in short supply, as with the delivery of maternal and neonatal services.¹⁴⁰

One way that sustainability might be encouraged is through the active planning of services at the local level, which is now being promoted through the DEPB interventions.¹⁴¹ This will only work if local authorities are given more authority to finance services. This remains a stumbling block with local planning, particularly around critical human resources where local authorities remain largely impotent.

¹³⁶ FGD_CC_1

¹³⁷ IDI_Health seeking mother2, IDI_Health seeking mother3, DI_Health seeking mother3

¹³⁸ IDI_SP_Child Health3, IDI_SCANU Mother4

¹³⁹ NAT_KII_6, NAT_KII_5, NAT_KII_4, Nat_FGD_20

¹⁴⁰ Nat_FGD_20, NAT_KII_7

¹⁴¹ NAT_KII_5

Evidence generated from the multiple interventions implemented during the UNICEF programme could have a vital role to play in helping government to plan (RQ15). One government respondent commented that more evidence of the impact on services from the interventions is required as a precursor to scaling and sustainability.¹⁴² Some of this evidence is already being generated and relates to the importance of developing a clear strategy for communicating evidence with various stakeholders. (RQ15).

¹⁴² Nat_KII_21



CONCLUSION



The mid-term assessment of the health sector programme suggests a large number of evident strengths that increases the likelihood the programme will impact on the sector. We have also identified a number of areas for improvement; largely these areas regard enhancing what is already intended (e.g. around generation of evidence), improving linkages particularly with other partners, and ensuring that information is collected and that facilitates improve monitoring and evaluation.

Relevance

The programme is closely aligned to GoB's own policy documents and strategic plan (HPNSP4). UNICEF has been a core partner and non-pool funder since the start of the Health SWAp process, and actively involved in the planning process. Within each programme area, interventions focus on lagging indicators and areas. UNICEF is highly regarded by most partners. It has a critical if changing role in the delivery of EPI and newborn services. It has become a key partner with GoB in the focus on adolescents. At the systems level, its responsive support for DHIS2 has led to its increasing use across the system. The ToC logic is broadly clear, although the management usefulness of the tool might be increased by making the links between specific risks/assumptions and outcomes more specific.

The changing context, including needs of a middle-income country and the nature of development partner engagement, suggests that the programme will need to re-orient in the future. The programme will need to focus on moving away from regular, micro-interventions and towards strategic health system support and evidence generation from well-evaluated demonstration projects.

UNICEF has an important role to play in the development of UHC. A number of roles appear to be important, which build on existing strengths including: 1) building on the quality improvement work to inform the delivery of a quality package of services; 2) strengthening the planning function at the local level; and, 3) proposing and advocating for a model of primary care that functions as part of an integrated UHC.

Output indicators may need revising to include activities that were not included before but are happening now or have now been considered as priority (e.g. climate, women friendly hospital initiatives) or where the indicator provides a less sensitive measure of programme effectiveness (e.g. knowledge indicator for community interventions). (RQ2)

To be SMART these indicators need to have a baseline and monitored actual values that are based on the areas in which activities are implemented. Indicators are available from several different sources and different levels of aggregation. DHS data based on household reporting are available down to division but not representative at to the district



level which would be needed to enable a focus on intervention area. HMIS data are available to district level but focus mainly on the public sector health facilities. (RQ3)

The management usefulness of the ToC could be increased by making the links between specific risks/assumptions and outcomes more specific. (RQ3)

To respond to the changing economic and social conditions the future programme should focus less on direct implementation towards technical advisory work (e.g. HSS) and piloting and evaluating small scale interventions for later scale up (e.g. QI). This transition is already underway in the current UNICEF plan so represents a confirmation about the programme evolution rather than the need for radical re-thinking. (RQ5)

HSS support is extremely important. UNICEF might become more active in ensuring that system advice and support is consistent with those of other actors (development partners and government). Highlighting where HSS support will have less impact because of other constraints is key. (RQ7)

UNICEF has a substantial contribution to UHC to make particularly focused on: i) quality improvement, expanding on its pilot work at key public hospitals; ii) local planning of resources through District Evidence-Based Planning & Budgeting (DEPB) initiative; and iii) promoting primary care as a vital part of Universal Health Care (UHC) strategies. (RQ8)

Coherence

The programme draws from a situation analysis that makes clear links between population needs and interventions. UNICEF's contribution is based on historic strengths (EPI, MNH), emerging international focus (AdoHealth) and more recent but well embedded HSS support to the sector (HMIS).

Although internally coherent, there are some misconceptions by partners of the interventions, and documents lack reference and linkage to other partner programmes. This suggests that more effort might be needed to recognise and link with similar activities of other partners. Better communication of evidence is one strategy to address this issue.

Improved coherence of the programme with the support from other partners could be achieved by the following:

There needs to be clearer communication of certain activities and their impact, particularly around DHIS2 and the linkage to DEPB systems, SCANU effectiveness and beneficiary impact and lessons from QI initiative. (RQ10)

Ensure that the contributions of other partners are reflected in strategy development documents and partners. This could improve overall coherence and point to potential gaps in support. (RQ12)

Effectiveness

With few exceptions, the output monitoring indicators and spending suggest that activities are on track. Where they are not, there are indications to suggest that outputs will be delivered during the last two years of the programme. In a number of areas, the effectiveness of the programme could be enhanced: i) greater linkage of the community/C4D interventions with the supply-side programme components; ii) a more consistent approach to the development, synthesis and communication of evidence including comparisons with other similar programmes; and, iii) increasing focus on the quality as well as quantity of data collected through the DHIS2 system. Although it is not surprising that much monitoring has focused on the quantity of service roll-out, it will be important to begin to monitor the content and quality of services if the gains in health outcomes envisaged are to be achieved. Human resource availability remains a severe constraint to the delivery of quality services.

The focus on evidence is vital to delivering effective interventions. We suggest that this function could be improved through a clearer knowledge transfer strategy including guidelines for evidence reporting, comparisons with other similar interventions and clear communication strategy. (RQ15)

The adolescent programme is already being scaled across the sector. We anticipate that evidence from this programme including package content and scalability will be of considerable interest internationally and we recommend that more attention is given to the precise composition of the adolescent package. (RQ16)

The DHIS2 has become well embedded in the HMIS. The targets of achievement should be revised to reflect the quality of the data perhaps by tracking one or two core indicators that can be linked to other surveys (e.g. skilled attendance at delivery). It could also focus on the coverage of non-government facilities. (RQ17)

Given the substantial interest in the QI initiative, priority should be given to documenting experience, assessing evidence of impact of this initiative and disseminating experience. (RQ17)

Community groups are functioning, but more support and monitoring may be required to ensure that the voice of members that should benefit from services are heard effectively. (RQ20)

Impact

It is too early to establish and attribute programme impact. However, data from DHIS2 suggest that major indicators are improving and that for some indicators there does seem to be greater improvement in UNICEF areas. These changes will require more rigorous evaluation at the end of the programme.

At this stage it is important to ensure that monitoring indicators are available to enable attribution at the end of the programme to inform programme continuation and scale-up. Indicators on impact are in principle available through the DHIS2 although it will be important to ensure that indicators for the



period before, during and after execution are available. Funding for each programme component and to each beneficiary area would improve the accuracy of the analysis. Some work is required to ensure that accurate attribution of spending can be guaranteed, although district level analysis may require some further apportionment.

UNICEF has commissioned a number of impact evaluations on various health programmes it is implementing or supporting. However, most of the impact evaluations for this country programmes have only done the baseline as of yet. Therefore, we could not use the impact evaluation results in this assignment. Updated information would be available during the midline and endline surveys of these evaluations.

Efficiency

Although we cannot yet establish the VfM or cost-effectiveness of the programme, evidence that resources are being well utilised can be assessed by examining how funds have been disbursed by programme. Mostly, the budget is being spent evenly across the programme with concomitant achievements in outputs as assessed by the measured indicators. The focus on vulnerable areas and groups has potential for substantial gain for resources expended. However, issues of human resource availability in the health system and other access barriers could undermine overall achievement.

UNICEF is working closely with the MoHFW, its responsible directors and operational plan line directors, and this collaboration has been highly regarded. UNICEF-UNFPA collaboration was also reported to be effective. The UNICEF health team is also working closely and efficiently with other cross-cutting teams within UNICEF, including in gender, WASH, innovation etc.

At the local level, staff availability is identified as the most important factor in reducing the efficiency of service provision. Greater support by UNICEF to government may be required to ensure that adequate staff are available to maximise the returns on investment including through the DEP planning process. (RQ28 and RQ33)

Some more support may be required to some priority districts to help ensure that results can be delivered on time given constraints at the local level. (RQ27)

Connectedness

A series of crucial partnerships are important for delivering the country health programme. The health programme is part of a broader life cycle country strategy. The necessary links with other units in the country office mostly exist and are well used. More linkage could perhaps be made with gender. Greater utilisation of C4D to help link up supply and demand sides of the programme could increase the impact

of the programme, particularly to vulnerable groups. The programme is extremely well connected to government and a number of development partners. Our assessment suggests that greater sharing of results across partners with similar programmes could improve the quality of the components and the evidence base. There is some linkage with national NGOs in the delivery of services, but mostly the programme focuses on the public sector. The programme would benefit from a strategy for working with the private sector particularly given the increasing importance of the urban areas.

More attention may be required in understanding the reasons for differential uptake of different aspects of adolescent services and why it appears that services in some facilities are underutilised. (RQ29)

There are non-government collaborations including with the for-profit private sector, but these are limited. Given the importance of this sector, particularly in the growing urban areas, UNICEF will probably need to engage more with the private sector and there is a need for a strategy for such engagement. (RQ31, RQ5)

Some attention may be required to ensure that the source of funding for activities is clearer to partners and funders. (RQ30)

Sustainability

Sustainability of the programme components remain a core issue. Improving the evidence base on the impact of interventions, particularly those that are relatively new or implemented on a pilot basis, such as SCANU and QI, is a core dimension in planning for incorporation of the interventions and scale-up. Evidence is at the heart of the UNICEF approach (ToC). Our assessment suggests that an evidence base is being developed through numerous evaluations but that further thought could be given to different ways this evidence is communicated. The extent to which components can be sustained is also substantially tied up with government systems in particular, the ability to deploy and motivate staff, and the way in which financial rules allow programmes to be decentralised and developed locally.

UNICEF has enormous potential to improve planning and sustainability of services through the DEPB activity. The potential of DEPB is limited by the extent to which government allows local planners flexibility to utilise resources including staffing. Building capabilities at local level and acceptability of the process at national level should be an important part of future support for this initiative. (RQ33)



LESSONS LEARNT

Evidence

A dominant theme of this assessment is the creation and curation of evidence for better policy making. This is emphasised in the ToC and indeed is a natural outcome of the way in which a number of UNICEF programme components function; interventions in a small number of areas that are then shared and rolled out across the country. It was argued by a number of respondents that increasing this role is one way the support by UNICEF should evolve in the future. We agree with this assessment but also believe that more attention to this evidence function is required to maximise effectiveness.

Creation of evidence: During this assignment we looked at a number of assessment reports of project components. These had a variety of research designs and often based on solid data sets including baseline and endline usually using primary data collection methods. This evidence might be enhanced in a number of ways. Firstly, research could pay more attention to other initiatives going on in the sector both in Bangladesh and in the region. Secondly, incorporation of cost-effectiveness and VfM would add to the usefulness of the information, particularly when considering scale-up. Finally, given the increasing quantity of useful HMIS data through DHIS2, more thought might be given to undertaking evaluations using administrative data. This might have an added benefit that using administrative data can often have a positive feedback effect on the quality and completeness of this data.

Curation of evidence: The second area of focus is on how the information is made available to stakeholders. Policy impact research suggests that evidence needs to be presented in a number of ways to be of relevance to policy makers. Substantive reports and publications that are preferably peer reviewed are needed to establish the scientific basis for a programme. But other forms of evidence such as policy briefs, contributions to strategy and modelling the scale-up of small to medium size pilots in financial and physical terms are also important. The evidence needs to be readily available and well publicised and seen as independent or at least dispassionate. Negative evidence can be just as important as positive evidence.

Indicators

Monitoring of the health programme is undertaken through a series of systems starting from the rolling work-programme through the spending reports and reports on achievement of indicators. A major challenge for the programme has been to decentralise budgets and activities. Some of the difficulties in obtaining information and conducting analysis arose because this process is still a work in progress. There appears to be a clear aim to continue to decentralise and make physical and financial attribution to programme activities more accurate. The rolling workplan for 2019-20 already incorporates some of these improvements.



The work to improve the collection of financial and physical information is important for the successful implementation and monitoring of programme components. We also believe that attention needs to be given to the content of some of the indicators and the way they are collected. One issue is that the outcome indicators, although completely relevant, are usually based on national level values for baseline and endline. Indicators that are more sensitive to the impact of the programme would state these values in the areas (preferably at district level) where UNICEF is operating. In refining these indicators, it may be necessary to substitute proxies if it turns out that some are not available at the district level.

A related issue is that several of the output indicators do not seem particularly sensitive to the real impact of the programme. One issue here is that various targets have already been exceeded for example for adolescent health and the community monitoring indicators. A further issue is that some indicators do not seem to be a particularly good measure of the effectiveness of the programme. An example here (see RQ20) is the knowledge indicator around newborn danger signs, which is already very high but may not actually translate into changed behaviour. The output indicators of adolescent health also seem a little crude; simply assessing the number of facilities with services in place and again the target is already exceeded following substantial additional funding for this area. It might be more useful to assess who uses these services, including a gender breakdown and what they are accessed for.

Monitoring of content and quality of care

In our discussions with respondents and in a snapshot of quantitative assessments we have observed substantial variation in the content and quality of services. For some, the programme's quality is already being addressed comprehensively. The drop-out rate, a major determinant of the quality of EPI services, is a major focus for the EPI component. There is a good prospect that the gap between low and high performing areas will close as a result. In other areas, more attention to the delivery of quality services, particularly to vulnerable groups is needed. This may be true for more complex services such as adolescent care and newborn services. These are predominantly vulnerable to other system factors such as staffing. With adolescent services the danger is that they will focus on counting services that are easier to provide such as reproductive health and neglect complex mental health and addiction services. We realise that UNICEF is expending substantial energy on developing service standards and recommend that the standards are used in an active way to monitor services including incorporation into regular monitoring (currently the DHIS2 adolescent indicators appear crude.¹⁴³)

Engagement with the private sector

Our assessment found that UNICEF is engaging with the private sector in a number of ways including work on EPI and adolescent health in urban areas and garment sector standards. We think that increasing urbanisation will mean engaging more with this sector; something that has been noted by a number of respondents. Engagement can take many forms but the main ones likely are:

¹⁴³ http://103.247.238.81/webportal/pages/dashboard_adolescent_health.php

- improving the regulation of the private sector; perhaps building on the quality improvement work with HEU;
- promoting services within private sector companies for the welfare of workers (as already happens for some garment workers); and,
- contracting private actors to deliver services on behalf of the programme.

None of these engagements are straightforward, yet are likely to be necessary given the changing context in the country. A practical first step would be to develop guidelines or principles for such an engagement.



RECOMMENDATIONS

The key recommendations from this evaluation are listed below. These recommendations have derived from the key findings and interpretations included in the earlier part of this section. These are the nine key recommendations that are most important and actionable. In addition to these, UNICEF may consider reviewing the other points highlighted in the conclusion section and identify potential other areas to address.

1. We suggest revising the output indicators to include activities that were not included earlier but are now considered as priority (e.g. climate, women friendly hospital initiatives). Moreover, areas where the indicator provides a less sensitive measure of programme effectiveness (e.g. knowledge indicator for community interventions) need revision.¹⁴⁴
2. In addition to direct implementation, the future programme should focus more on technical advisory work, as well as piloting and evaluating small scale interventions for later scale up.¹⁴⁵
3. Based on existing strengths, UNICEF's support to UHC in the future should focus particularly on: i) quality improvement, expanding on its pilot work at key public hospitals; ii) local level planning of resources through District Evidence-Based Planning & Budgeting (DEPB) initiative; and, iii) promoting primary care as a vital part of UHC strategies.¹⁴⁶
4. UNICEF should ensure that the contributions of other partners are reflected in strategy development documents. This could improve the overall coherence and point to potential gaps in support.¹⁴⁷
5. A clearer knowledge transfer strategy including guidelines for evidence reporting and comparisons with other similar interventions, as well as a clear communication strategy need to be formulated by 2022 to improve the evidence generation function.¹⁴⁸
6. While the HMIS is well integrated and functioning, the data quality and completeness can be improved by comparing indicators with national surveys, and by expanding the coverage by including non-government facilities.¹⁴⁹

¹⁴⁴ See Section 4.1: Relevance, Page 76 and Section 5.2: Lessons Learnt, Pages 80-81

¹⁴⁵ See Section 4.1: Relevance, Page 76

¹⁴⁶ See Section 4.1: Relevance, Pages 76 and 77

¹⁴⁷ See Section 4.2: Coherence, Page 77

¹⁴⁸ See Section 4.3: Effectiveness, Page 77

¹⁴⁹ See Section 4.3: Effectiveness, Page 77



7. Adolescent services are becoming well embedded but take-up of services is still quite uneven. More attention is needed to understand the reasons for differential use of services across facilities and on the service users to ensure that provision reflects user needs.¹⁵⁰
8. Given the importance of the private sector, particularly in the growing urban areas, UNICEF needs to engage more with this sector and facilitate a formation and endorsement of strategy for such engagement by 2022.¹⁵¹
9. Cost effectiveness and VfM assessments of the interventions should be included in the testing and piloting for scale up where and when possible.¹⁵²

¹⁵⁰ See Section 4.3: Effectiveness, Page 77, Section 4.6: Connectedness, Page 79 and Section 5.3: Monitoring and quality of care, Page 81

¹⁵¹ See Section 4.6: Connectedness and Section 5.4: Engagement with private sector, Page 81

¹⁵² See Section 4.5: Efficiency, Page 78 and Section 5.1: Evidence, Page 80

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