Monitoring & Evaluation Strategy and Action Plan

HEALTH, POPULATION, AND NUTRITION SECTOR DEVELOPMENT PROGRAM

December 2014

Program Management & Monitoring Unit, Planning Wing *
Ministry of Health and Family Welfare *
Goverment of the People's Republic of Bangladesh *

HEALTH, POPULATION AND NUTRITION SECTOR DEVELOPMENT PROGRAM (HPNSDP)

July 2011 - June 2016

MONITORING & EVALUATION (M&E) STRATEGY AND ACTION PLAN

PROGRAM MANAGEMENT & MONITORING UNIT (PMMU)
PLANNING WING
MINISTRY OF HEALTH AND FAMILY WELFARE
GOVERNMENT OF THE PEOPLE'S REPUBLIC OF BANGLADESH

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PREFACE

The Health, Population and Nutrition Sector Development Program (HPNSDP) is being implemented in Bangladesh since July 2011 with the strategic objective of improving access to and utilization of essential health, population and nutrition services, particularly by the poor. Based on the lessons learned from the previous HNP sector programs, HPNSDP focused on systems strengthening including monitoring and evaluation (M&E).

This Strategy for Bangladesh's HNP sector program, in particular to HPNSDP, has been prepared in response to recommendations from the 2012 and 2013 Annual Program Reviews (APRs) of HPNSDP that the Ministry of Health and Family Welfare (MOHFW) will develop an M&E Strategy to ensure that key MISs are able to operate complimentarily. It is intended to provide a strategic framework for the MOHFW to strengthen and streamline the M&E processes with institutional responsibilities towards a harmonized information system for the HNP sector.

The preparation and finalization of the M&E Strategy and Action Plan is a joint effort of the MESAP Technical Working Group, comprising different stakeholders and partners. Without their sincere efforts, support and cooperation the review and finalization process could not have been possible on time. The Planning Wing also recognizes the role of the MIS and Planning Units of DGHS and DGFP as well as that of the members of the Program Management and Monitoring Unit (PMMU) in preparing this Strategy and Action Plan. The support provided by the PMMU Technical Assistance Support Team (TAST) members (from MEASURE Evaluation and ICDDR,B) is duly appreciated.

I hope that the Report would be found relevant and useful by the Government, the Development Partners and other stakeholders working in Bangladesh's HNP sector.

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ABBREVIATIONS & ACRONYMS

ADP	Annual Development Program
AIDS	Acquired Immunodeficiency Syndrome
APIR	Annual Program Implementation Report
APR	Annual Program Review
BDHS	Bangladesh Demographic and Health Survey
BHFS	Bangladesh Health Facility Survey
BMMS	Bangladesh Maternal Mortality Survey
CC	Community Clinic
CDC	Communicable Disease Control
CHCP	Community Health Care Provider
CPR	Contraceptive Prevalence Rate
CSBA	Community Skilled Birth Attendant
DAAR	Disbursement for Accelerated Achievement of Results
DFID	UK Department for International Development
DGHS	Director General of Health Services
DGFP	Director General of Family Planning
ECNEC	Executive Committee of the National Economic Council
EmOC	Emergency Obstetric Care
EPI	Expanded Program of Immunization
FP	Family Planning
FWA	Family Welfare Assistant
FWV	Family Welfare Visitor
FY	Fiscal Year
GOB	Government of Bangladesh
HA	Health Assistant
HEF	Health Economics and Financing
HEU	Health Economics Unit
HIS & eH	Health Information System and E-Health
HIV	Human Immunodeficiency Virus
HNP	Health Nutrition and Population
HNPSP	Health Nutrition and Population Sector Program
HPSP	Health and Population Sector Program
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
ICT	Information and Communication Technology
IEDCR	Institute of Epidemiology and Disease Control Research
IMCI	Integrated Management of Childhood Illnesses
IMED	Implementation Monitoring and Evaluation Division
IRT	Independent Review Team
IST	In-Service Training
ITN	Insecticide treated nets
LCG	Local Consultative Group
LD	Line Director
LMIS	Logistical Management Information System
MCRAH	Maternal Child and Reproductive Health
MCWC	Maternal and Child Welfare Center
MDG	Millennium Development Goal
M&E	Monitoring & Evaluation
MIS	Management Information System
MMR	Maternal Mortality Ratio
MNCAH	Maternal Neonatal, Child and Adolescent Health
MOF	Ministry of Finance
MOHFW	Ministry of Health and Family Welfare
MOPA	Ministry of Public Administration
MTBF	Medium Term Budget Framework
NASP	National AIDS/STD Program
NGO	Non-Governmental Organization
NIPORT	National Institute of Population Research and Training
NIPSOM	National Institute of Preventive and Social Medicine
OP	Operational Plan
PAD	Project Appraisal Document
PBF	Performance Based Financing
PER	Public Expenditure Review
PIP	Program Implementation Plan
PME	Planning, Monitoring and Evaluation
PMR	Planning, Monitoring and Research
PW	Planning Wing
RFW	Results Framework
SACMO	Sub-Assistant Community Medical Officer
SBA	Skilled Birth Attendant
SWAp	Sector Wide Approach
SWPMM	Sector Wide Program Management and Monitoring
TRD	Training, Research and Development
UESD	Utilization of Essential Service Delivery
UHC	Upazila Health Complex
UH&FWC	Union Health and Family Welfare Center
UHFPO	Upazila Health & Family Planning Officer
UN	United Nations
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Simple, implementable monitoring and evaluation (M&E) plans that adhere to field practicalities and a set of accepted best practices are crucial to continually improve program performance. Particularly for sector-wide approaches in complex sector like health, nutrition and population (HNP), M&E processes can assist the public sector in evaluating its performance and identifying the factors which contribute to its service delivery outcomes.

From July 2011, the Ministry of Health and Family Welfare (MOHFW) has launched the Health, Population and Nutrition Sector Development Program (HPNSDP) for 2011-2016, which emphasized on strengthening overall health system and governance by establishing a sustainable M&E system as one of the key drivers. In response to recommendations from the 2012 and 2013 Annual Program Reviews (APRs) of HPNSDP that the Ministry of Health and Family Welfare (MOHFW) will develop an M&E Strategy to ensure that key MISs are able to operate complimentarily, this M&E Strategy and Action Plan (MESAP) has been developed. The main purposes of the MESAP are to (i) outline various roles and responsibilities regarding M&E with a view to tracking progress and demonstrating results, (ii) use it as a tool for monitoring progress both in physical and financial terms and (iii) use it as a communication tool for documenting the M&E mechanisms. Specifically, MESAP will allow the MOHFW to effectively assess the program performance and initiative specific steps and tools for strengthening M&E systems in the HNP sector. This elaborates an M&E framework for the ongoing HNP sector program that comprises a range of indicators at various levels to measure, monitor and evaluate both implementation and impact of HPNSDP – this framework is primarily based on the RFW approach, with the idea that achieving specific results at different levels would lead to desired health impact.

The development of MESAP has largely been informed by lessons from the Annual Program Reviews (APRs) of the current and the previous HNP sector programs in Bangladesh and assessments conducted by development partners (DPs) as well as technical agencies during the last few years. The technical approach and methodology followed for development of the MESAP was highly consultative and participatory in nature – a Technical Working Group (TWG) was responsible for overseeing its development, and it was finalized through stakeholder consultations involving MOHFW agencies, DPs, Civil Society, private sector and academia working in the HNP sector in Bangladesh.

The key strategic pillars of MESAP to help accelerate MOHFW's efforts in strengthening M&E system by addressing major limitations identified in Annex 6 are: 1) coordination and harmonization; 2) incentives for contribution to results; 3) standardized and streamlined data collection and reporting; 4) capacity building; and 5) resource allocation for M&E activities. Based on an overall situational assessment of the existing M&E mechanism and practices, the MESAP formulated two action plans outlining transitional adjustments required during HPNSDP and medium- to long-term activities to have an effective and sustainable M&E systems instituted in Bangladesh's HNP sector. In order to develop the activity package in the M&E Action Plan for HNP sector programs including HPNSDP, following key interventions were identified: a) strengthen M&E coordination within HNP sector program; b) carry out

performance reviews at regular intervals; c) enforce Data Quality Assurance mechanisms; and d) build capacity for M&E among MOHFW staff.

MESAP also includes a) Capacity Building Plan to facilitate and promote the development of monitoring and evaluation knowledge, skills and competence of MOHFW staff; b) Data Quality Plan to integrate periodic data quality assessment (DQA) using tools outlined in the Performance Monitoring Plan (PMP) of HPNSDP into ongoing activities; and c) Data Utilization Plan to ensure that generated data are being utilized for informed decision making within the MOHFW.

The Program Management and Monitoring Unit (PMMU) in close collaboration with Planning and MIS Units of the Directorates will take lead in capacity building, data quality assessment, and data utilization processes under the overall supervision of the Planning Wing. It is envisaged that timely implementation of action plan will help MOHFW and other stakeholders to institutionalize M&E mechanisms for strengthening the use of information at both national and sub-national levels.

CHAPTER 1. INTRODUCTION

The need to invest in well-functioning national health sector monitoring and evaluation (M&E) systems is widely acknowledged (Holvoet & Inberg 2013) in the context of sector-wide approaches (SWAp) and the considerable funding being put into the social sectors. An M&E system not only provides essential data for monitoring the services delivered, it also helps in guiding the planning, coordination, and implementation processes of a program and identifying areas for development, and thus improving the system as a whole.

Particularly for SWAps in complex sector like health, nutrition and population (HNP), the Government's major challenge is to become more effective in allocating and using resources. M&E processes can assist the public sector in evaluating its performance and identifying the factors which contribute to its service delivery outcomes. It provides an evidence base for resource allocation decisions and helps identify how challenges should be addressed and successes replicated (IEG 2012).

1.1 PURPOSE OF M&E STRATEGY

The main purposes of the M&E Strategy for the ongoing Health, Population and Nutrition Sector Development Program (HPNSDP) are to (i) outline various roles and responsibilities regarding M&E with a view to tracking progress and demonstrating results, (ii) use it as a tool for monitoring progress both in physical and financial terms and (iii) use it as a communication tool for documenting the M&E mechanisms. Specifically, an M&E Strategy will allow the Ministry of Health and Family Welfare (MOHFW), its implementing agencies and Development Partners (DP) to:

- assess more effectively how far the Program goals and objectives are being achieved;
- outline specific steps and tools for informed decision making;
- develop plans for data collection, analysis, use, and data quality;
- carry out oversight activities and program evaluation; and
- organize various M&E activities that must take place for tracking progress towards achieving results in a sustainable manner.

1.2 GOAL AND OBJECTIVES OF THE M&E STRATEGY

The M&E Strategy is aligned with one of the key drivers for HPNSDP (GOB 2011a). This duly acknowledges the necessity of developing a functional and robust M&E system for HPNSDP to provide useful and timely information to policymakers and program managers. The policymakers and managers track performance of the Program to ensure achievements of results through necessary course corrections during its implementation.

1.2.1 Goal

The goal is to establish a sustainable M&E system for tracking progress and demonstrating results of the Program and to ensure evidence-based decision making.

1.2.2 Specific objectives

The specific objectives of the M&E Strategy are to:

1) Improve the quality and capacity of the routine data collection systems, e.g., development of registries, routine data collection forms, type and frequency of reports, etc;
2) Outline specific activities required for strengthening the organizational capacity to conduct effective M&E
3) Ensure greater utilization of routine data sources; and
4) Strengthen the monitoring culture within MOHFW and its Directorates by promoting the use of locally generated health information.

1.2.3 Key outputs

The expected key outputs of the M&E Strategy are:

1) Prepare an M&E Action Plan for short- and medium-term
2) A functional robust, comprehensive, and well-coordinated M&E system for HPNSDP in place;
3) Regular updates on performance indicators available;
4) Implementation progress reports are produced on time;
5) Data sources outside the routine HIS, viz. periodic surveys (see Annex 3) are aligned to facilitate the end-line review and assess Program's impact.

1.2.4 Outcomes

The M&E Strategy is expected to result in:

1) Promoting the practice of evidence-based decision making, policy development and advocacy;
2) Reporting in time to MOHFW, DPs and other International Partners;
3) Objective decision making for performance improvement; planning and resource allocation; and
4) Promoting accountability of the MOHFW.

1.3 PROCESS OF DEVELOPING M&E STRATEGY

Involvement and ownership of MOHFW and other stakeholders in planning and implementation of HPNSDP were instrumental in developing an M&E Strategy. The Project Appraisal Document (PAD) by the World Bank for HPNSDP stated that an M&E Strategy and work plan for HPNSDP would be developed based on a comprehensive capacity assessment of the system at all levels (WB 2011). In order to meet both the requirements, following steps have been carried out in developing the M&E Strategy:

Desk review and production of draft strategy. The Program Management and Monitoring Unit (PMMU) Technical Assistance Support Team (TAST) conducted a rigorous desk review on published reports and gray literatures to produce a draft of the strategy and action plan.

Lessons learned from best practices in M&E in other countries, and project progress and technical reports from multiple government, non-government organizations and development partners working in the health sector in Bangladesh were also reviewed to produce the draft. The list of documents reviewed is provided in Annex 2.

Formation of Technical Working Group for review and revise draft strategy. The Planning Wing of MOHFW formed a Technical Working Group (TWG) comprising MOHFW officials; Line Directors (LDs) of relevant HPNSDP Operational Plans (OPs); and representatives from DPs, national/ international research organizations, and academia to review and revise the draft and develop a "near final" draft of the Strategy along with the Action Plan for wider consultation. The composition of TWG is provided in Annex 1.

Stakeholder consultation. The members of TWG and PMMU TAST conducted a series of consultative discussions/meetings with different stakeholders during the development phase of the M&E Strategy. Relevant feedback from the consultations was incorporated in the process of finalizing the draft.

Dissemination and Finalization. The final draft was disseminated on XX XXX 2014 and the final version of the M&E Strategy and Action Plan was presented in the M&E Task Group meeting on XX XXX 2014 for the final review and forward for approval by the MOHFW. Upon approval, the Strategy and Action Plan has been put in place.

1.4 ORGANIZATION OF THE REPORT

This document is organized to focus on major strategic issues in relation to M&E and outlining time-bound plans for implementing strategic actions on the basis of a rigorous review of the existing M&E frameworks in the HNP sector program in Bangladesh.

In this document, Chapter 1 describes the objectives of the M&E Strategy and outlines the process followed to develop the M&E Strategy and Action Plan. In Chapter 2, the M&E framework for HNP sector program in Bangladesh is presented. Chapter 3 presents the major strategic issues to strengthen the M&E activities in HPNSDP and the future sector programs. In line with the key M&E strategic issues for HPNSDP, key interventions under the M&E Strategy have been outlined in short- and medium-term Action Plans in Chapter 4. Chapter 4 also outlines plans for capacity building, data quality assurance and data utilization plans for HNP sector programs in Bangladesh.

The Annexures of the M&E Strategy and Action Plan lists the documents consulted for preparing the M&E Strategy (Annex 2), description of the existing M&E mechanisms in HNP sector programs (Annex 5) and its assessment (Annex 6), and HNP sector monitoring by other Government agencies outside the MOHFW (Annex 8).

CHAPTER 2. M&E FRAMEWORK FOR HNP SECTOR PROGRAM

This chapter discusses the overall M&E framework of the current sector HNP sector program, including M&E tools, data sources and dissemination arrangement. A detailed assessment of existing M&E arrangement in HNP SWAp is provided in Annex 6.

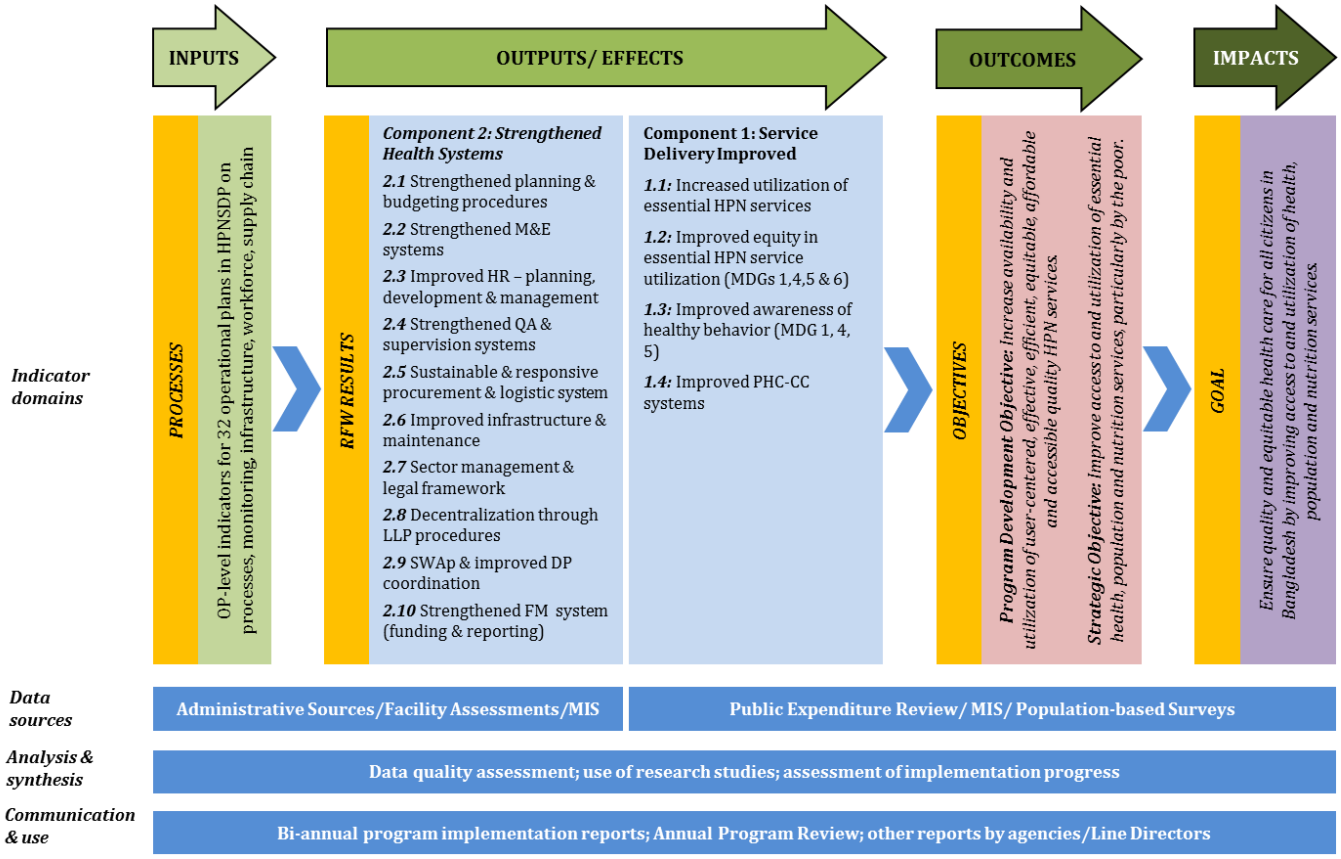
2.1 M&E FRAMEWORK FOR HPNSDP

In response to GOB's focus on results-based M&E, the Strategic Plan for HPNSDP (GOB 2011) noted that the existing MIS functions along with M&E mechanism in HNP SWAp were inadequate to reap the benefit of the support systems in the HNP sector. For this reason, the Strategic Plan puts "*Strengthening overall health system and governance include establishing a sustainable Monitoring and Evaluation System along with Health Information System (HIS)*" as one of the seven key drivers of HPNSDP (GOB 2011).

The follow up action on this 'driver' was to establish and institutionalize PMMU in the Planning Wing of MOHFW under the direct responsibility of the Joint Chief (Planning) to provide professional and sustainable support to the Ministry, to monitor progress of HPNSDP and to strengthen the monitoring capacities within MOHFW and the Directorates to efficiently use the routine data systems for decision making. An M&E Task Group headed by the Additional Secretary, MOHFW has also been established to review and guide the M&E functions in the MOHFW. A detailed description of M&E mechanisms during the previous and current HNP SWAps is provided in Annex 7.

As per the Strategic Plan and PIP, HPNSDP introduced Results Framework (RFW) at program as well as at individual OP levels to strengthen the monitoring culture within the MOHFW. The M&E Strategy for HPNSDP 2011-16 elaborates an M&E framework for the ongoing health SWAp in Bangladesh that comprises a range of indicators at various levels to measure, monitor and evaluate both implementation and impact of HPNSDP. The M&E Framework also lists the data sources, regularity of updating the indicators, and analysis and reporting of results. The M&E Framework is primarily based on the RFW approach, with the idea that achieving specific results at different levels would lead to desired health impact. Figure 1 tries to capture the logical sequence between inputs, outputs, outcome and impact using RFW results as the core output, complemented by identification of data sources and involving interactive use of data through analysis/synthesis and its role as an effective channel of communication.

Figure 1: M&E Framework for HPNSDP 2011-2016[1]



2.2 M&E TOOLS FOR HPNSDP

The tools to carry out M&E activities under the HPNSDP that document and track outputs and indicators consist of:

- Annual Development Program (ADP) Review by MOHFW on a monthly basis
- Annual Program Review (APR) jointly by MOHFW and DPs
- Results Framework and OP-level indicators update by Planning Wing
- DAAR and APR PAP Implementation Reviews by Planning Wing
- Periodic OP Review by OP Implementation Committee (OPIC)
- Quarterly National ADP Review by National Economic Council (NEC)
- End-line Evaluation by Implementation Monitoring and Evaluation Division (IMED)
- Implementation Completion Report (ICR) by the World Bank
- Periodic nationally representative sample surveys.

Annual Development Program (ADP) Review. The public sector development projects along with budgets in Bangladesh are included in the government's Annual Development Program (ADP). MOHFW conducts a monthly review meeting on financial progress along with physical progress and critical implementation issues of the OPs under HPNSDP and other development

[1] Adapted from: WHO/GAVI/GF/WB (2010).

projects in MOHFW. Since 2011, the financial information like fund allocation, fund release and spending rate are posted online by using a web-based platform developed by MIS/DGHS. The ADP review meetings take place every month and are usually chaired by the Secretary of MOHFW, with provision of chairmanship by the Honorable Minister for MOHFW on a quarterly basis.

Annual Program Review (APR). APR is a management instrument designed for both the GOB and DPs to monitor progress in the implementation of the Program and to verify that management and policy responsibilities are met in the health sector program. The overall objectives of the APR are to a) review implementation of SWAp in the light of RFW and OP-level indicators as provided in the Six-monthly Progress Report and APIR by PMMU; b) assess progress of the Program during the financial year (including the prioritized actions from the previous APR, disbursement for accelerated achievement of results [DAAR] indicators); c) review the financing arrangements and assess how well the GOB and DP support meets the priorities and requirements of the HNP sector; and d) undertake analysis in selected thematic areas to identify issues/challenges concerning effective delivery of services and recommend ways to improve progress. The APR Steering Committee consisting of GOB and DP representatives has primary responsibility for the oversight of overall process, and is chaired by Government (Joint Chief, Planning Wing, MOHFW). The main APR deliverables include thematic reports by the Independent Review Team (IRT) for the APR, a Priority Action Plan (PAP) to reflect major recommendations of the IRT, and an APR aide-memoire agreed between Government and DPs.

Results Framework (RFW). Based on the lessons learned from the previous SWAps, a robust RFW comprising 8 goal level- and 33 intermediate outcome-level indicators was developed for HPNSDP in order to monitor the physical progress and program impacts. The RFW was developed following a detailed process and involved a wide range of stakeholders including GOB, DPs and technical agencies. A Performance Monitoring Plan (PMP) has been developed to guide the collection of specific information for the RFW indicators and to assess Program progress for decision making. The PMP elaborates on MOHFW's commitments to assess program performance by monitoring the status of results indicators and provides detailed information and a calendar to explain when and how performance data will be collected and analyzed. It also includes indicator reference sheet for all RFW indicators and the revised OP-level indicators along with baseline values and targets for HPNSDP. The RFW indicators are to be revisited during MTR for updating in the light of learnt lessons.

Operational Plan-level Indicators. HPNSDP developed OP-level indicators for the first time in the history of HNP SWAp in Bangladesh, in addition to the RFW indicators for monitoring progress of program implementation at OP-level. Each of the 32 OPs in HPNSDP has separate indicator list reflecting OP activities. The 2012 APR had recommended a revision of OP-level indicators and PMMU already revised the OP indicators, which was finalized and approved in October 2013. The OP-indicator revision brought down the number of OP-level indicators to 158 from 342 in the original list, and aligned OP-indicators towards OP priorities and implementation processes.

DAAR Indicators. Building on the experience from previous SWAps, HPNSDP adopted a revised Performance-Based Financing (PBF) modality using a Disbursement for Accelerated

Achievement of Results (DAAR) approach. Under this modality, MOHFW is eligible to use a greater share of the total IDA credit from the World Bank each year to finance eligible expenditure to cover HPNSDP activities (effectively drawing down funds programmed for year five, which is US$ 71.78 million) upon attainment of agreed upon targets. For partially met DAAR targets, the additional allocation is disbursed on a pro-rata basis. The intent of DAAR approach is to leverage changes that are deemed to contribute to the HPNSDP objectives.

APR PAP Implementation Review. In response to the IRT recommendations, a detailed action plan is developed by the Planning Wing in consultation and agreement with the program implementers and DPs. The APR Prioritized Action Plan (PAP) is finalized in the APR's Policy Dialogue attended by a wide range of stakeholders and recommendations as well as agreed upon PAP (during the policy dialogue) are summarized in the APR Aide Memoire. The implementation of PAP items is closely monitored through periodic task group meetings and reported to the LCG Working Group for Health.

National ADP Review (by NEC). The national ADP is also reviewed on a quarterly basis by the National Economic Council (NEC) headed by the Honorable Prime Minister. As per the requirements of the NEC, the Implementation, Monitoring and Evaluation Division (IMED) of the Ministry of Planning is responsible to prepare working paper for the NEC meeting taking inputs from the line ministries (e.g. monthly and quarterly reports sent by each Ministry on IMED-mandated formats). The national level ADP review compares fund utilization of a Ministry with the national utilization rate, which forms a basis on the part of Ministry of Finance to allocate more or less fund in the revised ADP.

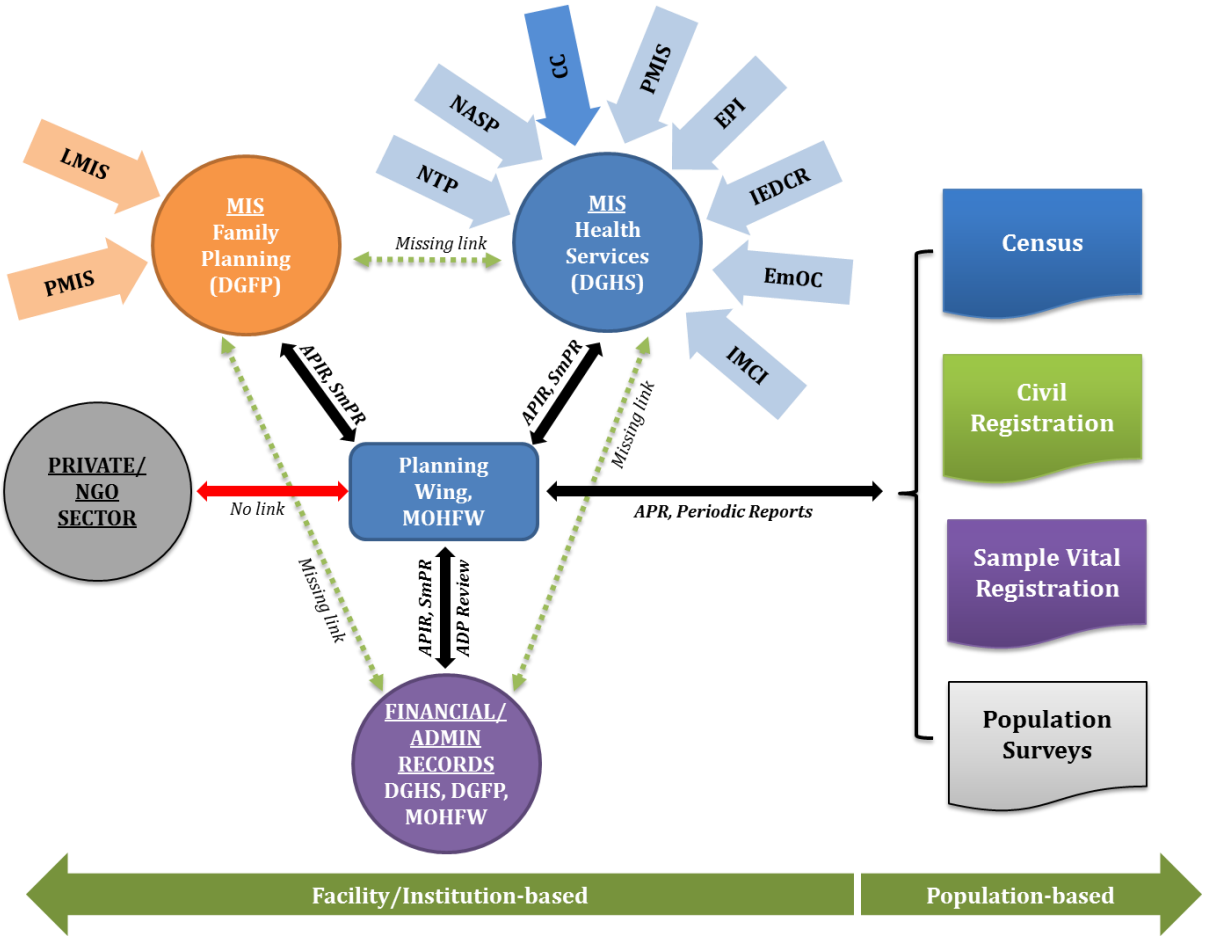
End-line Evaluation (by IMED). During the previous HNP SWAps, the Implementation Monitoring and Evaluation Division (IMED), Ministry of Planning, carried out end-line evaluations after completion of each Program. The objectives of end-line evaluations were to identify the successes and failures of SWAp operation and provide recommendations for future sector program. The end-line evaluation of HNP SWAp looks into the implementation status of major OPs, fiduciary arrangements, improvement in health indicators, equitable access to health services, and clients and service providers' feedback on SWAp implementation. Both qualitative and quantitative approaches are adopted to collect information for the end-line evaluation through review of huge number of documents and policy papers, consultative meetings with stakeholders at national and field level, group discussions/interview of clients and service providers, and direct observation of service provision at selected health facilities.

Implementation Completion Report (by the World Bank). The World Bank prepares an Implementation Completion Report (ICR) for each lending operation it finances. It is prepared at the time of project completion and assesses (a) the degree to which the project achieved its development objective and outputs as set out in the Project Appraisal Document (PAD); (b) other significant outcomes and impacts; (c) prospects for the project's sustainability; and (d) Bank and borrower performance, including compliance with relevant Bank safeguard and business policies. It also provides the data and analysis to substantiate these assessments, and identifies the lessons learned from implementation. The borrower's (government's) own evaluation report (e.g. end-line evaluation by IMED) on the project's execution and comments of co-financiers and other stakeholders (as appropriate) feed into the Bank's ICR. Later, a separate evaluation on ICR is done by the World Bank's Independent Evaluation Group (IEG).

2.3 SOURCES OF DATA FOR HPNSDP MONITORING

Sources of HNP data in Bangladesh are guided by different information needs, particularly of the Government, DPs, NGOs and private sector. Data needs of the HNP SWAp are based on agreed performance indicators (RFW, OP-level, and specific program-based) to facilitate monitoring, evaluation, reporting and decision-making. There exist multiple data generation systems in MOHFW with little or no linkage between them (see Figure 2). Moreover, beyond specific programs involving public-private partnership (e.g. National Tuberculosis Program), information from private and NGO organizations is not accessed/utilized by the public sector for monitoring the sector program. The major sources used for HNP SWAp are provided below.

Figure 2: Multiplicity of M&E Data Sources in HNP Sector[2]



Service statistics. Data on service contacts at the facility are collected by all public health and family planning service delivery facilities, from CCs to tertiary-level hospitals. In addition, routine data is generated from different programs of DGHS and DGFP on specific activities (immunization, IMCI, etc.). The routine data collection processes follow established data collection methods and tools by MISs of DGHS and DGFP, and are aggregated at upazila, district

[2] Adapted from: HMN (2009); p.18 & 23

and national levels. Apart from service contacts, NIPORT conducts Bangladesh Health Facility Survey to assess the capacity and service provision of health facilities.

The MIS units of DGHS and DGFP use structured tools for collecting information on service contacts, both at the facility and at the field. Data collected during health and family planning service delivery are critical for tracking performance and trend analysis, and hence form an important source of data for measuring progress of the program implementation. The data collection formats used under MISs have the following categories of information: data on service provided to clients, information on curative services at the facility, resource management e.g. inventories (staff list, health facility, equipment), logistics and commodities, finance/user fees and supervision visits. Web-based in-patient reporting systems are currently being piloted in a number of health facilities, which has the potentiality to be scaled up in the coming months. In MIS/DGHS, a Geographical Reconnaissance (GR) is implemented by DGHS fieldworkers visiting every household and filling up a machine-readable questionnaire.

Administrative records. Administrative data on health inventories, supervision, management meetings, logistics management, human and financial resources, and trainings, among others, are aggregated at OP levels. From 2012, availability of drugs, equipment and HR in government health facilities are routinely reported through Local Health Bulletin of MIS/DGHS.

Ministries, government departments/ agencies, and service providers maintain administrative records, including budget allocation and spending figures, which serve as a major source of program monitoring. This also includes information on expansion of critical program/services (e.g. Local-level Planning, Demand side financing), financial management (FM) reports, human resources status, etc. Administrative records provide updates on a number of RFW indicators and a large proportion of OP-level indicators. In the absence of a formal, integrated Human Resource Information System (HRIS) at MOHFW, both the Directorates house Personnel Management Information System (PMIS), which is used for collecting, processing, managing and disseminating data and information on human resource for health (HRH).

Both the Health and Family Planning Directorates have established LMIS/Supply Chain Management System (SCMS) to strengthen the information systems for medicines, contraceptives, and other health supplies. This system aims to allow agencies to conduct web based ordering; as the agencies should find it convenient to disseminate information about ordering, prices and available quantities through the web to the facilities.

Population-based surveys. Household-level, population-based sample surveys are routinely carried out by National Institute of Population Research and Training (NIPORT) and other government/non-government institutions including the DPs. Research institutions and academia that carry out health systems research, clinical trials and longitudinal studies also provide data for use by the sector program. Major nationally representative sample surveys include the following:

- National Health Accounts by Health Economics Unit
- Bangladesh Demographic and Health Survey by NIPORT and USAID
- Utilization of Essential Service Delivery Survey by NIPORT
- Bangladesh Maternal Mortality Survey by NIPORT and USAID
- Bangladesh Health Facility Survey by NIPORT and WB/USAID
- Multiple Indicator Cluster Survey by BBS and UNICEF

- Coverage Evaluation Survey (CES) by DGHS and WHO/UNICEF
- Food Security and Nutritional Surveillance Project by BRAC University
- Routine Surveillance (Disease Profile) by IEDCR
- Bangladesh HIV Sero-Surveillance by NASP
- Geographical Reconnaissance by MIS/DGHS.

Civil registration and sample vital registration system (SVRS). The Birth and Death Registration Act 1873 was repealed and a new act was adopted in 2004 and implemented in 2006 requiring a birth certificate as a proof of age for services that directly affect children, including school enrolment, marriage registration and transfer of property, as well as to access other services (GOB 2007). Civil registration records, particularly the birth registration, are integrated into MOHFW's immunization program (UNICEF 2010). Through the Sample Vital Registration System (SVRS), Bangladesh Bureau of Statistics (BBS) under the Statistics Division of Ministry of Planning conducts surveys to estimate the determinants of annual population change and provide national and regional data on births and deaths, including the causes of death and expectation of life. Its coverage is about 1000 primary sampling units (PSUs) each comprising about 250 compact households. The surveys are conducted throughout the year and dissemination is done in every 2-3 years (WHO SEARO 2007).

Population and Household Census. A decennial National Census is carried out by BBS, which serves as the primary source on size of the population and its geographic distribution. Annual population figures along with their age structure at national and sub-national levels are used by different MOHFW agencies.

Survey questionnaire/schedules are designed and employed on regular intervals to collect data from beneficiaries/stakeholders in a structured manner. All the national-level surveys commissioned by NIPORT are overseen by a Technical Review Committee (TRC) comprising MOHFW officials, notable researchers and academicians, and representatives from funders/DPs, who will make sure the quality and appropriateness of the survey tools used. Surveys often collect qualitative data for in-depth understanding on care-seeking behavior.

2.4 DISSEMINATION OF HPNSDP MONITORING DATA

Data generated from different sources are translated into information that is relevant for utilization at different levels of decision-making. Progress in HNP sector is also monitored by different GOB and DP entities outside MOHFW, which is described in Annex 8. The major modalities of data dissemination are described below.

Electronic Reporting: Both the MISs from DGHS and DGFP make MIS data available electronically. Aggregated, selected health indicators (including GIS maps for selected services) are available from MIS/DGHS at www.dghs.gov.bd/index.php/en/data. Information on service statistics, HR and equipment status of all public hospitals and health facilities in Bangladesh (around 550 in number) as reported in Local Health Bulletin are also available in this link. MIS/DGFP reports detailed, monthly RH/FP/MCH service statistics by geographic locations at www.dgfpmis.org/ss/menuss.php.

Monthly/Bi-annual MIS Reports: MIS/DGHS publishes EmOC and IMCI newsletters bi-annually with assistance from UNICEF. The contents of EmOC Newsletter includes data, analysis and reports on pregnancy and emergency obstetric care services, pregnancy complications, type of deliveries, number of child births, number of child and maternal deaths, etc. The IMCI Newsletter publishes service statistics, analysis and reports on child health services from national, regional, district and sub-district level public/NGO hospitals (including CCs) designated as IMCI hospitals. Apart from online reporting, MIS/DGFP publishes monthly RH/FP/MCH service statistics.

Annual MIS Reports: The most accessed and utilized sources of routine HNP information are the Annual Reports published by MISs of DGHS and DGFP. The annual report of DGHS, titled Health Bulletin, provides Bangladesh's current health situation enriched with data, statistics and reports on health programs and performances of organizations under DGHS. The Annual Report published by MIS/DGFP provides service statistics information/data received from field workers, service delivery point's clinics and NGOs to help program implementers to plan, formulate, monitor and evaluate FP program performance. To supplement annual MIS reports, EPI under DGHS has been conducting nationwide Coverage Evaluation Survey (CES) every year since 1991 to assess the routine childhood vaccination coverage, TT vaccination coverage among women with children 0-11 months, oral polio vaccine (OPV), Vitamin A and Albendazole (de-worming) coverage during the National Immunization Day (NID), TT vaccination coverage among the women of 18-49 years age and immunization program quantity coverage (valid and crude).

Survey Reports: Survey reports in the health sector are the most commonly disseminated and utilized tools in monitoring progress in Bangladesh's HNP sector. Major surveys (mentioned under the Section 2.3) are conducted in regular intervals to provide update on a number of impact- and outcome-level indicators and used as a basis to confirm the occurrence of change. In order to inform the HNP sector program, a number of institution conducts HNP-related surveys including public and private institutions e.g. NIPORT, BBS, icddr,b, etc. Most of the leading surveys like BDHS are disseminated centrally and regionally, and results in policy note to highlight specific findings requiring policy attention.

Six-monthly Progress Report (SmPR): PMMU produced the first HPNSDP Six-monthly Progress Report (SmPR) for July–December 2012, the first ever such 6-monthly reporting in HNP SWAp in Bangladesh. The Report presented – in addition to information on financial utilization, progress in achieving OP indicators and the status of training, etc. – probing analyses of the reasons for slower utilization of funds during the first half of the FY and highlighted specific actions needed for improving service delivery and for strengthening systems. It also drew attention to some less attended issues mainly surrounding reform initiatives and problems of sectoral management. The 2nd SmPR for July–December 2013 was published in April, 2014.

Annual Program Implementation Report (APIR): The APIR is useful in highlighting areas of progress and challenges in implementing the HPNSDP. The report assesses progress on the annual work plans and an overall assessment of sector performance against the targets set in the HPNSDP. All 32 OPs under HPNSDP are requested to provide their reports to PMMU under the Planning Wing of MOHFW by the end of July/early August every year for compilation, and use them for performance review. The APIR brings together all data from different sources, including the facility reporting system, household surveys, administrative data (minutes,

supervision reports, financial reports, SCM reports, HRIS reports, etc) and research studies, to answer the key questions on progress and performance using the HPSNDP RFW and OP-level indicators and health goals . The APIR presents a detailed account of annual performance against the core and programmatic indicators of the sector strategic plan, comparing current results with results of previous years, and formulate challenges and recommendations by cluster and program. The APIR provides the background and in-depth information to feed into the APR every year.

Quarterly IMED Report. The Implementation Monitoring and Evaluation Division (IMED) under the Ministry of Planning monitors more than 1,200 projects under the ADP and evaluates around 200 projects on an annual basis (IMF 2013). It routinely collects data on project inputs, outputs, outcomes and impact according to their monitoring framework and produce analytical reports (i.e. reports explaining progress or lack of progress) to NEC/ECNEC and project portfolio performance reports to the ministries. Particularly the quarterly financial progress reports for projects and programs like HPNSDP list both the financial and physical progresses under each of the program components. The IMED quarterly report also collects information on implementation problems and suggested measures taken during the reporting period.

CHAPTER 3. STRATEGY TO GUIDE M&E PROCESSES IN THE HNP SECTOR PROGRAM

This chapter reports on priority strategic issues and actions considered under the M&E Strategy for HPNSDP. The details of MOHFW's M&E mechanism and assessment of the mechanism may be seen at Annex 7 and Annex 6 respectively.

3.1 STRATEGIC ISSUES AND ACTIONS FOR STRENGTHENING M&E IN HPNSDP

Focus on five major strategic issues have been given here primarily to help accelerate MOHFW's efforts in strengthening M&E system by addressing major limitations identified in Annex 6. The strategic issues are: 1) coordination and harmonization; 2) incentives for contribution to results; 3) standardized and streamlined data collection and reporting; 4) capacity building; and 5) resource allocation for M&E activities. Following sub-sections elaborate the major activities under each strategic pillar of this M&E Strategy. Table 2 below summarizes key strategic issues, challenges and possible actions on M&E under the HPNSDP.

Table 2: Summary of Key Strategic Issues, Challenges and Possible Actions on M&E under HPNSDP

Overall M&E Task	**Monitor and provide feedback on implementation progress of HPNSDP**				
Strategic M&E Issues	***1. Coordination and harmonization***	***2. Incentives for contribution to results***	***3. Standardized data collection and reporting***	***4. Capacity building***	***5. Resource allocation for M&E***
Available positive elements in MOHFW	- Functional MIS Units in DGHS and DGFP - Functional METG as nexus of M&E activities in HNP SWAp - Functional PMMU to carry out critical monitoring and coordination activities - Data warehouse exists	- Monthly ADP monitoring meeting conducted - GOB-wise focus on results-based M&E as outlined in 6th FYP - Existing modality on performance based financing (PBF) - Annual program review jointly by GOB and DPs to assess program performance	- Standard data collection forms/ templates are used for APIR/ and SmPR - Existing results framework is robust and owned by MOHFW and implementing agencies - Both MISs are heavily investing in computerization - Strengthening RHIS pilot showed success in streamlining data collection tools	- Favorable GOB policy for both pre- and in-service training - Training and workshops are integral part of the SWAp and considerable effort is given to improve HR capacity through trainings (local and foreign); - Availability of local researchers, local academic and training institutes to build GOB capacity.	- Budget available in 5 OPs - DPs willing to provide both financial and TA support for M&E activities

Strategic M&E Issues	*1. Coordination and harmonization*	*2. Incentives for contribution to results*	*3. Standardized data collection and reporting*	*4. Capacity building*	*5. Resource allocation for M&E*
Remaining Challenges	- MIS systems remain splintered and use of different platforms for service as well as HR information - Harmonization between MISs of DGHS and DGFP - Stages of computerization in the MISs are not coordinated - Data warehouse remains largely unutilized - Planning Units in DGHS and DGFP are not actively involved in M&E	- Insufficient staff and logistics for monitoring and supervision activities - Limited use made of MIS for implementation monitoring outside PBF - MIS data from private sector including NGOs not received as a practice	- Data collection, supervision and reporting by the Directorates remain separate, from central to community level - Data Quality assessment (also validity and reliability) not conducted	- Absence of posts in MIS at different levels for data management and system engineers - Vacancy in statistician and data entry positions - Insufficient training in the area of MIS and data collection for statisticians and other staff involved with data entry, management and reporting -	- Limited funding for M&E activities available through no arrangement for separate budget for M&E set-up and permanent HR - Inadequate operational budget for M&E activities - Weak M&E role by Planning and monitoring Units within the Directorates
Possible actions to address the challenges	- Planning Wing of MOHFW to continue as the logical champion of bringing alignment, coherence and synergy to results management and M&E activities in the HNP SWAp - Build towards functional integration of information systems - Improve the role of Planning and monitoring Units in DGHS and DGFP in M&E activities	- Monitoring and Supervision Systems need to be made functional for regular performance appraisal including capacity development of the managers and program personnel. - Recognition of and reward for best managers and staff	- To sustain massive computerization, both the MISs will require organizational strengthening (particularly on maintenance of procured hardware and system engineering) - Conduct regular meetings at different levels and exchange of data between MISs - An effective routine DQA system in place	- All MISs need to develop multi-year, comprehensive training plans for field staff with adequate budget - Provide training (first time & refresher) to staff at health facilities involved in feeding data into MIS systems (e.g. data entering in DHIS platform, use of tablets/laptops, etc.)	- Total budgetary requirement along with permanent HR needs to be worked out - the proposal has to be sent to MOF and MOPA for approval. - Budget to be made available through MTBF - A permanent M&E structure comprising full-time GOB staff needs to be in place by mid-2016 for the sustenance of improved M&E system in MOHFW

3.1.1 Coordination and harmonization

The most obvious characteristic in relation to M&E in MOHFW is the bifurcation of MIS functions among different Directorates, which calls for better coordination and harmonization. Substantial savings can be achieved from streamlining and rationalizing M&E requirements and activities that currently differ in terms of criteria, format and periodicity between the Directorates and programs. In particular, it will be important that there is congruence and synergy in the data collection formats and guidelines that are currently being used by the Line Directorates and projects/programs. The development of a common terminology, reporting periodicity, and interoperable MIS platform for both the MISs would be a practical point of departure for better coordination and harmonization.

In conjunction with an increasing emphasis on results and M&E, experience in other countries suggests the value of having a designated agency within MOHFW, and a senior official within it, as an anchor for coordination, advocacy and capacity-building. With its central role in the planning and development budget processes, the Planning Wing of MOHFW appears as the logical champion of M&E in HNP sector program. With support from PMMU, PW will take the leading role to coordinate with the MISs and facilitate reform processes to improve harmonization. In addition, PW/PMMU will also enable M&ETG to carry out its broad oversight responsibility that includes coordination of external or independent evaluations by different agencies, particularly by the DPs.

Strategies to review, monitor and evaluate implementation of HPNSDP and impact thereof are described in Table 3 below.

Table 3: HPNSDP Monitoring and Review Process

Activity	Frequency	Output	Focus	Level of monitoring and review
ADP progress review	Monthly	- Online report on financial progress including fund allocation, fund release and spending rate - Meeting minutes issued	Done internally by Planning Wing and LDs to review and discuss on financial progress along with major physical progress and critical implementation issues faced by the OPs of HPNSDP	- Primarily inputs and process - Meeting held under the chairmanship of the Honorable Minister/ Secretary of MOHFW in the presence of Agency Heads and Wing Chiefs under MOHFW
Annual Program Review (APR)	Annually	- Annual progress reports by Independent Review Team (IRT), resulting agreed-upon priority action plan (PAP) for follow up - RFW and OP-level indicators updated - APR report published	Done Jointly by DPs and MOHFW to review progress against set targets and outcomes, and highlight areas for improvement	Input, process, output, and outcome levels
OP Implementation Committee (OPIC)/Project Steering Committee	Six-monthly/ as needed	Report/ meeting minutes	OP-specific review of progress take necessary measures to ensure smooth program implementation	Meeting held under the chairmanship of the Joint Chief (Planning) of MOHFW
National ADP Review by National Economic Council (NEC)	Quarterly	Progress report prepared and presented to National Economic Council (NEC)	Primarily focused on financial progress along with physical progress (weighted average) of projects and programs within MOHFW	NEC meetings are held under the chairmanship of Honorable Prime Minister

Activity	Frequency	Output	Focus	Level of monitoring and review
Performance assessment	Six monthly	- Report prepared outlining progress in financial, physical and training activities - Issues for systemic change are highlighted - DAAR implementation progress updated - APIR and SmPR reports published	Done by Planning Wing to review of progress against targets and planned activities.	Inputs, process, outputs
Mid Term Review (MTR)	After halfway of the program	- Midterm review report followed by revised Operational Plans - MTR report and revised Program Implementation Plan (RPIP) produced	Done Jointly by DPs and MOHFW to assess program achievements/ shortfalls including systemic issues and revise program structure, indicators (and budget envelope) as needed	Input, process, output, outcome and impact levels
End Term Evaluation/ Impact Evaluation	After completion of the program	- End Term Evaluation report by IMED - Project Completion Report (PCR) by IMED - Implementation Completion Report (ICR) by the World Bank	- Independent evaluations conducted separately by Ministry of Planning (IMED) and DPs (e.g. WB) - Progress against planned targets and impact thereof are assessed	Input, output, outcome and impact levels

HPNSDP Steering Committee has the mandate to oversee SWAp implementation and review M&E reports as necessary. Institutionalization of PMMU would be critical for Planning Wing to effectively carry out role of monitoring and review of activities through a mainstreamed specialized set-up and full-time HR. Availability of human resources and technical capacity in the Planning Units and MIS Units within the Directorates will need to be ensured, and a multi-year, comprehensive plan need to be developed to guide training of field staff and proper utilization of procured hardware to contribute towards the monitoring goal of MOHFW.

3.1.2 Incentives for contribution to results

M&E can flourish where there is a policy- and management-level demand for what is produced through M&E; where its practice follows as a consequence of the incentives embedded in public service systems; where rewards and sanctions are guided by achievement of results; and where managers and implementers collectively perceive a self-interest in adopting tools for continuous assessment and learning. The M&E may not be robust and sustained unless the above mentioned statements click together.

The best way of ascertaining that managers are motivated to achieve results is the alignment of incentives to those results. In ADP monitoring and budget discussions in MOHFW, performance

is determined more in terms of money spent or "absorptive capacity" of the OPs than achievement of indicators, physical progress or contributions to improving HNP status of the citizens.

To strengthen the attention of MOHFW on HNP outcomes, the definition of goals, performance and implementation success needs to be broadened from an emphasis on processes and outputs to encompass achievements in contributing to outcomes. An immediate step would be to broaden the focus of monthly ADP review meetings to include physical progress along with financial progress.

Strengthened central coordination is needed for setting standards for output oriented budgeting, while the performance assessment of the LDs and core OP staff should include both spending rate by the OP and implementation progress as measured by OP-level indicators. During the Monthly ADP Review Meeting at MOHFW, physical progress as per the Annual Work Plan (AWP) and critical implementation issues for specific OPs could be given attention along with financial performance while reviewing implementation progress.

The performance based financing (PBF) modality of HPNSDP, e.g. Disbursement for the Accelerated Achievement of Results (DAAR), may continue to focus on critical M&E issues to strengthen the monitoring process.

3.1.3 Standardized and streamlined data collection and reporting

The major focus to strengthen M&E activities under HPNSDP will be on bringing alignment, coherence and synergy to data collection and reporting formats, including guidelines and work planning instruments, between the MIS/DGHS and MIS/DGFP. The mandate of current efforts to define a streamlined format for monitoring program implementation will be expanded in the shortest possible time to encompass all the health and family planning service facilities and their staff. The results of the Strengthening RHIS pilot will be disseminated to MOHFW and other stakeholders to ensure that necessary resources are available for its nationwide scale up in a phased approach. The MIS/DGHS currently houses a central database of routine MISs, which will serve as a repository for all service delivery data and information at national level.

Whilst the quality and reliability management of survey data are already established, PMMU will work with the MISs to review routine health information systems periodically using standard techniques in collaboration with other technical agencies. All the reports submitted to PMMU for producing APIR need to be reviewed for accuracy and clarification may be sought where necessary. The Performance Monitoring Plan (PMP) of HPNSDP includes the Indicator Reference Sheets (IRS) for all RFW and OP-level indicators with a section on data quality issues including dates of quality assessment and known data limitations. The PMP also provides data quality assessment tools (including a checklist) to be followed at regular intervals.

Data quality assurance processes will include periodic Data Quality Audits (DQA) of recorded data by supervisors; regular training of staff, and provision of routine feedback to staff at all levels on completeness, reliability and validity of data; and dissemination of results at different levels (national, divisional). DQA will be carried out at points of data collection, collation and analysis by the technical staff of MIS in collaboration with PMMU. Standardized DQA tools will be developed for application at all levels. The major data sources for HNP SWAp monitoring and evaluation will require different approaches to data quality assessment/checks:

- For the survey data, quality is ensured through a number of quality control teams to carry out post-enumeration checks during the survey. In the surveys implemented by NIPORT (viz. BDHS, UESD), NIPORT monitors fieldwork by using designated quality control teams. Data quality is also monitored through field check tables generated concurrently with data processing, which is particularly useful because the quality control teams are able to advise field teams of problems detected during data entry.
- For administrative records, Data Quality Checklists (see Annex 4) will be implemented. The checklist will focus on making sure that steps are taken and processes are in place to produce good quality data.
- For program-related data and service statistics, main methods for quality assurance are a) manual feedback reporting, where designated experts check incoming reports manually and provide feedback to health facilities by report or by visit; b) automated feedback reporting through built-in consistency and range checks in the MIS data platform DHIS-2; and c) quality assurance of MIS data as part of integrated Quality Assurance (QA) of health facilities.

Key data quality assessment activities for HNP sector programs are outlined in Table 4 below.

Table 4: Tools and Actions for Data Quality Assessment by Levels

Activity	***Frequency***	***Tools***	***Output***	***Responsibility***
National Level				
Review the results of DQA	Annually	Data Quality Audit report	Minutes of review and decisions taken (if any)	Ministry; Directorate General; MIS and Planning Units
Administrative data quality assurance	Bi-annually	Data quality audit tool	Quality Assurance reports	MIS and Planning Units
Service delivery data validation exercises	Bi-annually	Data quality audit tool	Quality Assurance reports	LD and respective OP staff
Division Level				
Supervision of data validation exercises at district level and below	Bi-annually	Data quality audit checklist	Review report	Divisional Directors, HS and FP
District Level				
Service delivery data validation exercises	Quarterly	Data quality audit tool	Data quality audit reports	Civil Surgeon/Deputy Director-FP
Service delivery data sharing between Health and FP service providers	Two-monthly	Aggregated service statistics	Meeting minutes	Civil Surgeon/Deputy Director-FP
Health Facility level				
Administrative data quality assurance	Quarterly	Data quality audit tool	Quality Assurance reports	UHFPO/UFPO/MO-MCH/FWV
Service delivery data validation exercises	Monthly	Data quality audit tool	Data quality audit reports	UHFPO/UFPO/MO-MCH/FWV

3.1.4 Capacity building

M&E draws on a broad range of technical fields, social science research methodology, contract administration, information management, general management and "process facilitation" or consulting skills. MOHFW has a fairly well developed infrastructure for training in these fields, and still there are shortcomings and need for institutional strengthening.

Under this M&E Strategy, an approach to capacity building will be adopted that focuses on managing monitoring systems and providing M&E training. Substantive demand from the government is a prerequisite to successful institutionalization, i.e. the M&E system must produce monitoring information and evaluation findings that are judged valuable by key stakeholders, which are then used to improve performance, and which respond to sufficient demand for the M&E function to ensure its sustainability for the foreseeable future. For this reason the M&E Strategy will also focus on increasing awareness of M&E and its potential uses including M&E tools, methods, and techniques.

The M&E capacity building activity will primarily focus on two levels where capacity is required to ensure overall performance of the M&E system under the HPNSDP: individual-level and organizational level. The individual level refers to the individual job performance and actions of staff with M&E responsibilities under HPNSDP, and the capacity building elements for this level include job requirements, skill levels and needs, performance reviews, access to information, and training/re-training. The organizational level refers to the infrastructure and operations that need to be in place within each organization to support the collection, verification and use of data for program monitoring and management. Capacity building elements for this level include management process, HR system and personnel structure, financial resources, information infrastructure and organizational motivation.

Section 4.4 of this document outlines a capacity building plan for M&E, to be pursued during the rest of the HPNSDP implementation period.

3.1.5 Resource allocation for M&E

A key function of planning for M&E is to estimate the costs, staff, and other resources that are needed to properly carry out M&E activities. It is hence important to weigh in on the requirement of M&E budget needs at the program design stage so that funds are allocated specifically to M&E and are available to implement key M&E tasks through the relevant OPs.

As per the PIP of HPNSDP, 3.6% of the total HPNSDP budget has been allocated to 5 OPs (HIS & eH, MIS/FP, PME-FP, PMR and SWPMM) directly involved in monitoring SWAp implementation and planned targets, which is at the lower side of the recommended range for program's budget allocation for M&E (3% – 10%[3]). After incorporating budgets for M&E-related activities in all other OPs (22 in total), total HPNSDP budget allocated for M&E stands at 6.1% for 2011-2016 (see Annex 6).

On the backdrop of HPNSDP mid-term review (MTR), all 32 OPs would be revised (including budget) to incorporate the following actions and increase the overall allocation for M&E activities towards a target of 10% of the program cost:

- Allocate sufficient funds to HIS&eH and MIS-FP OPs and to expand RHIS pilot in a phased manner in DGHS and DGFP respectively.
- Allocate resources to MIS and service delivery OPs for capacity building in M&E activities.

[3] Frankel N and A Gage. 2007. "M&E Fundamentals: A Self-Guided Minicourse." United States Agency for International Development (USAID), Washington, DC. Available at: http://www.cpc.unc.edu/measure/publications/pdf/ms-07-20.pdf

- Allocate resources to individual OPs to enable them tracking respective OP-level indicators efficiently and on time.
- Support specific OPs (e.g. TRD) to carry out planned surveys to feed into RFW and program evaluation in time.

3.2 M&E REVIEW RESPONSIBILITIES AND ACTION BY LEVELS

At the MOHFW level, the M&E Task Group (METG) with support from Planning Wing will carry out overall responsibility of establishing effective communication and better information sharing mechanisms among MOHFW agencies and the DPs. Major roles of the METG will be to:

- Oversee M&E functions of MOHFW and MIS Units of its Directorates in relation to HPNSDP.
- Strengthen routine health information systems of MOHFW in collaboration with the MIS Units, DPs and other agencies.
- Review and endorse performance management plans and M&E frameworks for HNP sector program.
- Coordinate survey and research activities including need assessment for additional survey/ research.
- Review and follow up APR priority actions and report back to LCG Working Group on Health.
- Provide overall guidance to PMMU to discharge its responsibilities.

At the MOHFW level, Planning Wing with assistance from PMMU will be responsible for:

- Monitoring and evaluating the performance of the HNP sector program by producing Six-monthly Progress Reports and Annual Program Implementation Reports.
- Coordinating the processing, analysis, and dissemination of health data/information generated by different OPs/programs for bi-annual reporting and policy advisory services to MOHFW.
- Meeting data requirement by other agencies of GOB, viz. Ministry of Finance, Planning Commission, etc.
- Management and coordination among OPs and selected TAs for systems strengthening.
- Carrying out routine ADP Review and APR processes involving stakeholders including the DPs.
- Reviewing and recommending approval of M&E guidelines and supervision systems, developed for the Directorates.

At the Directorate Generals' level, At the Directorate Generals' level, strengthen the Planning Units of DGHS and DGFP for carrying out planning and coordination activities consistent with HPNSDP. The MIS Line Directors and their core OP staff will be responsible for:

- Providing overall implementation support for M&E activities at the facility and community levels using routine information systems.
- Building capacity of managers and service providers (including fieldworkers) through basic and refreshers' trainings.
- Receiving routine data (including those from the tertiary hospitals) in a common, interchangeable data platform (viz. District Health Information System – 2).
- Analyzing the quality of all reports received and ensuring follow-up in case of incompleteness, problems with validity, as well as delays.
- Consolidating reports from all the levels to be published online at regular periodic intervals.
- Visiting fields as part of routine supervision and ensuring data quality through validation check.
- Developing guideline and supervision systems related to M&E activities.

Also at specific Line Directorate levels, the Line Directors and their core OP staff will be responsible for:

- Ensuring that periodic surveys like BDHS, UESD, BHFS, BMMS, etc. are completed on time (by TRD OP).
- Assessing need and commissioning specific research activity (by PME, PMR, TRD and other OPs).
- Producing National Health Accounts and Public Expenditure Review in the HNP sector (by HEF OP).

At Divisional level, the Divisional Directors of Health Services and Family Planning will be responsible for:

- Assuming a supervisory role for health and FP services at district level and below.
- Arranging HR provision for supervision and feedback at divisional level.
- Providing periodic feed-back on implementation progress.

At District level, the Civil Surgeon's / Deputy Director-FP's Office will be responsible for:

- Supervising Statistician/Statistical Assistant in entering service contacts and other routine data into the DHIS 2 portal
- Analyzing the quality of all reports received and ensuring follow-up in case of incompleteness, problems with validity, as well as delays.
- Forwarding the report electronically to the respective MIS by the 28th day of the following month with a copy to the respective Divisional Director.
- Organizing quarterly routine data dissemination between CS/DD-FP and LD-MISs.

At Upazila level, the UHFPO/UFPO will be responsible for:

- Supervising Statistician/Statistical Assistant in entering service contacts and other routine data into the DHIS 2 portal and forwarding the report electronically to the CS/DD-FP Office by 15th day of the following month.
- Organizing monthly meeting among DGHS and DGFP field workers and supervisors to discuss and compare collected data quality.
- Receiving service contacts data from all union and below level facilities.
- Feeding quarterly input to Local Health Bulletin and providing feed-back to the health providers on the basis of LHB comparisons.

At Union level, the Medical Officer/Family Welfare Visitor of the Union Health and Family Welfare Centre will be responsible for:

- Collecting patient data using relevant patient forms.
- Compiling relevant patient data from patient forms and entering it into the patient registers on a daily basis.
- Forwarding the report electronically to UHFPO/UFPO's Office by the 7th day of the following month.

At the community level, the Community Health Care Provider (CHCP) of the Community Clinic will be responsible for:

- Liaising with CHCP, HA and FWA assigned to the CC for collecting client information and activity data using relevant forms.
- Compiling data from the relevant forms and entering it into the CC Register on a regular basis.
- Forwarding or delivering the monthly report from CC Register to the nearest UHC by the 5th day of the following month.

CHAPTER 4. PLANS FOR IMPLEMENTATION OF STRATEGIC ACTIONS

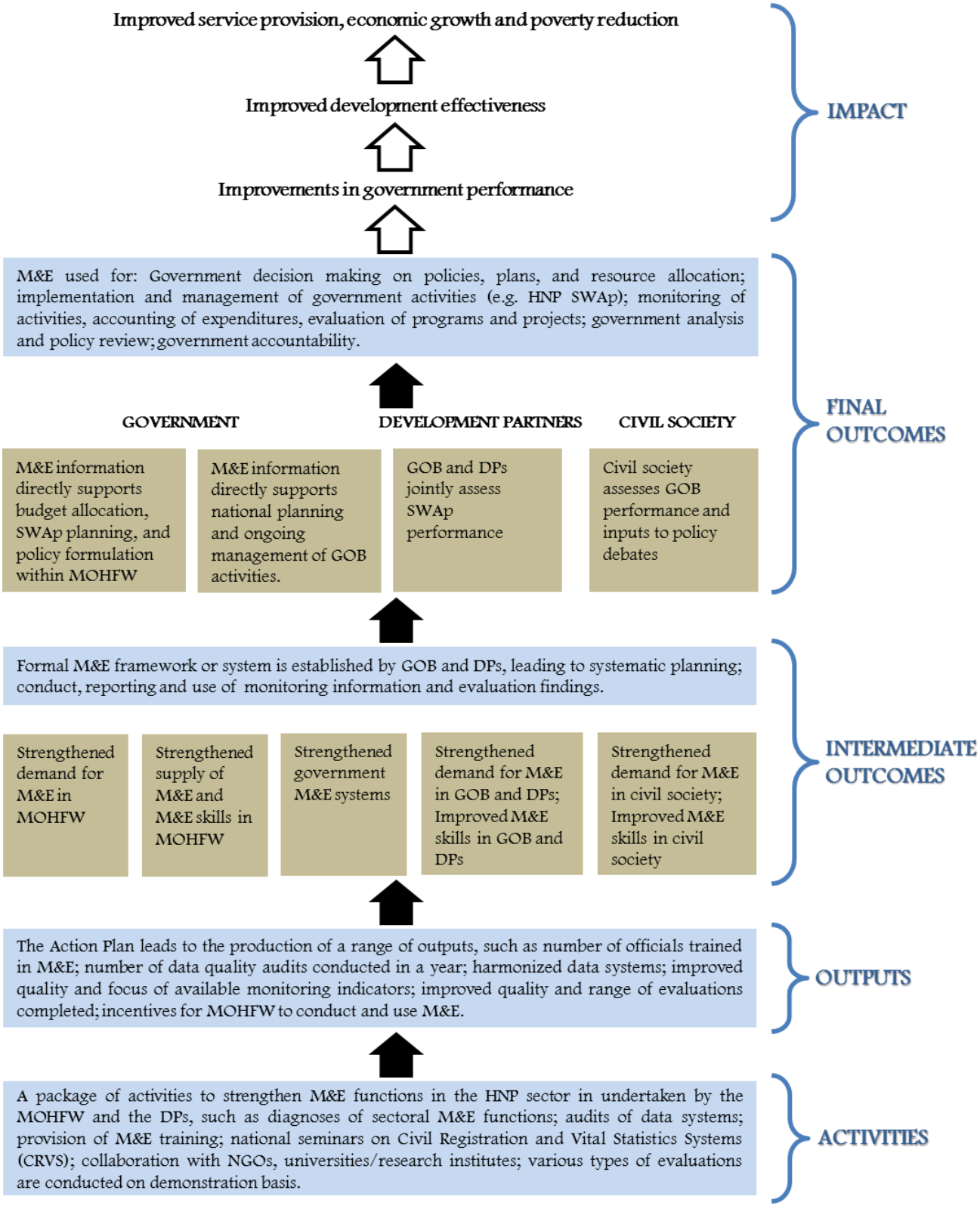
This section describes how the HNP sector will undertake and coordinate M&E plan for HPNSDP implementation indicating the strategies and interventions, M&E Plan tasks, clear roles, and responsibilities.

4.1 AIM OF M&E ACTION PLAN FOR HNP SECTOR PROGRAM

Action plan to strengthen an existing M&E system has to be tailored closely to country circumstances. Findings from the previous Annual Program Reviews on M&E thematic area and the assessment in Annex 6 on M&E system under HPNSDP have served as the basis for developing an action plan in this document.

This action plan on M&E Strategy has drawn on previous works (GTZ 2010; JSI Bangladesh 2005) in Bangladesh and on the international lessons from building country M&E systems (GOU 2011; Mackay 2007). The purpose of the action plan is to strengthen demand and supply-side issues of M&E system in both short- and long-terms. A results chain for building an M&E system is shown in Figure 6 – this provides a simplified representation of how a package of time-bound activities outlined in this this action plan is expected to result in specific outputs, such as harmonized data systems, the number of officials trained in M&E, improved quality of monitoring indicators, and so on. These outputs in turn lead to intermediate outcomes such as strengthened demand for M&E, and to final outcomes, including the utilization of monitoring information and evaluation findings (e.g. from implementing agencies under the Directorates to MOHFW to ECNEC) for policy review and decision-making regarding program implementation. It is hoped that these outcomes would help lead to final impacts, including improved performance, improved development effectiveness, improved service provision, and ultimately to overall human development and poverty reduction.

Figure 6: Results chain of M&E Action Plan for HNP Sector Program in Bangladesh[4]



[4] Adopted from Mackay (2007)

4.2 KEY INTERVENTIONS UNDER M&E STRATEGY

In order to develop the activity package in the M&E Action Plan for HNP sector programs including HPNSDP, following key interventions were identified based on the key strategic issues outlined in Section 3.1.

Key intervention 1: Strengthen M&E coordination within HNP sector program

- Approve and implement M&E Strategy and Action Plan for HNP Sector Program
- Strengthen the roles of Planning and MIS Units of all the Directorates and PMMU/Planning Wing in MOHFW
- Build on learnings from ongoing RHIS pilot and scale up selected processes
- Develop multi-year, comprehensive plans for M&E activities, including training of field staff, under the sector program
- Operationalize DMIS.

Key intervention 2: Carry out performance reviews at regular intervals.

- Conduct monthly ADP Review on financial and physical progress by the OPs
- Prepare and disseminate Six-monthly Progress Report (SmPR) and Annual Program Implementation Report (APIR)
- Conduct Annual Program Review by Independent Review Team (IRT)
- Conduct the periodic surveys as planned for updating RFW indicators in regular intervals – an updated list of surveys and their indicative dates are provided in **Annex 3**.

Key intervention 3: Enforce Data Quality Assurance mechanisms

- Integrate quality assurance (QA) procedures into the existing MISs with systematic verification procedures
- Data quality checks taking place on regular intervals
- Conduct workshop on data validation to build capacity of the program managers.

Key intervention 4: Build capacity for M&E among MOHFW staff

- Conduct orientation of LDs and core OP staff in Planning, Monitoring and Coordination.
- Assess needs and develop multi-year M&E training plan for managers and field-staff.
- Develop M&E training curriculum (in M&E, statistics, epidemiology, ICT).
- Conduct regular training in M&E and statistics/epidemiology/ ICT for LD, district and upazila staff.

A detailed table on specific activities towards the key interventions along with proposed responsibility and timeline is provided in Table 5 below. Table 5A outlines the activities to be undertaken during the remainder of HPNSDP period and Table 5B does so for future HNP sector programs.

Table 5A: M&E Action Plan for HNP Sector Program – activities during HPNSDP

Strategic Objective	Specific Activities	Responsibility	Timeline	Notes/ Assumptions
Strengthen M&E coordination within SWAp	Fill in key positions to make MISs and PMMU fully functional	Joint Secretary (Admin); Director (Admin) at the Directorates	Ongoing	
	Approve and implement M&E Strategy and Action Plan for HNP Sector Program	Chair-METG	December 2014	
	Sharing of Performance Monitoring Plan (PMP) of HPNSDP with relevant stakeholders	Joint Chief (Planning)	June 2014	PMP has been shared with IRTs for 2013 APR and 2014 MTR
	Strengthen functional and working relationships of PMMU with the various research based OPs and institutes	CTA-PMMU; Relevant LDs	Ongoing	OPs are PME, PMR, NIPORT, NIPSOM and IEDCR
	Develop multi-year, comprehensive plans for the future on how the current level of investment in hardware will contribute to the monitoring goal of MOHFW	LD-HIS & eH; LD-MIS/FP	February, 2015	
Align OP activities towards HPNSDP goals	RFW and Operational Plan-level indicators are reviewed and updated, as required, to better reflect HPNSDP objectives and priorities	CTA-PMMU	January 2015	RFW can be revised after MTR and OP- indicators during OP revision for R-PIP
	Relevant Operational Plans revised to strengthen focus on M&E (including research and surveys)	LDs – SWPMM and relevant OPs	January 2015	Resource for M&E activities increased within OPs towards 10% of total cost
Streamline RHIS processes, covering data collection and reporting, by different entities	Results from *Strengthening RHIS Pilot* disseminated and a scale up plan prepared on the basis of results	CTA-PMMU; LD-HIS & eH; LD-MIS/FP; Director - ICDDR,B	January 2015	This will include project documentation and briefs for reference.
	Scaling up RHIS project to two districts in Hobiganj and Tangail, with necessary logistics and training support	Chair-METG; CTA-PMMU; LDs –HIS & eH and MIS/FP	January 2015	Based on revised resource allocation
	Assess the impact of strengthening RHIS in two districts; and develop and support the implementation of a national scale up	LDs – MNCAH, MCRAH, HIS & eH, MIS/FP	December 2015	TA will be required for MIS Units at Directorate level for national scale up.

Strategic Objective	Specific Activities	Responsibility	Timeline	Notes/ Assumptions
	Build on learnings from ongoing GIS mapping activity and scale up selected processes	LDs – SWPMM, HIS & eH, MIS/FP	April 2015	
	Initiate processes to establish a streamlined HRIS under MOHFW	Chair/Co-Chair-HRTG; LD-HRM	December 2015	
	Strengthen/Utilize Local Health Bulletins by MIS/DGHS to monitor UHCs and DGs; establish mechanisms similar to Local Health Bulletins for monitoring FP facilities as well	LDs – HIS & eH, MIS/FP, in collab. with technical agencies	December 2015	
Enforce Data Quality Assurance mechanisms	Integrate quality assurance (QA) procedures into the existing MISs with systematic verification procedures	LDs – HIS & eH, MIS/FP, in collab. with PMMU	February 2015	Require incorporating activities to revised OP
	Data quality checks taking place on regular intervals	LDs – HIS & eH, MIS/FP, in collab. with PMMU	Ongoing	As outlined in Table 4, Chapter 3
	Conduct workshop on data validation to build capacity of the program managers	LDs – HIS & eH and MIS/FP	April 2015	
Operationalize DMIS	Redesign DMIS for automated data feeding and report generation	LDs – HIS & eH and MIS/FP	July 2015	
	Establish functional linkages with existing MISs and routine information systems to effectively serve as a data warehouse	LDs – HIS & eH, MIS/FP, in collaboration with PMMU		
	Develop a data analysis tool to produce periodic reports on core performance indicators and key health systems data.	LDs – HIS & eH, MIS/FP, in collab. with PMMU	July 2014	
Production and dissemination of MIS reports	Produce and distribute Monthly MIS reports on FP services	LD-MIS/FP	Every month	And update web portal in regular intervals
	Produce and distribute bi-annual Voice of MIS on EmOC services	LD-HIS & eH	Every 6 months	
	Produce and distribute bi-annual IMCI Newsletter on performance report of IMCI program	LDs – MNCAH and HIS & eH	Every 6 months	

Strategic Objective	Specific Activities	Responsibility	Timeline	Notes/ Assumptions
	Produce and disseminate Annual MIS Reports	LDs – HIS & eH, MIS/FP	Every year	Dissemination defined as key results shared with stakeholders and discussed
	Organize annual MIS Conference to discuss and share MIS experience and improve processes	LD-HIS & eH	Every year	
Carry our performance reviews at regular intervals	Conduct ADP Review on budget allocation, fund release and spending rate by OPs	Joint Chief (Planning)	Every month	
	Prepare and disseminate Six-monthly Progress Report (SmPR)	Joint Chief (Planning) supported by PMMU	Every April	
	Prepare and disseminate Annual Program Implementation Report (APIR) to feed into the APR	Joint Chief (Planning) supported by PMMU	Every September	
	Conduct Annual Program Review by Independent Review Team (IRT)	Joint Chief (Planning) in collab. with DPs	Every December	Scope and design of the IRT will be decided by the APR SC.
Conduct Periodic Surveys	Bangladesh Demographic and Health Survey	DG-NIPORT in collab. with USAID	2014, 2017	
	Utilization of Essential Service Delivery (UESD) Survey	DG-NIPORT in collab. with technical agencies	2015, 2016	
	Public Expenditure Review in HNP sector	LD-HEF	Every year	NHA/PER are main sources for health financing data
	National Health Accounts (NHA)	LD-HEF	April 2014	NHA/PER are main sources for health financing data
	HIV Sero-surveillance/Integrated Bio-behavioral Survey	LD-NASP	Every two years (2014)	
	Bangladesh Health Facility Survey (BHFS)	DG-NIPORT in collab. with USAID	2014, 2016	
	Bangladesh Maternal Mortality Survey (BMMS)	DG-NIPORT in collab. with USAID	2016	
	Coverage Evaluation Survey (CES)	LD-MNCAH, with TA support	Every year	

Strategic Objective	Specific Activities	Responsibility	Timeline	Notes/ Assumptions
Build capacity for M&E among MOHFW staff	Assess needs and develop multi-year M&E training plan for managers and field-staff	LDs – HIS & eH, MIS/FP	Every two years	This includes refreshers' training
	Develop M&E training curriculum (in M&E, statistics, epidemiology, ICT)	LD-IST in collab. with LDs – HIS & eH, MIS/FP	December 2014	TA may be required for this activity
	Conduct orientation of LDs and core OP staff in Planning, Monitoring and Coordination	LD-SWPMM supported by PMMU	Once in a year	
	Conduct regular training in M&E and statistics/epidemiology/ICT for LD, core OP staff, district and upazila-level staff	LDs – HIS & eH, MIS/FP, IST	Ongoing	

A set of similar activities are outlined in Table 5B below, indicating medium and long-term M&E activities to be undertaken in the subsequent HNP SWAps.

Table 5B: M&E Action Plan for HNP Sector Program – activities for future HNP sector programs

Strategic Objective	Specific Activities	Responsibility	Indicative Timeline	Notes/ Assumptions
Strengthen M&E coordination within SWAp	M&E Task Group is strengthened and meeting in regular intervals to supervise M&E activities under MOHFW	Chair/Co-Chair-METG; Joint Chief (Planning)	Ongoing	
	Fill in key positions to make MIS Units and Planning Units within the Directorates and PMMU at Planning Wing fully functional	Joint Secretary (Admin); Director (Admin) at the Directorates	Ongoing	Assess the HR capacity and requirement of MIS and Planning Units at the Directorate levels
	Build capacity of GOB staff at MIS/DGHS, MIS/FP, PME, PMR, TRD, IEDCR and SWPMM to Strengthen functional and working relationships and carry out planning, M&E and coordination activities	Joint Chief (Planning); CTA-PMMU; Relevant LDs	Ongoing	
	Develop multi-year, comprehensive plans for rolling out strengthening RHIS initiatives including digitization of routine reporting and establishing individual health records in the public sector	LD-HIS & eH; LD-MIS/FP; LD-SWPMM; DPs	January 2017	
	Allocate adequate resources for M&E activities	Chair/Co-Chair-METG; Joint Chief (Planning); DPs	During design of a new SWAp	Resource for M&E activities increased within OPs towards 10% of total cost
Align OP activities towards SWAp goals	Review and revise Performance Monitoring Plan (PMP) for HNP SWAp	Chair-METG; LD-SWPMM with support from PMMU	At regular intervals	Including Indicator Reference Sheet (IRS) to incorporate new RFW and OP-level indicators
	RFW and Operational Plan-level indicators are reviewed and updated, as required, to better reflect SWAp objectives and priorities	CTA-PMMU	During MTR	RFW can be revised after MTR and OP- indicators during OP revision
Enforce Data Quality Assurance mechanisms	Review and revise Data Quality Assurance (QA) procedures in the MISs with systematic verification procedures	LDs – HIS & eH, MIS/FP, in collab. with PMMU	During design of a new SWAp	

Strategic Objective	Specific Activities	Responsibility	Indicative Timeline	Notes/ Assumptions
	Data quality checks taking place on regular intervals	LDs – HIS & eH, MIS/FP, in collab. with PMMU	Ongoing	As outlined in Table 4, Chapter 3
Operationalize DMIS	Review and revise (if required) functional linkages with existing MISs and routine information systems to effectively serve as a data warehouse	LDs – HIS & eH, MIS/FP, in collab. with PMMU		
	Publish monthly reports on core performance indicators and key health systems data.	LDs – HIS & eH, MIS/FP, in collab. with PMMU	September 2014	
Production and dissemination of MIS reports	Produce and distribute Monthly MIS reports on FP services	LD-MIS/FP	Every month	And update web portal in regular intervals
	Produce and distribute bi-annual Voice of MIS on EmOC services	LD-HIS & eH	Every 6 months	
	Produce and distribute bi-annual IMCI Newsletter on performance report of IMCI program	LDs – MNCAH and HIS & eH	Every 6 months	
	Produce and disseminate Annual Reports	LDs – HIS & eH, MIS/FP	Every year	Dissemination defined as key results shared with stakeholders and discussed
	Organize annual MIS Conference to discuss and share MIS experience and improve processes	LD-HIS & eH	Every year	
Carry our performance reviews in regular intervals	Conduct ADP Review on budget allocation, fund release and spending rate by OPs	Joint Chief (Planning)	Every month	
	Planning Units at DGHS and DGFP taking a more active role in coordinating and monitoring program implementation	ADGs (Planning); Directors (Planning)	Ongoing	
	Prepare and disseminate Six-monthly Progress Report (SmPR)	Joint Chief (Planning) supported by PMMU	Every April	
	Prepare and disseminate Annual Program Implementation Report to feed into the APR	Joint Chief (Planning) supported by PMMU	Every September	
	Conduct Annual Program Review by Independent Review Team (IRT)	Joint Chief (Planning) in collab. with DPs	Every year	Scope and design of the IRT will be decided by the APR SC.

Strategic Objective	Specific Activities	Responsibility	Indicative Timeline	Notes/ Assumptions
Conduct Periodic Sample Surveys	Bangladesh Demographic and Health Survey	DG-NIPORT in collab. with USAID	2020, 2023	
	Utilization of Essential Service Delivery (UESD) Survey	DG-NIPORT in collab. with ICDDR,B	2018, 2019, 2021, 2022	
	Public Expenditure Review	LD-HEF	April 2014	NHA/PER are main sources for health financing data
	National Health Account (NHA)	LD-HEF	Once every 3 years	NHA/PER are main sources for health financing data
	HIV Sero-surveillance/Integrated Bio-behavioral Survey	LD-NASP	Every two years	
	Bangladesh Health Facility Survey (BHFS)	DG-NIPORT in collab. with USAID	2018, 2020, 2022	
	Bangladesh Maternal Mortality Survey (BMMS)	DG-NIPORT in collab. with USAID	TBD	
	Coverage Evaluation Survey (CES)	LD-MNCAH, with TA support	Every year	
Build capacity for M&E among MOHFW staff	Assess needs and develop multi-year M&E training plan for managers and field-staff	LDs – HIS & eH, MIS/FP	Every year	This includes refreshers' training
	Review and revise M&E training curriculum (in M&E, statistics, epidemiology, ICT)	LD-IST in collab. with LDs – HIS & eH, MIS/FP	During design of a new SWAp	TA may be required for this activity
	Conduct orientation of LDs and core OP staff in Planning, Monitoring and Coordination	LD-SWPMM supported by PMMU	Once in a year	
	Conduct regular training in M&E and statistics/epidemiology/ ICT for LD, district and upazila staff	LDs – HIS & eH, MIS/FP, IST	Ongoing	

4.3 CAPACITY BUILDING PLAN

The goal of the Capacity Building Plan under the M&E Strategy is to facilitate and promote the development of monitoring and evaluation knowledge, skills and competence of HNP SWAp leading to health systems strengthening in Bangladesh.

In line with the performance indicators outlined above, the key tasks for implementation of the M&E capacity building plan will include:

- ***Development of Standardized M&E Training Materials.*** In conjunction with In-Service Training (IST) OP, MIS/DGHS and MIS/DGFP will develop, disseminate and conduct training utilizing:
    a. Standardized Basic M&E Training Materials
    b. Standardized Advanced M&E Training Materials (including statistics and epidemiology)

    The standardized training materials will be informed by training needs and are in-keeping with the international best practices. In developing the training materials, available training materials will be consulted.

- ***Development of a Cadre of Skilled M&E trainers through a Train-the-Trainer (TOT) Program.*** MIS/DGHS and MIS/DGFP will design and conduct TOT sessions with staff of selected partner agencies (DP, NGOs, private institutions) to deliver the training materials that have been developed.

- ***Development of a multi-year training plan to facilitate structured and sequenced M&E Training.*** Both the MISs will develop a multi-year capacity building plan to ensure that the current level of investments in computerizing the routine data systems will sustain and operate efficiently. A training database will be developed to ensure that relevant, targeted individuals access the package of M&E trainings. In an effort to systematically develop participants knowledge, skills and competencies to become fully functional M&E practitioners in their respective positions, participants will be encouraged to access a package of training opportunities including refreshers' training. The target groups for training will be as follows:

Table 6: Target groups for M&E training

Recipient	Data entry	Basic M&E	ICT	Statistics	Epide-miology
Line Directors		X			
Core OP staff		X	X	X	
MIS Directorate Staff		X	X	X	X
Medical Officer		X	X		X
Statistician – District Hospital	X	X	X	X	X
Statistician – Upazila Health Complex	X	X	X	X	
Field Workers (HA, FWA, CHCP)	X		X		

- ***Implement training using the Capacity-Building Modalities.*** Both the MISs will deliver its training package utilizing different training modalities and utilize the staff trained under TOT program. Given their leadership role, the MISs will continuously develop their capacity and remain up-to-date on recent international developments in M&E and in training methodologies.

4.4 DATA QUALITY PLAN

The PMMU integrates data quality assessment into ongoing activities (e.g., combines a random check of routine health information systems data with a regularly scheduled site visit). This minimizes the costs associated with data quality assessment. As outlined in the Performance Monitoring Plan (PMP) of HPNSDP, team members will use the Data Quality Checklist (see Annex 4) while conducting data quality assessments – this checklist is only illustrative and it will be customized before data collection from LDs. Following the assessment, the findings will be written up in a short memo and shared with relevant Line Directors and the MOHFW. If the PMMU determines any data limitations exist for performance indicators (either during initial or periodic assessments), it will correct the limitations to the greatest extent possible. The PMMU will also document any actions taken to address data quality problems (see Table 7) in the appropriate Indicator Reference Sheets (IRS) of the PMP. If data limitations prove too intractable and damaging to data quality, the PMMU will seek alternative data sources, or develops alternative indicators (GOB 2014).

Table 7: Common data limitations and mitigating measures[5]

Common Data Limitations	Action Plans to Address Data Limitation	Responsibility
Lack of consistent terms	When possible, standardized data collection forms for uniformity of terms used and data tracked.	PMMU, Planning Wing
Accurate attribution of results to MOHFW supported program activities	Indicators are clearly defined to the best extent possible to capture results achieved through MOHFW and partners' activities.	PMMU, Planning Wing
Underreporting results	Results will be reported to capture full impact of program efforts -	PMMU, Planning Wing
Lack of objective and consistent application of evaluation criteria	Review regularly with program managers/first-line staff to ensure adherence to evaluation criteria that have been established for data collection.	PMMU, Planning Wing
Uncertainty related to definition of indicator	Clearly define indicators using unambiguous terms. When possible, standardize data collection forms for uniformity of terms used and data tracked.	PMMU, Planning Wing

At a minimum, data quality assessments will be performed at an interval of three years from the date of the most recent data assessment for all RFW indicators (for some, it may be more often, even annually). The dates planned for each indicator in the PMP are indicated on the Indicator Reference Sheets.

PMMU and other relevant Planning Wing/MOHFW staff in coordination with relevant MIS Line Directorates, will perform site visits, monitor databases and evaluate, using different tools such as data checklists, interviews with providers and clients as well as semiannual meetings cooperating agencies and national/international partners. If deemed necessary, additional external evaluations of data quality will be commissioned.

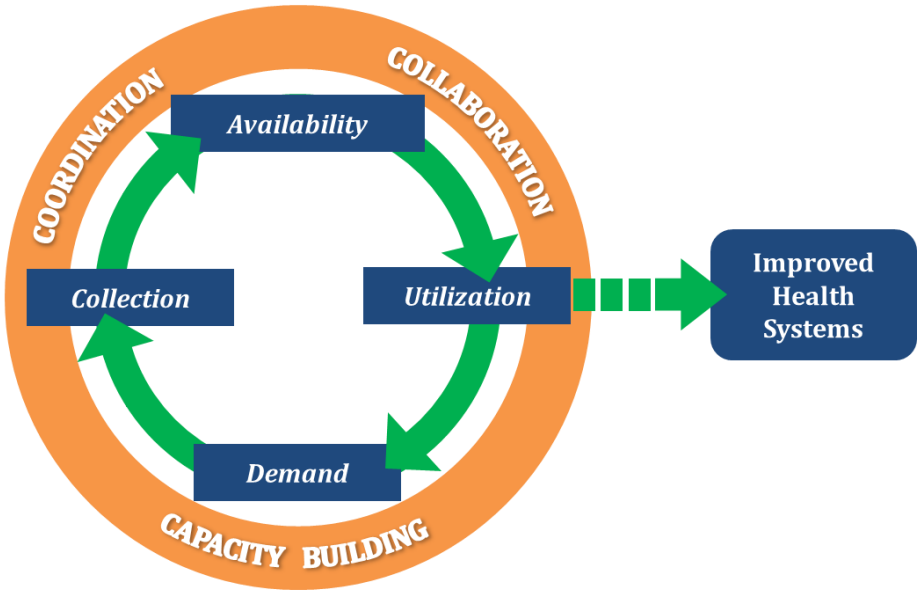
[5] Performance Monitoring Plan (PMP) of HPNSDP (GOB 2014)

4.5 DATA UTILIZATION PLAN

Data collection systems are often designed and developed with the goal to report to national governments or international donor agencies. Huge volumes of data are created, but less is actually used to directly benefit programs and people (MEASURE Evaluation 2007). Health data and information lack value unless they are used to inform decisions. Interventions that increase local demand for information and facilitate its use enhance evidence-based decision making – fostering effective data demand and utilization, therefore, is critical to improving health system effectiveness (MEASURE Evaluation 2011, MEASURE Evaluation 2012).

The basic conceptual framework to illustrate different aspects of data utilization in the HNP sector is a cycle connecting data demand, data collection/analysis, information availability, and data and information use (see Figure 8). This cycle is supported by collaboration, coordination, and capacity building. In this framework, there is a clear and consistent link between the use of health information and the commitment to improving the quality and availability of data.

Figure 7: Conceptual Framework of Data Demand and Use in the HNP Sector[6]



Routinely collected data are often underutilized because of a) technical constraints (viz. technical skills, availability of computers, data system design, definition of indicators, lack of data quality assurance protocols, etc.); b) organizational constraints (viz. clarity of roles, support, flow of information, political interference, etc.); and c) individual constraints (viz. decision making process, staff motivation, etc.) (LaFond, Fields and Lippeveld 2005). In order to ensure that generated data are being utilized for informed decision making, the major steps comprise identifying and addressing barriers to data utilization. In the light of M&E systems assessment in Annex 6, Table 7 outlines the common barriers in Bangladesh's HNP sector program. It is envisaged that this planning matrix for addressing the common barriers to data utilization in decision making will help MOHFW and other stakeholders to institutionalize

[6] MEASURE Evaluation 2011

mechanisms and tools for strengthening the use of information at both national and sub-national levels.

Table 8. Planning matrix for addressing barriers to effective data utilization in decision making[7]

Common barriers	Proposed intervention	Steps involved	Persons Responsible	Other stakeholder
Lack of capacity at the facility level to produce accurate data	Build capacity of relevant staff in collecting, collating and reporting data	a. On the job training b. Continuous mentoring	Statistician; Nurses; Data entry Operators; Fieldworkers	Program Manager; Medical Officer
Lack of coordination of data from facility level to LD in a timely manner	Establish a functional data flow mechanism	a. Identify focal persons for data collection and collation b. Identify and provide feasible access to collated data	MIS LDs; Program Manager; Facility staff	Chair, M&E Task Group; M&E Advisor/ Specialist, PMMU
Lack of synchronization between data platforms for analyzing and interpreting data	Develop a user-friendly and secure database at MIS-LD levels	a. Allocate resources to establish uniform data platform b. Provide training of software and maintenance	MIS LDs; Database Consultants; Training Coordinator	Chair, M&E Task Group; DG, Directorate Generals; M&E Advisor/ Specialist, PMMU
Lack of filtering in data for specific levels (i.e. same amount of data available from facility level to ministry level)	Set up data requirement for different levels	a. Assess information need by major levels, i.e. facility, program, LD, and Ministry levels b. Customize database software to produce different types of reports by level	MIS LDs; Database Consultants; Training Coordinator	Chair, M&E Task Group; DG, Directorate Generals; Joint Chief (Planning); M&E Advisor/ Specialist, PMMU
Lack of understanding about the data being generated routinely and its use for effective monitoring	Orient LDs and core OP staff on Planning, Monitoring and Coordination in regular intervals	Organize workshops/ orientation sessions for LDs and core OP staff	LDs/PMs/DPMs; Advisors, PMMU	Joint Chief (Planning)

[7] Adapted from MEASURE Evaluation 2011

ANNEXURES

ANNEX.1 MOHFW NOTIFICATION ON M&E STRATEGY AND ACTION PLAN TWG

Government of the People's Republic of Bangladesh
Ministry of Health and Family Welfare
Planning Wing, Health-5
Bangladesh Secretariat, Dhaka

No. MOHFW/Plan/FW-6/ME/HPNSDP/01/2012/42 Date: 04.05.2014

Notification

The Government of Bangladesh (GOB) have been pleased to constitute a Technical Working Group (TWG) for reviewing the preliminary draft Monitoring and Evaluation Strategy and Action Plan (MESAP) prepared by the Program Management and Monitoring Unit (PMMU) under Ministry of Health and Family Welfare (MOHFW) as follows:

2. Composition of TWG:

1	Joint Chief (Planning), Planning Wing, MOHFW	Chairperson
2	Deputy Chief (Health), Planning Wing, MOHFW	Member
3	Deputy Chief (FW), Planning Wing, MOHFW	Member
4	Line Director, TRD, NIPORT	Member
5	Director, NIPSOM	Member
6	Line Director, eHealth & HIS, DGHS	Member
7	Line Director, MIS-FP, DGFP	Member
8	Line Director, PMR, DGHS	Member
9	Line Director, PME, DGFP	Member
10	Representative, USAID	Member
11	Representative, World Bank	Member
12	Representative, GIZ	Member
13	Representative, Population Council	Member
14	Chief Technical Advisor and other TA Staff ,PMMU	Member
15	Senior Assistant Chief, Health-5 , PW, MOHFW	Member-Secretary

3. Objective. Under overall supervision of the Chair and Co-Chair of M&E Task Group (METG), the TWG will provide comments and feedback to PMMU for finalizing the draft strategy. PMMU will prepare and submit the final version of MESAP for METG's endorsement and Secretary's approval through Planning Wing, MOHFW.

4. Terms of Reference for the TWG:

1. Review the preliminary draft prepared by PMMU and provides feedback in relation to a) appropriateness and b) functionality of the draft MESAP.
2. Assist the PMMU through guidance and suggestions for finalization of the MESAP.
3. Participate in workshops towards finalization of the MESAP.
4. Meet as often as necessary, with secretarial support from PMMU.
5. Complete the process of review and feedback by June 15, 2014.

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6. This order is issued with the approval of appropriate authority and it will come into effect immediately.

04.05.14

Md. Ibrahim Khalil
Assistant Chief
Phone-9570662

Distribution (not according to seniority):

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2. Director General, Directorate General of Family Planning, Kawran Bazar, Dhaka
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CC:

1. P.S to Secretary, Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.
2. PO to Additional Secretary, Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.
3. PO to Joint Chief (Planning), Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.

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ANNEX.3 INDICATIVE TIMETABLE FOR SURVEYS (FOR RFW UPDATE)

Survey name	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Sample coverage*	Cost* (USD)	Funding source*	Implem-enter
Bangladesh Demographic and Health Survey (BDHS)		■				■			■			■	Ever-married women age 15-49 from 18,000 HH	1.0m	USAID	NIPORT
Utilization of Essential Service Delivery (UESD) Survey	■		■		■			■		■			Ever-married women age 15-49 from 12,000 HH	200,000	HPNSDP /USAID	NIPORT
Bangladesh Maternal Mortality Survey (BMMS)					■					■			Ever-married women age 13-49 from 176,000 HH	3.5m	USAID/ HPNSDP	NIPORT
Bangladesh Urban Health Survey (BUHS)	■							■					55,000 persons	1.1m	USAID	NIPORT
Multiple Indicator Cluster Survey (MICS)	■			■			■			■			55,000 HH	1.0m	UNICEF	BBS
Coverage Evaluation Survey (CES)	■	■	■	■	■	■	■	■	■	■	■	■	15,000 under-five children		WHO/EU /UNICEF	EPI
Bangladesh Household Income & Expenditure Survey (HIES)					■					■			10,080 HH	1.0m	GOB	BBS
Bangladesh Medical Equipment Survey			■				■						50 health facilities, and secondary information for 2000-05	0.15m	HNPSP	Contract or
Bangladesh Health Facility Survey (BHFS)				■		■			■		■		885 health facilities, 5 exit interviews from each facility	0.40m	HPNSDP /USAID	NIPORT/ Contract or
National HIV Serological Surveillance	■	■			■								12,800 people high risk groups	0.6m	HNPSP	NASP
Integrated bio-behavioral Survey (IBBS)							■		■		■				HPNSDP	NASP
Bangladesh National Health Accounts (NHA)				■					■				Secondary sources, NGO survey, etc.	0.6m	HPNSDP	HEU
Public Expenditure Review (PER) of the Health Sector		■	■	■	■	■	■	■	■	■	■	■	Secondary sources, information from cost centres, etc.		HPNSDP	HEU

Implemented or currently underway ■ Planned ■

* Information from the most recent round available

Source: Updated from HSDP Project Appraisal Document (PAD) by the World Bank

ANNEX.4 DATA QUALITY ASSESSMENT CHECKLIST AND TOOLS

A. Data Quality Assessment Checklist

Name of Strategic Objective:	
Name of Intermediate Result (if applicable):	
Name of Performance Indicator:	
Data Source(s):	___ Survey ___ Service Statistics ___ Health Facility Assessment ___ Other
PMMU Control Over Data:	___ High (MOHFW/PMMU controls data) ___ Medium (Implementing partner is data source) ___ Low (Data are from a secondary source)
Partner or Contractor Who Provided the Data:	
Year or Period for Which the Data Are Being Reported:	
Is This Indicator Reported in the Annual Report?	Yes No
Date(s) of Assessment:	
Location(s) of Assessment:	
Assessment Team Members:	
For Office Use Only Deputy Chief (PMM) approval Signature_____ Date_____ Chief Technical Advisor, TA Support Team: Signature_____ Date_____ Copies to: Comments:	

B. Data Quality Assessment Tool

Goal:	
Name of Intermediate Result (if applicable):	
Name of Performance Indicator:	
Data Source(s):	___ Survey ___ Service Statistics ___ Health facility assessment (HFA) ___ Other
PMMU Control Over Data:	___ High (MOHFW is source or controls data) ___ Medium (Implementing partner is data source) ___ Low (Data are from a secondary source.)
Partner or Contractor Who Provided the Data (if applicable):	
Year or Period for Which the Data Are Being Reported:	
Is This Indicator Reported in the Annual Report?	*(circle one)* YES NO
Date(s) of Assessment:	
Location(s) of Assessment:	
Assessment Team Members:	
For Office Use Only Deputy Chief (PMM) approval: X_____Date_____ Chief Technical Advisor, TA Support Team: X_____Date_____ Copies to:	
Comments:	

CATEGORY	YES	NO	COMMENTS
VALIDITY			
Is there a solid logical relation between the program activity and what is being measured?			
Are the people collecting data qualified and properly supervised?			
Were known data collection problems appropriately assessed?			
Are steps being taken to limit transcription error?			
Are steps taken to correct known data errors?			
RELIABILITY			
Is a consistent data collection process used from year to year, location to location, data source to data source?			
Are there procedures in place for periodic review of data collection, maintenance and processing?			

Are data collection, cleaning, analysis, reporting and quality assessment procedures documented in writing?			
Are data quality problems clearly described in final reports?			
TIMELINESS			
Is a regularized schedule of data collection in place to meet program management needs?			
Is data properly stored and readily available?			
PRECISION			
Is there a method for detecting duplicate data?			
Is there a method for detecting missing data?			
INTEGRITY			
Are there proper safeguards in place to prevent unauthorized changes to the data?			
Has there been or is there planned an independent review of results reported?			

IF NO RELEVANT DATA WERE AVAILABLE	**COMMENTS**
If no recent relevant data are available for this indicator, why not?	
What concrete actions are now being undertaken to collect and report these data as soon as possible?	
When will data be reported?	
SUMMARY	**COMMENTS**
Based on the assessment relative to the five standards, what is the overall conclusion regarding the quality of the data?	
Significance of limitations (if any):	
Actions needed to address limitations (given level of PMMU control over data):	

ANNEX.5 MOHFW NOTIFICATION ON PMMU

Government of the People's Republic of Bangladesh
Ministry of Health and Family Welfare
Planning Wing
www.mohfw.gov.bd

No. 45.184.136.00.00.27.2011- 112 Date: 14.12.2011

NOTIFICATION

The Ministry of Health and Family Welfare has constituted "**Program Management and Monitoring Unit (PMMU)**" under 'Sector Wide Program Management and Monitoring' Operational Plan of MOHFW. PMMU is established for management, monitoring and evaluation of implementation progress of **'Health, Population and Nutrition Sector Development Program (HPNSDP)'**. The composition and ToR of PMMU is stated below.

2. **Composition of PMMU**:

1	Joint Chief (Planning), MOHFW	Unit Head
2	Deputy Chief(Program Management and Monitoring) (attachment from Planning Wing, MOHFW)	Member
3	Sr. Assistant Chief/Assistant Chief (Monitoring and Evaluation) (attachment from Planning Wing, MOHFW)	Member
4	Sr. Assistant Chief/Assistant Chief (Aid Management and Coordination) (attachment from Planning Wing, MOHFW)	Member
5	Sr. Assistant Chief/Assistant Chief (Governance and Stewardship) (attachment from Planning Wing, MOHFW)	Member
6	Program Management Officer(Health) (deputation from DGHS)	Member
7	Program Management Officer(Family Planning) (deputation from DGFP)	Member
8	Accountant-cum-Computer Operator (1)	support staff of the unit
9	Data entry operator (3)	-do-
10	Driver (1)	-do-
11	MLSS (1)	-do-

3. **Terms of Reference (ToR) of PMMU**:

A. Assist Planning wing, MOHFW for regular monitoring and assessment of implementation progress of Operational Plan(OP) of HPNSDP through review of Annual Work plan of OPs;
B. Assist Planning Wing, MOHFW for preparation of Annual Work plan and formulation of Monitoring and Evaluation Strategy;
C. Development of routine data/information management system through coordination with MISs of DGHS, DGFP and other agencies and skill development of relevant manpower;
D. Provide Technical support for conducting Annual Program Review(APR) and Mid-Term Review(MTR) jointly undertaken by Government of Bangladesh and Development Partners(DPs);
E. Establish effective communication and better information/data sharing mechanisms among MOHFW and agencies for proper monitoring and implementation of HPNSDP;
F. Monitoring and Evaluation (M & E) of the progress of HPNSDP Result Frame-work (RFW), key indicators of 32 OPs and provide recommendations in light with M & E;
G. Collection of data and establish Data Management and Information System (DMIS) as information warehouse, and publish a six-monthly performance progress report;
H. Establish coordination with releveant ministries, departments, agencies, Line Directors(LDs) and Development Partners(DPs) for proper implementation of HPNSDP;
I. Identify need for periodic survey and coordination of activities to facilitate and conduct surveys;
J. Assist in capacity building of officials of MOHFW and agencies, regarding Monitoring and Evaluation, MIS and Research activities of HPNSDP;
K. Identify need for research related to implementation and improvement of HPNSDP, and archiving, disseminating and recommending useful utilization of data/findings derived from research conducted by different national and international organizations;
L. Assist different wings of MOHFW in formulation of policy and strategy related to Governance and Stewardship;

M. Maintain coordination with MOHFW and DPs to avoid duplication of HPNSDP activities with respect to other parallel projects implemented by Development Partners(DPs);
N. Carry-out other tasks related to HPNSDP management, implementation and monitoring, as and when required.

4. This order is issued with the approval of appropriate authority and it will come into effect immediately.

By the order of the President,
Government of the People's Republic of Bangladesh

১৫/১২/২০১১

(ABDULLAH AL MAMUN)
Senior Assistant Chief
Phone-7173843

Distribution (not according to seniority):

1. Secretary, Ministry of Finance, Bangladesh Secretariat, Dhaka.
2. Secretary, Prime Minister's Office, Tejgaon, Dhaka.
3. Secretary, Economic Relations Division, Sher-e-bangla Nagar, Dhaka.
4. Secretary, Ministry of Public Administration, Bangladesh Secretariat, Dhaka.
5. Secretary, IMED, Ministry of Planning, Sher-e-bangla Nagar, Dhaka.
6. Member, SEI Division, Planning Commission, Sher-e-bangla Nagar, Dhaka.
7. Member, Programming Division, Planning Commission, Sher-e-bangla Nagar, Dhaka.
8. Additional Secretary, Ministry of Health and Family Welfare, Bangladesh Secretariat Dhaka.
9. Director General, Directorate General of Health Services, Mohakhali, Dhaka.
10. Director General, Directorate General of Family Planning, Karwan bazar, Dhaka.
11. Director General, NIPORT, Azimpur, Dhaka.
12. Director General, Directorate General of Drug Administration, 105-106, Mothijheel C/A, Dhaka.
13. Joint Secretary (Administration), Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.
14. Joint Secretary (Hospital), Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.
15. Joint Secretary (Family Planning), Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka
16. Joint Secretary (PH and WH), Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka
17. Joint Secretary (Dev. and ME), Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.
18. Joint Secretary (FM and Audit), Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.
19. Joint Chief (HE Unit), Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.
20. Joint Chief (Health Wing), S E I Division, Planning Commission, Sher-e-Bangla Nagar, Dhaka.
21. Chief Engineer (Health Engineering Dept.), 105-106, Mothijheel C/A, Dhaka.
22. Director, Directorate of Nursing Services, 14-15, Mothijheel C/A, Dhaka.
23. Deputy Chief (Health/ FW), Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.
24. Chief Accounts Officer, Ministry of Health and Family Welfare, Segun Bagicha, Dhaka.
25. Co-chair, LCG working group-Health and DP consortium chair, DFID, United House, 10 Gulshan Avenue, Gulshan, Dhaka-1212.
26. Task Team Leader, World Bank, E-32, Agargaon, Sher-e-Bangla Nagar, Dhaka.
27. Sr. Assistant Chief, Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.

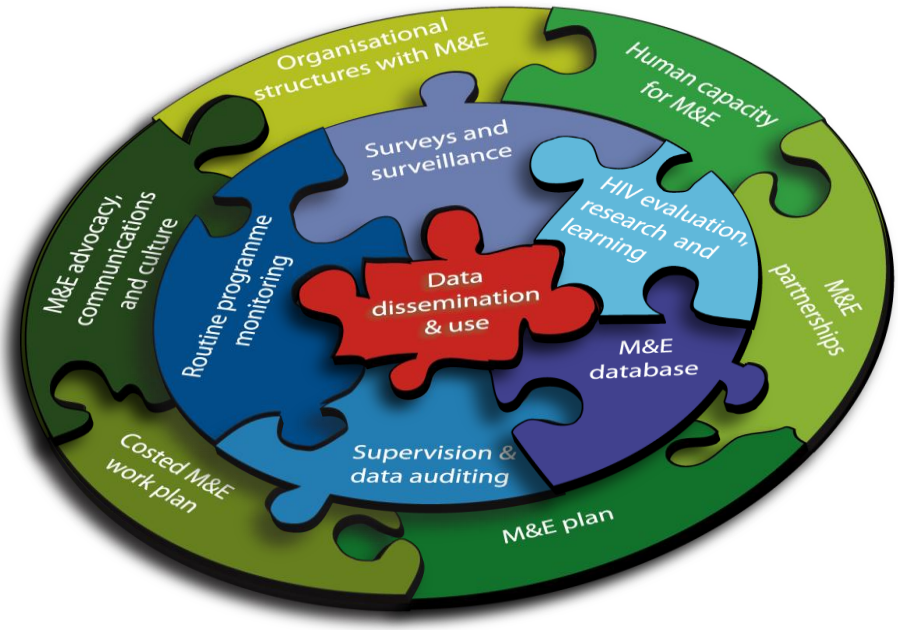
CC:

1. PS to Hon'ble Minister, Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.
2. PS to Hon'ble State Minister, Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.
3. PS. to Secretary, Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.
4. PO to Joint Chief (planning), Ministry of Health and Family Welfare, Bangladesh Secretariat, Dhaka.

ANNEX.6 ASSESSMENT OF EXISTING M&E MECHANISM OF HPNSDP

The components as identified by the Global AIDS Monitoring and Evaluation Team (GAMET) of the World Bank (Görgens-Albino and Nzima 2006) may be applied to assess the existing M&E mechanism of HPNSDP (See Figure 3).

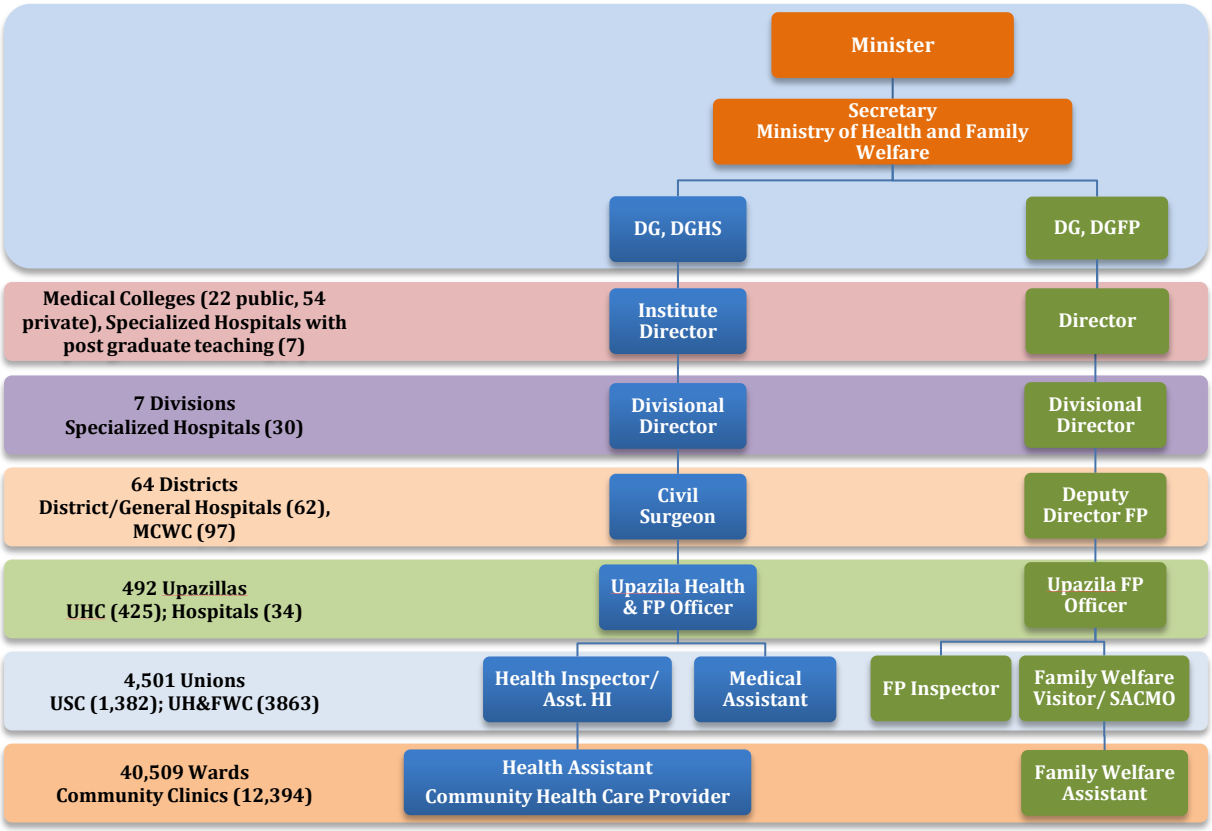
Figure 3: 12 Core Components of Functional M&E Systems



Component 1: Organizational Structure for M&E in Bangladesh's HNP sector

MOHFW is responsible for the implementation, management, coordination and regulation of national health and family planning related activities, programs and policies. The core functions are identified as planning and monitoring, budget management, information management, reform management, aid management, and the management of contracts and commissions (HLSP/Mott MacDonald Ltd. 2010). The public sector health services delivery is built on the country's administrative pattern which follows the national government, divisional administration, district administration, upazila (sub-district) administration, Union administration and Ward administration (see Figure 4).

Figure 4: MOHFW's Structure of Health Services Delivery[8] [CHECK WITH MPIR]



The routine health information system in MOHFW is bifurcated between the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP). The primary responsibility of M&E activities in the lowest 4 tiers (see Figure 4) lies with three different MISs (viz. MIS/DGHS in district and upazila levels, MIS/DGFP in union level, and CC MIS in CC-level). In order to coordinate and manage results at the MOHFW and feed the Program's progress into the APRs, an M&E Unit (MEU) was formally established in December 2006 under the Planning Wing during HNPSP. However, the MEU did not get formally integrated within the organizational structure of the MOHFW and operated by only three people, two staff provided by DP (GTZ), and one staff member seconded from DGFP. Outside MISs, National Institute of Population Research and Training (NIPORT) conducts periodic surveys that collect data on outcome and impact level indicators.

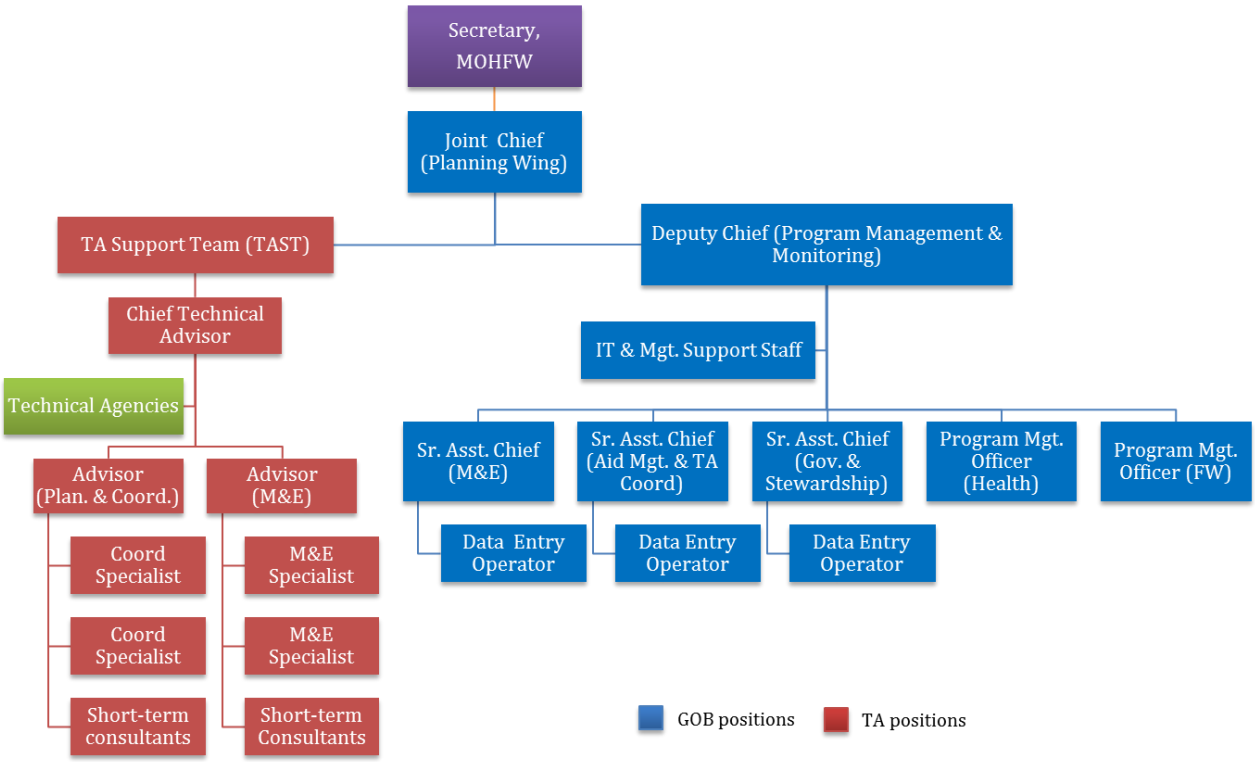
Component 2: Human capacity in performing M&E functions within the organization

As an effective M&E system needs to be coordinated by a central authority that should have dedicated M&E unit equipped with staff, along with the mandate and authority to coordinate M&E activities and ask for data from all relevant offices within the structure. As MEU was not in a position to function properly due to lack of capacity and capability, logistics, etc. (GOB 2011), PMMU was established within the Planning Wing of MOHFW consisting of GOB staff and detailed terms of reference at the very beginning of HPNSDP implementation vide a notification issued in December 2011 (see Annex 5). Under the overall leadership and supervision of the Joint Chief (Planning) of MOHFW, PMMU has four Planning Wing officials assigned as Deputy

[8] Source: GOB (2014a)

Chief/Sr. Assistant Chief/Assistant Chief and two Program Management Officers (PMOs) each deputed from DGHS and DGFP (see Figure 5). Also, under USAID and DfID technical assistance (TA), a five-member TA Support Team (TAST) works fulltime for PMMU (see Figure 5). The PMMU is entrusted with the responsibility of assisting the PW in appropriate planning, budgeting and monitoring for coordinated and efficient utilization of resources and for improving overall performance of the HNP sector (see Annex 5 for detailed terms of reference).

Figure 5: Structure of Program Management and Monitoring Unit (PMMU)[9] in MOHFW



In the area of MIS data collection, statisticians and other staff are involved with data entry, management and reporting at the district and upazila level facilities. Given the ongoing progress towards MIS automation and web-based data entry up to the community clinic-level in both the directorates, APR 2013 identified the need for training on the web-based platforms and software currently being used.

Component 3: Partnerships to Plan, Coordinate and Manage the M&E System

For effective M&E system it is imperative that all stakeholders within the MOHFW are involved in M&E activities along with other ministries, other government and non-governmental and private health service providers. The success of such a system depends on the establishment and maintenance of a partnership among the organizations, specifically among the organizational units responsible for M&E activities.

[9] Source: GOB (2011a)

An inclusive approach was adopted during designing of HPNSDP to develop the RFW. The first draft of the HPNSDP RFW, prepared as part of the initial version of HPNSDP Strategy Document, was extensively reviewed in a stakeholders consultation organized in 31 January 2010. Based on the consultation, a revised version was developed by the core technical team (Planning Wing, HPNSDP Program Preparation Cell – PPC, USAID, World Bank, ICDDR,B and MEASURE Evaluation) for the Pre-Appraisal Mission from September 26 to October 13, 2010. The HPNSDP's RFW Consultative Review Workshop was held in November 10, 2010. Around 130 participants including the policy makers attended the meeting and the Honorable Minister of MOHFW as the chief guest. Following the workshop, the RFW was finalized and subsequently incorporated into the PIP of HPNSDP and the PAD of the World Bank.

In order to plan and coordinate M&E activities in HPNSDP, a Monitoring and Evaluation Task Group (METG) was established with the Additional Secretary MOHFW as Chair and the Joint Chief (Planning) as the Member Secretary. The main objective of METG is to establish effective communication and better information/data sharing mechanism among MOHFW and its agencies for proper monitoring and implementation of HPNSDP.

PMMU coordinates with agencies under MOHFW to collect, collate and manage data and carry out monitoring activities for HPNSDP. However, a National M&E Technical Working Group involving other ministries or a mechanism to coordinate all stakeholders within Bangladesh's health sector is yet to be in place.

Component 4: National Multi-Sectoral M&E Plan for HNP sector program

Relevant policies including the national health policy have clearly explained the importance and necessity of the M&E for HNP sector program. The objectives of the national M&E plan are therefore explicitly linked to the National Strategic Plan or operational plans of the HPNSDP to ensure that relevant data are collected to measure the progress.

During the previous SWAp, HNPSP, one M&E Plan[10] for the sector program and one M&E Framework and draft Action Plan[11] for M&E Strengthening and Improvement for the health sector had been developed, which were neither approved by the MOHFW nor implemented during the program's lifetime.

The GOB's SFYP (by the Ministry of Planning) has set 37 (12 impact level and 25 output level) indicators to monitor the progress of HNP sector during FY 2011-15. Though not entirely, yet the HPNSDP RFW indicators and the SFYP key performance indicators are more or less same and largely overlap.

The 2013 APR of HPNSDP, recommended for development of M&E Strategic Plan as one of the prioritized actions before the 2014 MTR with[12] the following elements in place:

- broad-based multi-sectoral participation through a Technical Working Group in developing the M&E plan;

[10] JSI Bangladesh 2005
[11] GTZ 2010
[12] GTZ 2010

- the Plan is explicitly linked to the HPNSDP operational plans and other relevant planning documents; and
- the M&E plan adheres to international and national technical standards for M&E.

Component 5: Annual Costed National M&E Work Plan

A costed M&E work plan is critical that describes the priority M&E activities for the year with defined responsibilities for implementation, costs for each activity, identified funding, and a clear timeline for delivery of outputs. The costed national M&E work plan should reflect agreement on who will implement and finance each activity. All these are required to operationalize the M&E work plan effectively.

Though costed national M&E plan for the HPNSDP is not available, the estimated budget of different OPs involving M&E activities were prepared and incorporated into the HPNSDP PIP. SWPMM, MIS/DGHS, MIS/DGFP, PME, PMR, and TRD OPs are primarily responsible for performance monitoring of HPNSDP, and account for around 4% of HPNSDP development budget estimated for 2011-2016. Besides, there are other OPs as well (e.g. CDC, CBHC, MNCAH, TB/LC, NASP) who invest in generating routine data for monitoring implementation progress.

Component 6: Advocacy, Communication and Culture for M&E

Creating a supportive M&E culture and exposing M&E to minimize negative implication of sectoral interventions is important for a successful M&E system. To ensure advocacy, communication and commitment to M&E, the required elements are:

- the HNP sector communication strategy includes a specific M&E communication and advocacy plan;
- the M&E is explicitly referenced in health policies and the sector programs;
- the M&E champions' among high-level officials are identified for actively endorsing M&E actions; and
- the M&E materials are available that target different audiences and support data sharing and use.

Evidence and data are explicitly referenced in HNP policies and the sector programs in Bangladesh, and the Additional Secretary and the Joint Chief (Planning) effectively serve as the M&E champions' among high-level officials in MOHFW. However, there is no health sector communication strategy that includes a specific M&E communication and advocacy plan.

Component 7: Routine Program Monitoring

The data needs of different stakeholders should be determined and routine data from facilities and communities are captured in the sectoral M&E system on a timely basis to allow for their inclusion in routine reports and other information products. This will help guide evidence-based decision making at all levels.

Routine data collection from both facility and community-based services (community clinics, community health assistants, family welfare assistants) are ongoing in the HPNSDP using standardized data collection formats.

A Strengthening RHIS Pilot is also currently going on to review the existing paper-based MIS tools. This pilot by this time has already allowed to revise, redesign, pretest (in 1 sub-district)and finalize the recording, reporting tools at all levels of health and family planning up to sub-district level. The piloting resulted in 100% reductions in data collection forms for in-patient records, 60% reduction in monthly reports by HAs, and 50% reduction of registers used by FWVs. Under the piloting, technical support was also provided to design an electronic data capturing system and online reporting tools for DGHS (viz. individual level in-patient data entry system for UHC and district hospital, monthly reporting tools for UH&FWC, CC, HA, CSBA) and DGFP (viz. pregnancy registration system, online version of MIS 3, MIS 2, and monthly reporting tool for CSBA).

Component 8: Surveys and Surveillance

Surveillance and surveys are essential to determine the status and driving force of the HNP services in a given society. Over the last two decades a series of surveys of international standard, such as the Demographic and Health Survey, Service Provision Assessment (of health facilities), and the Multiple Indicator Cluster Survey, has been taking place at regular intervals.

The National HIV/AIDS program introduced a facility-based surveillance system since 1998, covering the most at risk population. Disease surveillance is one of the main activities of IEDCR under the DGHS. It runs well-functioning biological surveillance systems, which include Priority Communicable Diseases, Sentinel Surveillance, and Institutional Disease Surveillance.

Component 9: Comprehensive MOHFW Databases

Though a national health and family welfare database is not a prerequisite for a functional M&E system, it plays a critical role in ensuring an appropriate and timely data flow at different levels of data use. Moreover, it also allows the information to be captured in a way that facilitates data verification, data sharing, and data use.

A 26 month GIZ-funded project titled “Data Management and Information System (DMIS)” to develop a central data warehouse for the integration of data from different routine data sources completed in 2011 and was handed over to the MOHFW. The main objectives of DMIS were to make routine data centrally available allowing users to access data in a timely manner, to compare and combine data from different sources and to generate dynamic reports and queries from the system. However, integration of data from different routine data sources could not be achieved, and currently DMIS is located at MIS/DGHS to serve as the data warehouse, storing routine data from MIS/DGHS and MIS/DGFP.

Component 10: Supportive Supervision and Data Auditing

Supportive supervision means overseeing and directing the performance of others and transferring the knowledge, attitudes, and skills that are essential for successful M&E. It offers an opportunity to take stock of the work that has been done; critically reflect on it; provide feed-back to staff at lower levels of organization; and where appropriate, to provide specific guidance for making improvements. Data auditing is a process of verifying the completeness and accuracy of reported aggregate data.

Presently, several vertical programs have their own quality assurance system (EPI, EmOC) and conduct their specific audits (maternal death review, neonatal death), which are initiated and conducted from the central level or from the District level (DGFP, 8 regions) mostly on an ad-hoc basis . MIS/DGFP sends 4 supervision teams each month for validating and improving recording and reporting on sample basis for assurance of quality data. However, supervision of data quality remains a critical element as the FWA registers are entered in paper forms, and are aggregated up to the district level, before the information is sent electronically. MIS/DGHS has set up data transfer centres from paper to electronic entry using the DHIS system that has inbuilt data checking capabilities. However, there is no system in place for internal Data Quality Assessments (DQA) on regular intervals and overall M&E Data Quality Plan to provide oversight in monitoring quality (including accuracy, completeness and timeliness) of routinely collected data through the MIS systems.

Component 11: Evaluation and Research

In an M&E system, evaluation and research are essential but often found to be as neglected components. Proper use of evaluation/research data ensures that the planning is based on the best available evidence and guides ongoing program improvement. To get the maximum out of the research and evaluations, the following elements should be in place:

- Inventory of completed and ongoing evaluation and research studies.
- Inventory of local evaluation and research capacity, including major research institutions and their focus of work.
- National health sector evaluation and research agenda.
- Ethical approval procedures and standards.
- Guidance on evaluation and research standards and appropriate methods.
- National conference or forum for dissemination and discussion of health research and evaluation findings.
- Evidence of use of evaluation and research findings (e.g., referenced in planning documents).

Planning, Monitoring and Research (PMR) OP of DGHS and Training, Research and Development (TRD) OP of National Institute of Population Research and Training (NIPORT) have the primary responsibility of research activities within the HNP sector program. However, no national process has been established by these entities for identifying evaluation/research gaps relevant to the HNP Strategic Plan and for coordinating evaluation/research partners helps ensure that evaluation/research studies are relevant to the needs and provide actionable results.

During the previous HNP SWAps, MOHFW financed endline evaluations carried out by IMED of the Ministry of Planning (IMED 2003; IMED 2011).

Component 12: Data Dissemination and Use

There is a wealth of information available through the MISs of MOHFW. DGHS publishes the Health Bulletin annually and also makes it available on-line. Other publications include the EmOC and IMCI newsletters. DGFP also produces an annual report, as well as a monthly publication.

Major Limitations in M&E System under HNP Sector Programs

In addition to the assessment in Section 2.6, the main findings in relation to M&E from a number of studies, working papers, evaluations etc. on the two earlier HNP SWAps in Bangladesh[13] are listed below:

- **Fragmentation in M&E activities.** In the absence of an overall M&E strategy, each directorate (e.g. DGHS, DGFP) or program (e.g. EPI, TB&LC) concentrates on its own data and information needs. Lack of coordination between OPs (38 in total) and various programs in generating data to monitor and evaluate the implementation of their activities led to a multitude of reporting forms and requirements and repetitive collection of similar data. Information that flows from different M&E streams cannot easily be aggregated or compared for purposes of broader, cross-sectoral policy analysis.
- **Duplication of efforts.** Several routine data collection systems operate in parallel. Health facilities are overburdened with different reporting forms and formats (sometimes for the same indicators); Stressing/overloading the system's capacity at all levels due to "seasonal" collection of relevant data, e.g. APIR and other periodical reports.
- **Over-centralization of data utilization.** Health facilities, union, upazila and district health offices report aggregated data to the central level. The system does not provide tools for analysis at the periphery and the information needs of the local health and hospital management are barely satisfied/data are not accessible.
- **Under-funding.** M&E offices are short-staffed and lack specifically skilled personnel (e.g. in IT, epidemiology, etc.).
- **Delays and unreliability in routine reporting.** Overburdened by reporting requirements, and demoralized because of lack of feed-back, reporting is incomplete (sometimes even fake), too late, contradictory, and often not processed or analyzed at national level, poor quality of data and lack of ownership at service / facility level (lack of systematic feed-back from the central to the district and sub-district level), and consequently lack of data use in decision making processes at all levels.

HPSP aimed to establish a multi-level ESP-based M&E System based on 47 impact and output indicators and adapted a unified MIS to support the system. A Unified Management Information System (UMIS) was introduced during HPSP, reflecting the strategic approach of merging parallel structures maintained with both DGHS and DGFP under MOHFW. However, unification of FP and Health MISs could not be achieved and interim data gaps for M&E were partially covered by periodic surveys. Though the Program faced difficulties in monitoring and supervising program activities at national, district and field levels (IMED 2003), a results-based approach to monitoring and evaluation was maintained even in the absence of reliable data from MOHFW. The M&E framework for HPSP, which included annual program expenditure reviews, national health accounts and service delivery surveys, was carried out as planned, bringing the necessary information to stakeholders to assess program progress given the absence of MIS data.

[13] Spohr 2005; Ensor 2006; GTZ 2010; Schmidt 2006; Chabot et al. 2009

HNPSP initiated two separate monitoring frameworks – a Results Framework comprising 62 indicators and a Logical Framework with 90 indicators. The large number of indicators in both the frameworks involved huge level of effort and volumes of resources (for collection and analysis) and consequently the monitoring process was described as overly ambitious, complex and, for the most part, un-measurable. Over the program period the Results Framework, in which 42 indicators had no baseline and 35 indicators had no information available on progress, was used for monitoring HNPSP outcomes until the revision of RFW in 2010. The Annual Program Reviews and the Mid-term Review of HNPSP reported that the existing data management system (including HR MIS) in MOHFW failed to feed the data needs for the manager at different levels of the system and a non-existent feedback mechanism including lack of use of information in decision making process hampered M&E activities. Weak service statistics reporting – hardly any outpatient data were collected and data for inpatients had been coming only from a limited number of selected hospitals along with lack of use of ICT to modernize MIS remained as the major binding constraints in improving MISs.

Following recommendations of earlier assessments of M&E system in Bangladesh's health sector, creation of the Data Management and Information System (DMIS) during HNPSP was another notable attempt with the mandate to make data from different sources available and accessible centrally and to improve their reliability. Also during HNPSP, one M&E Plan for the sector program (2005) and one M&E Framework and draft Action Plan for M&E Strengthening and Improvement for the health sector (2010) had been developed, which were neither formally approved by the MOHFW nor implemented during the Program's lifetime.

In terms of critical gaps and challenges in data management, the Health Information System Assessment by Health Metrics Network in 2009 noted that the data management system in MOHFW; which covers all aspects of data handling from collection, storage, quality-assurance and flow, to processing, compilation and analysis; was "not adequate at all" with an average score of zero out of 15. The assessment observed that a) starting from the ministry level up to lowest tiered facility level, there is no written set of procedure for data management; b) lack of understanding about data makes the manager reluctant to handle data; c) no provision of "Metadata" available at national or sub-national level to identify source or methodology of data collection; and d) no functional coordination exists with private health service providers in relation to data management. The assessment identified that limited government budget funds for HMIS that led to over reliance on donor project resources and inadequate HR for implementation at all levels of the HNP service delivery structure were the major reasons for the current inadequate state of data management system in MOHFW (HMN 2009).

Following the comprehensive analyses of the HNP sector program's annual reviews in the past years, a number of recommendations were made for improving data management process in the monitoring of HPNSDP implementation:

- Improve the level of prioritization of information management in the sector. Appropriate and strategic advocacy should be carried out for various aspects of sector managers and decision-makers. Particular efforts may be made for appropriate funding (level, mechanisms) for information management.
- Address HR issues at the various levels through recruitment to fill up the vacant posts at MOHFW and strengthen the capacity of MISs by recruiting Biostatisticians at the Line Directorate level and Health Information Assistants at health facility levels.

- Establish systems for regular training and updating of skills for data collection and reporting for health workers.
- Streamline and improve MIS tools to manage workload of the fieldworkers.
- Establish mechanisms of data sharing by all MISs and enhance data use through provision of timely analysis and effective dissemination.

Overall, there is an urgent need to improve the timeliness, completeness and quality of facility-generated data with the help of information technology and supported by an up-to-date national health facility database (that aims to cover all public and private health facilities) with data on infrastructure, equipment and commodities, service delivery, and health workforce.

ANNEX.7 M&E SYSTEMS IN PREVIOUS AND CURRENT HNP SECTOR PROGRAMS

HPSP and HNPSP

Before introduction of Sector Wide Approach (SWAp) in Bangladesh, the health sector had many development projects with diversified objectives which had little coordinated impact on the overall improvement of the health service delivery in Bangladesh (Martinez 2008). The Health and Population Strategy of 1997 marked the decision to move away from a project-based modality to a sector-wide approach (SWAp) in the health sector of the Fifth Five-Year Plan, which began in 1998. This ensured Government's leadership in preparing and implementing the program in one hand and created an opportunity for better coordination, harmonization and alignment of multiple donor-funded projects and resources on the other (Martinez 2008). The SWAp helped to focus on critical development objectives like equity and access and also led to efficiency gains. It enabled the government to establish linkages between identified objectives, strategies, activities, resources and outcomes and reduced transaction cost in terms of DP engagements (GOB 2011).

The first SWAp was known as the Health and Population Sector Program (HPSP) 1998-2003 (GOB 1998). From July 2003, the second health SWAp titled Health, Nutrition and Population Sector Program (HNPSP) was implemented during 2003-2011 (GOB 2005). The implementation of HPSP, inter alia, started with the objectives of unified service delivery along with a unified management information system (UMIS) for both the Directorate General of Health Services (DGHS) and the Directorate General of Family Planning (DGFP) with a view to strengthen the M&E activities; this arrangement had to be reversed after three years of implementation of HPSP. The HNPSP implementation period ended in consolidating the earlier practices of separate Management Information Systems (MIS) of DGHS and DGFP and M&E mechanisms, with the exception of developing a Data Management Information System (DMIS) in the MOHFW. A draft M&E Framework was also prepared during HNPSP period, but no further work was carried out for finalization of the draft. Both the periods of HPSP and HNPSP could not devote much time and resources for strengthening the M&E system of HNP SWAp. However, a number of studies were carried out to identify the challenges and bottlenecks for an effective M&E system. MOHFW has decided to make a complete review of the studies and work done during HPSP and HNPSP along with lessons learned and develop an M&E Strategy and Action Plan by the Mid Term Review (MTR) of HPNSDP in 2014.

HPNSDP

In 2011, the MOHFW adopted the third HNP SWAp titled Health, Population, and Nutrition Sector Development Program (HPNSDP) 2011-2016 with the intention to strengthen health systems and improve health services (GOB 2011a). Based on the lessons learned from the previous SWAps, HPNSDP implemented a number of activities to support capacity building, streamlining, and scaling up of M&E systems in the HNP sector in Bangladesh (WB 2011).

Data for M&E flow vertically through the MOHFW's health services delivery structure, starting at the wards-level (Community Clinics – CC), and continues up to the union-level (Union Sub Center – USC and Union Health & Family Welfare Centre – UH&FWC), the upazila-level (Upazila Health Complex – UHC and hospitals) and the district-level (district/general hospitals and

Maternal & Child Welfare Centre – MCWCs). There are also division-level specialized hospitals. The routine MIS systems (MIS/DGFP, MIS/DGHS) vary in terms of the administrative level where data are aggregated and entered electronically instead of paper forms, and at what level direct entry into web-based systems occur. OPs are responsible for the collection and compilation of the implementation progress of operational plans as an input to the MOHFW's monthly monitoring of its ADP. Moreover, all the Line Directors submit monthly IMED report to MOHFW and Planning Commission which covers both physical and financial progress of OP activities (Muyeed and Al-Sabir 2013).

The MIS/DGFP, established for record keeping and reporting at the grass root level to generate reproductive health/family planning/maternal and child health (RH/FP/MCH) performance data, has three components: Service Statistics (SS), Logistics Management Information System (LMIS) and Personnel Management Information System (PMIS). The unit is involved in designing, developing, printing and implementing FWA register throughout the country for improved recording and reporting of service statistics. MIS/DGFP has introduced approaches to gather longitudinal data collection mechanism through FWA registers, various clinic registers and reporting formats – household and community level data is collected by FWAs using the FWA registers, from FWCs at the union level and by FP officers at the upazila level. This information is forwarded upwards to the district and divisional levels using a paper based system. This information is then sent from the district level to the MIS-FP headquarters through electronic data entry (Muyeed and Al-Sabir 2013). As of 2011, MIS/DGFP developed a web-based database that collects upazila-level data at the district level (DGFP 2012).

The MIS/DGHS uses District Health Information System (DHIS-2), a routine electronic information system for collecting health services data from the Upazila Heath Complex-level to the national level. Also, information from community-level is increasingly coming from CCs where laptops have been provided. Data entry is electronic at source (CCs and union facilities where internet connection is available, all MOHFW offices and hospitals at upazila level and above inclusive of district, divisional and national level) and data are entered into web-based systems directly using DHIS-2. In health facilities below upazila level, where there is no laptop or internet connection, data entry is paper-based and sent to upazila level for data entry electronically (Muyeed and Al-Sabir 2013).

Several other programs under the directorates, particularly under DGHS, also run their separate MISs for data entry and analysis. The Expanded Program on Immunization (EPI) has a strong and established information system for collecting and maintaining regular EPI related information from the community level in program office using their own software. EPI program also conducts Coverage Evaluation Survey (CES) annually to estimate immunization coverage at the household level. The Emergency Obstetric Care (EmOC) program under MNCAH OP collects and sends in-depth facility based obstetric care-related information from over 500 health facilities to their program office and publishes regular report about their achievements. The Integrated Management of Childhood Illness (IMCI) program under MNCAH OP also collects IMCI statistics (age and sex-disaggregated information of out-patient, emergency and in-patient children, availability and quality of services) from 275 sub-districts. Several sub-programs under the CDC OP, particularly the Institute of Epidemiology, Disease Control and Research (IEDCR) under the DGHS also has its own system of data collection and analysis from surveys and surveillance systems.

A Procurement and Logistics Monitoring Cell (PLMC) under the direct supervision of the Additional Secretary (Development and Medical Education) of MOHFW was established to, among other logistic management activities, introduce an electronic procurement tracking mechanism (WB 2011). TA support is being provided by USAID for the MOHFW and Logistics and Supply Units of DGFP and DGHS, to build logistic management capacity under the HPNSDP and strengthen the Logistics MIS (WB 2011; GOB 2011a).

A Program Management and Monitoring Unit (PMMU) has been instrumental in assisting the Planning Wing in monitoring the implementation process of the HPNSDP through producing key documents such as Six-monthly Progress Implementation Reports (SmPR) and Annual Program Implementation Reports (APIR) on time for Annual Program Review (APR), with relevant information and analysis. It also closely collaborates with DGHS and DGFP MISs and other agencies in activities related to strengthening and streamlining the routine health information systems.

ANNEX.8 HNP SECTOR MONITORING OUTSIDE MOHFW

Performance Monitoring by the Ministry of Planning

Historically GOB's focus of M&E activities had been on tracking public spending in terms of achieving financial targets (GOB 2011b). However, the GOB's Sixth Five Year Plan (SFYP) covering FY 2011-16 put emphasis on monitoring of results and aimed to strengthen capacities of the Planning Commission and the line ministries to undertake results-based M&E. This shift in focus entailed adopting proper M&E Frameworks, improving the database, and strengthening technical skills. The steps for developing an effective results-based M&E for the SFYP were outlined as: i) readiness assessment; ii) agreeing on outcomes to monitor; iii) selecting indicators to monitor; iv) establishing baseline data on indicators; v) monitoring for results; vi) emphasizing the role of evaluation; vii) reporting the findings; viii) using the findings; and ix) sustaining the M&E system within organization (GOB 2011b; Kusek & Rist 2004).

The SFYP's strategy to institute a results-based M&E involved the following actions (GOB 2011b):

- Assign lead responsibility for instituting a results-based M&E to the General Economics Division (GED) of the Planning Commission in collaboration with the IMED.
- Capacity of the Bangladesh Bureau of Statistics (BBS) will be strengthened to conduct surveys, special surveys and censuses and to enable it to produce quality data.
- The capacity of the GED and IMED will be strengthened with better staffing, technology, training and technical assistance to guide the M&E working groups, coordinate their activities and carryout analytical work.
- Results-based M&E good practices from international experiences including from those in India, Chile, Malaysia, Korea and Thailand will be reviewed and adapted to the specific context of Bangladesh.
- GED will collaborate with the line ministries, research institutions, and civil society.
- Proper review and dissemination of M&E results will be ensured to make this a useful tool for policy making.

The MDG goals have been well integrated into the SFYP, and it has been envisaged that reproductive health care system will be strengthened, while population control program would be revitalized to reduce population growth. The SFYP listed 12 impact/outcome- and 25 output-level indicators (37 in total) to track HNP progress of Bangladesh against specific targets as outlined below.

Table 1: HNP targets for the SFYP 2011-2015[14]

Sl.	Indicators	Base value with year	Target in FY 2015	2011 Update*
	Impact/Outcome			
1.	Life- Expectancy	66.6 (SVRS 2007)	70	69.0 (SVRS 2011)
2.	Population Growth Rate	1.40 (SVRS 2007)	1.3	1.37 (SVRS 2011)
3.	Maternal Mortality Ratio (MMR) (per 100,000 live births)	194 (BMMS 2010)	143	N/A
4.	Neonatal Mortality Rate (per 1000 live births)	37 (BDHS 2007)	27	32 (BDHS 2011)
5.	Infant Mortality Rate (per 1000 live births)	52 (BDHS 2007)	31	43 (BDHS 2011)
6.	Under 5 mortality Rate (per 1000 live births)	65 (BDHS 2007)	50	53 (BDHS 2011)
7.	Malaria mortality-(per 100000 population)	4.4	2.2	0.11 (NMCP 2013)
8.	Maintain low prevalence of HIV	<1%	<1%	0.1% (WB 2013)
9.	Prevalence of Night blindness among pregnant women	2.90%	1%	2.74% (MoHFW 2013)
10.	Underweight of Under 5 children (6-59 months)	41% (BDHS 2007)	33%	36% (BDHS 2011)
11.	Stunting of Under- 5 children 16-59 months)	43% (BDHS 2007)	25%	38.7% (UESD 2013)
12.	Total Fertility Rate (TFR)	2.7 (BDHS 2007)	2.2	2.3 (BDHS 2011)
	Output			
13.	Contraceptive Prevalence Rate (CPR)	55.8% (BDHS 2007)	74%	62% (UESD 2013)
14.	Modern Method of Contraceptives	47.5 (BDHS 2007)	63%	53.1% (UESD 2013)
15.	Discontinuation rate of FP methods	56.5% (BDHS 2007)	20%	35.7% (BDHS 2011)
16.	Unmet need for Family Planning	17.1% (BDHS 2007)	7.6%	13.5% (BDHS 2011)
17.	Contraceptives use rate of married adolescent	37.6% (BDHS 2007)	50%	42.4% (BDHS 2011)
18.	Permanent & Long acting FP (of CPR)	7.3% (BDHS 2007)	20%	8% (BDHS 2011)
19.	TB case detection rate	73% (NTP 2008)	75%	70% (NTP 2012)
20.	TB cure rate	92% (NTP 2008)	95%	92% (NTP 2012)
21.	Effective malaria prevention to 100% population at risk	5 districts	5 districts	-
22.	Proportion of household own at least 1 Insecticide Treated Net (ITN)	64%	80%	82% (MoHFW 2013)
23.	Under 5 children sleep under ITN	70%	80%	90% (NMCP 2013)

[14] Source: GOB (2011b)

Sl.	Indicators	Base value with year	Target in FY 2015	2011 Update*
24.	Births attended by skilled health personnel	26.5% (UESD 2010)	50%	34.4% (UESD 2013)
25.	Facility level delivery	15% (BDHS 2007)	40%	28.8 (BDHS 2011)
26.	Antenatal care (ANC) coverage (4 visits)	20.6% (BDHS 2007)	50%	26.8% (INFSU 2013)
27.	Postnatal care coverage (Mother)	21.3% (BDHS 2007)	50%	27.1% (BDHS 2011)
28.	Postnatal care coverage (children)	21.9% (BDHS 2007)	50%	29.6% (BDHS 2011)
29.	Met need for EOC services	22.4% (BDHS 2007)	80%	55.95% (BDHS 2011)
30.	TT coverage (children protected at birth from Tetanus)	93% (CES, 2008)	95%	94% (WB 2013)
31.	Valid coverage of full Immunized children	75.2% (CES, 2008)	90%	81.2% (CES 2013)
32.	Immunization of 1- year old children against Measles	83% (CES, 2008)	90%	84% (BDHS 2011)
33.	VAC coverage (6 m-6 y)	98%-100%	98-100%	94% (WB 2013)
34.	Postnatal VAC supplementation	29%	80%	75% (UESD 2013)
35.	Severe anemia (Children)	64%	50%	33% (BMNS 2012)
36.	Severe anemia (Pregnant women)	46%	40%	42.4% (BDHS 2011)
37.	Exclusive breast feeding of children (less than 6 months)	42%	80%	63.4% (INFSU 2013)

* MOHFW's update to Planning Commission in April, 2014

Performance Monitoring by the Ministry of Finance

Program Planning and Budgeting: The PW of the MOHFW is responsible for the development of the medium (3-year, 5- year) and long term plans and development budget of the Ministry including the Program Implementation Plan (PIP) of HPNSDP based on the medium term budget framework (MTBF) by the Ministry of Finance (MOF) while respective LDs prepare their OPs based on the PIP. The Development and the Non-development budgets of the MOHFW are currently prepared based on MTBF resource envelop.

As per the recent Medium-Term Budgetary Framework (MTBF) covering 2013-14 to 2017-18, the MOF has outlined the medium-term strategic objectives and activities for the MOHFW with the focus on ensuring affordable and quality health care and family planning services for all by improving the HNP sector and building a healthy, strong and effective workforce (GOB 2013b). In consultation with the MOHFW, MOF has also developed a list of key performance indicators (KPI) with medium-term targets for MOHFW (see Table 2).

Table 2: Key Performance Indicators for MOHFW under MTBF 2013/14 – 2017/18

Sl.	Indicators	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
1.	Under 5 Mortality Rate (per 1000 live births)	53	51	50	49	48	47	46
2.	Maternal Mortality Ratio (MMR) (per 1000 live births)	1.80	1.70	1.61	1.51	1.43	1.33	1.23
3.	Delivery Rate by Trained Birth Attendant (percent)	31.7	36	41	46	50	54	58
4.	Total Fertility Rate (per woman)	2.3	2.22	2.14	2.07	2.0	2.0	2.0
5.	Under 5 Malnutrition Rate (percent)	36.4	36	35	34	33	32	31
6.	Expansion of EPI Coverage (percent)	80	82	86	88	90	90	92

In order to feed into the Annual Economic Review published by the Ministry of Finance, yearly update on progress made in the previous year is provided by MOHFW.

HNP Sector Reviews for Global Reporting

Global reporting requirements will be based on ongoing country processes of data generation, compilation, analysis and synthesis, communication and use for decision making. The M&E Strategy will serve as the basis for all M&E related processes for HNP SWAps and closely collaborate with program activities supported by GAVI, the Global Fund and other DPs, and for disease- and program-specific needs.

Reporting Requirements on International Commitments and Resolutions

Bangladesh is a signatory to a number of international commitments and initiatives including the Millennium Development Goals (MDGs), Commission on information and accountability for Women's and Children's Health (COIA), the U.S. Global Health Initiative, the International Conference on Population and Development (ICPD), United Nations General Assembly Special Session (UNGASS) on HIV/AIDS, the Paris Declaration on Harmonization and Alignment, etc. The HNP sector program in Bangladesh follows the principles of the Paris Declaration and the Accra Agenda for Action in the interaction and collaboration with national and international development partners.

Millennium Development Goals (MDGs). Bangladesh is committed to achieving the MDGs by 2015. The MDGs directly relevant to the health sector are: MDG 4: Child Health; MDG 5: Maternal Health; MDG 6: HIV and AIDS. The health sector also bears indirect responsibility in the achievement of MDG 1: End poverty and hunger; MDG 3: Gender equality; and MDG 7: Environmental sustainability. Most of the HNP related MDGs are reflected in the RFW of HNP SWAp, and periodic surveys (e.g. BDHS, MICS) capture the updates of these indicators on regular intervals. The annual report from MIS/DGHS also provides update on HNP-related MDG indicators.

Commission on Information and Accountability for Women's and Children's Health (COIA). The United Nations Commission on Information and Accountability for Women's and Children's Health, established in December 2010 by the UN Secretary-General Ban Ki-moon, was charged with developing a framework for global reporting, oversight, and accountability related to the Global Strategy for Women's and Children's Health[15]. As a COIA country, Bangladesh periodically provides update on the 11 core indicators identified by the Commission to track progress in increasing coverage of interventions needed to ensure the health of women and children across the continuum of care. Due to the nature of the core COIA indicators (eight measures of intervention coverage and three measures of impact), updates on these indicators are primarily captured through periodic surveys. Though the responsibility for major parts of the follow-up on this accountability agenda, including annual reporting and analysis of country-specific information on the Commission's key indicators of coverage and its determinants lie with "Countdown to 2015"[16], MIS/DGHS is currently working on providing periodic updates on coverage indicators using routine information systems.

United Nations General Assembly Special Session (UNGASS). As a signatory to the UNGASS Declaration of Commitment on HIV/AIDS IN 2001, Bangladesh continues monitoring progress in combating HIV/AIDS by the National AIDS/Sexually Transmitted Disease Program (NASP) under DGHS. Its four major components are intervention in high-risk groups; advocacy and behavior change communication; blood safety; and institutional strengthening and capacity building, and are implemented through NGOs. NASP has developed M&E mechanisms to assist with follow-up in measuring and assessing progress, developed appropriate monitoring and evaluation instruments, with adequate epidemiological data. Bangladesh submits annual reports based on the UNGASS indicators.

United States Global Health Initiative (GHI). Since 2009, the Global Health Initiative (GHI) strategically combines the capacities of U.S. Government agencies to address global health challenges that threaten lives at home and around the world[17]. GHI in Bangladesh offers an opportunity for the US Government to provide immediate assistance and support for the country's efforts to ensure health and nutrition services, and stabilize population. The GHI is timed for enhancing US Government's support to GOB's HNP sector program for 2011-16. The GHI's results framework is closely aligned with HPNSDP's RFW and focuses on the three intermediate results to revitalize family planning, improving health services, and systems and governance. Also under GHI, a number of technical assistance supports on improving M&E systems for reporting and decision making in MOHFW are ongoing.

Performance Monitoring and Review for Global Health Grants

The HNP sector in Bangladesh is also supported through international grants like the Global Fund for Tuberculosis, HIV/AIDS and Malaria (GFTAM) and Global Alliance for Vaccines and Immunization (GAVI), which provide funds based on performance. All these require M&E Plans at the time of Grant/Loan signature and ongoing disbursements are linked to the achievement of clear and measurable programmatic results.

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[15] http://www.countdown2015mnch.org/about-countdown/accountability
[16] http://www.countdown2015mnch.org/country-profiles/bangladesh
[17] http://www.ghi.gov/about/howWeWork/index.html#.UqTpWvQW2d0

Global Alliance for Vaccines and Immunization (GAVI). GAVI, a public-private partnership of major stakeholders in immunization, was set-up in 2000 to save children's lives and protect people's health by increasing access to immunization in developing countries. Bangladesh receives supports from GAVI on immunization services and health systems strengthening (HSS)[18]. GAVI supported activities are implemented by OPs under DGHS and the monitoring framework uses the routine information from MIS/DGHS.

Global Fund for HIV/AIDS, Tuberculosis and Malaria (GFATM). Though 10 active grants at this moment, GFATM has been supporting Bangladesh in the fight against TB, malaria and HIV/AIDS since 2003[19]. Programs supported by the Global Fund have made an increasingly significant contribution to the international targets for key services such as the provision of lifesaving anti-retroviral therapy for people living with HIV, TB treatment under Directly Observed Treatment Short Course (DOTS) and ITN to prevent the transmission of malaria. Though a national M&E committee consisting of representatives of the government, NGO's and development partners is responsible for monitoring and evaluation of GFATM components, it uses the routine information systems for updating indicators.

[18] http://www.gavialliance.org/country/bangladesh/documents/#dqa
[19] http://portfolio.theglobalfund.org/en/Country/Index/BGD