BANGLADESH

Pro-poor Targeting

Targeting the Poor for UHC Program Inclusion: Exploring a More Effective Pro-poor Targeting Approach

1. Introduction

Universal Health Coverage (UHC) is target 3.8 of the Sustainable Development Goals (SDGs), to be achieved globally by 2030. UHC implies that every person everywhere has access to quality health care without suffering financial hardship. To achieve UHC means reaching every person in a country, including the poor, marginalized, and disadvantaged. It is important to ensure that social protection programs are designed and targeted to specifically reach these populations – without targeting, programs often miss precisely those at highest risk. The Government of Bangladesh (GoB) has endorsed UHC as part its SDGs.

Bangladesh has rich experience in implementing a large number of social safety net programs (SSNPs) that rely on targeting as a key operational tool. The Power and Participation Research Centre (PPRC) conducted a qualitative review, with support from USAID's Health Finance & Governance (HFG) project, of current targeting approaches and experiences in order to explore more effective pro-poor targeting strategies for UHC-related program design. A literature review was conducted on targeting and SSNPs to identify how targeting is conceptualized and operationalized. A qualitative review of six SSNPs was then carried out covering the areas of health, workfare, and food assistance. The purpose was to develop an operational map of the various aspects of targeting strategies, and to develop recommendations for improved and operationally effective targeting for UHC-related programs in Bangladesh. This includes a set of clear criteria to identify and target the poor as beneficiaries, and an approach to reduce both exclusion and inclusion errors. Additionally, a review of the National Household Database (NHD) initiative was also undertaken to understand how it might contribute to targeting in Bangladesh.

This brief highlights the learnings and recommendations from the review in order to improve operationally effective targeting approaches for UHC-related programs in Bangladesh.

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2. Key Elements of Pro-Poor Targeting

An important operational concern in UHC-related program design is the effectiveness of targeting. While universality is an inherent ambition in the UHC goal, targeting the poor and disadvantaged is often a real-life necessity, particularly in resource-constrained developing societies.

Targeting refers to concentrating social protection program resources (e.g., for food security, disaster relief, health, education, or employment) on the poor and vulnerable so that they are the main beneficiaries.

Targeting has both advantages and costs, and there are several methods of implementation, none of which are foolproof. An important objective is to maximize impact using cost effective program implementation, minimizing inclusion of non-target populations (inclusion errors) while avoiding unwarranted exclusion of the target population (exclusion errors).

3. Key Conceptual and Operational Insights from Literature Review

Literature on targeting and social safety net programs from Bangladesh and globally were thoroughly reviewed (see References). The literature review was then summarized to identify how targeting is conceptualized and operationalized.

Conceptual Insights

Targets of social safety net programs could be: i) all of the poor in a specific program location; ii) specific segments of the poor (e.g., urban poor); iii) all households in poverty-prone geographic pockets; and/or iv) specific demographic segments (e.g., women, children, or disabled).

The two types of errors usually found in targeting are inclusion errors (i.e., leakage or inclusion of non-target persons), and exclusion errors (due to under-coverage or social discrimination).

Targeting performance can be understood as either targeting effectiveness (i.e., minimizing inclusion errors), or targeting efficiency (i.e., effectiveness and cost-efficiency in delivery). There is a **trade-off** between improving targeting effectiveness and targeting efficiency – over-elaborate targeting may increase administrative costs to the detriment of resources available for program coverage, and is a typical dilemma for program managers.

Operational Insights

There are **five major categories** of targeting methods: i) means testing based on household income; ii) proxy means testing based on easier-to-collect income proxy variables; iii) participatory targeting based on target identification through guided participation of the beneficiary community; iv) self-selection whereby the very nature of the benefit (e.g., casual employment or an inferior good) ensures that only intended target (e.g., rural extreme poor) will apply; and v) geographic targeting. Two **types of information** are relevant to effective targeting – information on the area or community, and information on the beneficiaries. There are two options to **collect beneficiary information** – program workers visit beneficiaries at home or at their workplace, or beneficiaries visit the local program office. Home/workplace visits have cost implications for the program. For effective targeting, other relevant **contextual factors** include: i) administrative capacity to undertake targeting; ii) availability and quality of public information on target populations; iii) community/ beneficiary willingness to participate; and iv) clarity on who bears fiscal responsibility for the subsidy burden of targeting.

4. Methodology for Review of SSNPs

PPRC conducted a qualitative review of selected operational SSNPs. Initially a core expert group was convened to brainstorm on targeting and how a review exercise would be best pursued. A total of six programs covering both government and non-government sectors, as well as health and non-health programs, were selected for review due to time and budget constraints (see Table 1).

Table 1: List of Selected Programs Implementing Targeting Approaches

Name of Program	Program Focus	Implementing Organization
Maternal Health Voucher Scheme/Demand Side Financing (DSF) program	Maternal and reproductive healthcare for pregnant women	Ministry of Health and Family Welfare
Employment Generation Program for the Poorest (EGPP)	Eighty days guaranteed employment	• Department of Disaster Management • Union Parishad
Vulnerable Group Feeding (VGF) program	Food support	• Department of Disaster Management • Union Parishad
Urban Primary Health Care Project (UPHCP)	Maternal and child healthcare	• Ministry of Local Government, Rural Development and Co-operatives (LGRD) • City Corporation/ Pourashava • Non-governmental organization (NGO)
Sajeda Foundation program	Primary healthcare	NGO
Gano Shashthaya Kendro (GSK) program	Primary healthcare	NGO

The purpose of this review was not to assess the performance of SSNPs, but to learn about and draw lessons for effective targeting in order to accelerate progress towards UHC in Bangladesh.

During the review, the study team attempted to answer the following questions:

- What are the main features of the targeting approaches?
- What are the rationales behind a specific targeting approach?
- What actions are taken during implementation of targeting?
- What are the gaps in targeting approaches, and what is recommended to overcome them?

Data collection was conducted at the head offices of the six SSNPs, along with field offices in Tarail upazila and Kishoreganj Pourashava of Kishoreganj district, Dhamrai and Keraniganj upazilas of Dhaka district, and Debidar upazila of Comilla district. The research involved focus group discussions (FGDs), key informant interviews (KIIs), and program related document reviews. FGDs were conducted with managers and service providers. KIIs were conducted with senior managers of the programs at national level.

5. Findings from Review of SSNPs

Findings from the document reviews, FGDs, and KIIs with the six SSNPs were categorized and schemed into a program-wise summary. Table 2 (below) summarizes the results for each of the six programs.

Table 2: Summary of Findings from the selected SSNPs

DESCRIPTION	PROGRAMS					
	DSF	EGPP	VGF	UPHCP	Sajeda Foundation	GSK
Targeting Approaches						
Target population	Poor pregnant women in selected upazilas.	Rural extreme poor.	Rural poor.	Urban poor of selected pourashava/city corporation.	Urban and peri-urban poor.	Rural population in the catchment of an area office and its sub-centers.
Eligibility criteria for inclusion in the program	• Functionally landless (owning less than 0.15 acres of land). • Earning extremely low and irregular income or no income (less than Tk. 2,500 per household per month). • Owning no productive assets, such as livestock, orchards, rickshaw or van.	• Land-ownership below 10 decimals, or • Monthly family income below Tk. 4,000, or • Primary occupation is wage labor, or • No ownership of livestock or fishing ground.	Any four of the following criteria: • Landless except for homestead; • Main occupation is wage labor; • Female-headed household; • Dependent on begging, do not consume two meals per day for a significant part of the year; • No adult earner; • Children sent to work instead of school; • No income-generating assets; • Divorced or abandoned woman; • Household head is a poor freedom fighter; • Household head has disabilities; • No access to micro-credit; and/or • Food-insecure due to disaster.	• Indicators on: i) monthly income; ii) monthly expenditure; iii) monthly house rent; iv) family assets; v) annual expenditure on food, health, and education; vi) debt; vii) source of water; and viii) presence of a disabled member. • Only those scoring below 20 in major city corporations, below 15 in other city corporations, and below 10 in municipalities are eligible for free service for defined ailments in a defined health facility in the locality. • Scoring procedure is explicitly spelt out.	• All those who pay an annual fee of Tk. 150 are eligible for a health card either for an individual or for a family. • Micro-credit borrowers are eligible for a card against an annual fee • No explicit eligibility criteria to identify 'poor'. Patients who walk-in may be assessed subjectively by the attending physician as to whether they are eligible for a discount.	Households are grouped into six categories and provided with color-coded health cards: • Group A (extreme poor/ poor): i) no fixed residence; and ii) dependent on others for living. • Group B (lower middle class): i) monthly income between Tk. 3-5,000; and ii) mainly labor occupations. • Group C (upper middle class): monthly income between Tk. 5-10,000; and ii) mainly marginal farmers/ petty business. • Group D (less rich): i) monthly income between Tk. 10-20,000; ii) service/business occupations, and also surplus agri-production; and iii) • Group E (rich): i) monthly income between Tk. 20-30,000; ii multiple occupations; and iii) vehicle owner.

Description	DSF	EGPP	VGF	UPHCP	Sajeda Foundation	GSK
Eligibility criteria for inclusion in the program						• Group F (very rich): i) multiple income sources; ii) multiple houses; and iii) socially identified as rich.
Implementer	• Union Parishad. • Resident Medical Officer (Upazila Health Complex).	• Department of Disaster Management. • Upazila Administration. • Union Parishad.	• Department of Disaster Management. • Upazila Administration. • Union Parishad.	• Project Director (Local Government Division) • Municipality/City Corporation • Selected NGO	Area Office	Area Hospital Manager and Field Worker
Beneficiary identification and services	• Family Welfare Assistant identifies pregnant women in poor neighborhoods. • Information on the identified pregnant women are collected through a prescribed form. • Union DSF Committee reviews the collected forms and prepares an initial list of beneficiaries. • The beneficiary list is finalized by the upazila DSF committee based on the number of beneficiaries centrally allocated for the upazila.	**Similar process for both EGPP and VGF:** • Ward Committee identifies eligible beneficiaries based on both verbal requests by potential beneficiaries and the committee's assessment of applicants against eligibility criteria. The number of beneficiaries is determined based on the quota limit, which is set centrally. • Once a list has been prepared, the Ward Committee collects socio-economic data relevant to the eligibility criteria for each of the listed individuals. This data and list is sent first to the Union and then to upazila for final approval.		• Field workers identify poor neighborhoods through visual observation, i.e. low-income settlements, and further identify poor households in low-income settlements through visual observation. • Identified households are asked to provide information using a prescribed form. • On the basis of the information collected, identified house holds are assigned scores and classified. • Households classified into the two poorest categories are issued separated color-coded cards against which benefits are availed.	• Individuals who walk into the area office-cum-hospital are asked to provide demographic data for their discount card. The person pays an annual fee of Tk. 150 for the card. • The discount card offers certain entitlements against a fee chart, which is described in a brochure and publicly displayed. • Poor beneficiaries are not separately identified but if a patient seeks additional discounts, this is a discretionary decision by the doctor based on visual assessment of the poverty status of the patient.	• All households in the catchment are surveyed with a brief socio-economic data form, which is undertaken by Field Workers assigned to the sub-center. • Information is collected on three main indicators – reported income, housing, and occupation. • Based on classification, households are issued with color-coded health cards with the following premium chart: - Group A : No premium - Group B: Annual premium of Tk. 300 - Group C: Annual premium of Tk. 350 - Group D: Annual premium of Tk. 400 • Insurance covers medical consultation for all groups. • For extreme poor, there is an additional facility of 10% discount on medicine. • Ready-made garment female workers are provided with a 50% discount on cesarean costs.
Targeting in Operation as Reported by Program Managers						
Inclusion or exclusion errors	• Move from universal coverage to a quota has led to exclusion of some target population. • Some inclusion errors were noted.	Program managers estimated both inclusion and exclusion errors of up to 10%.	Program managers estimated both inclusion and exclusion errors of up to 10%.	No examples provided.	Since the hospital has no specific targeting strategy beyond a general strategy of targeting poorer localities, issue of inclusion or exclusion error does not apply.	Program has an approximate 15% inclusion error due to pressure from the three upper-income groups listed by the program.

Description	DSF	EGPP	VGF	UPHCP	Sajeda Foundation	GSK
Monitoring system to ensure targeting	Four-stage monitoring system: • Union Parishad health workers; • Ward member; • Union Parishad chairman; and • Upazila DSF committee.	Formal monitoring system is in place but implementation is not robust.	Formal monitoring system is in place.	• Field worker collects and verifies beneficiary information. • Supervisor verifies to assign economic classification to households.	Strong monitoring system for overall service-delivery, but not for targeting.	• Flexible monitoring system. • Monthly monitoring report is sent to the central research cell.
Grievance redressal system	• No specific grievance redressal system in place, but there is a complaints box in the upazila health complex. • No written complaints received, but several verbal complaints.	Formal grievance redressal system is in place, but few written complaints have been received.	Formal grievance redressal system is in place, but few written complaints have been received.	• No formal system. • Complaints box for written complaints but no written complaints have been received. • Usually verbal complaints. • Follow-up is at the discretion of the supervisor.	• Complaints box in service centers but no written complaints have been received. • Complaints are mostly verbal • Many complaints are actually suggestions.	• No formal system. • Some verbal complaints.
Barriers to implementation	• Higher number of eligible women excluded due to declining annual quota. • Pressure for inclusion from economically sound families. • Delays in allocation from Ministry.	• Eligibility criteria of age limit to 60 years excludes many applicants. • Nepotism among local government functionaries.	• Some beneficiaries without a token have to be accommodated. • Often allocated amounts were not distributed	• No dedicated space or budget for satellite clinics hampers service delivery. • Lack of privacy affects the quality of services for pregnant women.	Poor road infrastructure hinders proper delivery of services, including movement of ambulances.	• Upper groups were unwilling to participate in the survey. • Households categorized as 'lower middle class' put pressure to be listed in the 'poor' category.
Weakness in capacity	• No additional personnel provided. • Nepotism among local government functionaries.	Newly elected local government members take time to get acquainted with the task.	None reported by the program manager.	• Lack of information about the service among the community. • No full-time gynecologist service available.	Lack of specialists is a general weakness, but not relevant to the issue of targeting.	• Shortage of field level health workers. • Work-load of field workers, as well as low salary for doctors, are disincentives.
Suggestions for improvements	Women who have had miscarriages in their first and second pregnancies are excluded under current rule, which may be changed.	• Raise age limit to 65 years. • Make land ownership eligibility criteria flexible.	Food ration should be distributed in pre-packed bags.	Provide funds for dedicated space for satellite clinics.	Stronger information campaign to make local people aware of services.	• For better implementation of targeting approach, there is a need for improved human resources including more health workers.

6. Key Lessons from Review of SSNPs

- Targeting advantages must be balanced with the costs of targeting – overly elaborate eligibility criteria and large investments in beneficiary household data collection (e.g., means testing or proxy means testing) can improve targeting effectiveness but reduce efficiency in terms of the adequacy of program scope and duration.
- At the program level, an information campaign among the target population is a crucial complimentary investment to ensure better targeting outcomes.
- Targeting methods, such as means testing or proxy means testing, may be suitable for contexts characterized by chronic poverty, but are unsuitable for contexts with transient poverty, i.e., where there is significant mobility among the poor such as in urban areas of Bangladesh.
- Where spatial concentration of poverty is a strong feature (e.g., in urban or peri-urban areas), the location of the program facility is a critical success factor.
- Choice of proxy variables for targeting remains a research challenge – for example, while housing was a strong poverty correlate up to the 1990s, this is now much less significant.
- Fee-based entitlement cards are a promising entry point for popularizing health insurance, as well as for targeting, provided supply-side bottlenecks do not become critical.
- Satellite clinics without dedicated space or privacy are inadequate in the context of maternal and child health services for the urban poor.
- Targeting strategies that combine multiple methods have been found to be more effective.
- Both national and global experience is mixed on the success of targeting approaches.

- Targeting mechanisms need not be mutually exclusive. While strong evidence is lacking, several targeting methods applied simultaneously appear to prove more effective than reliance on a single mechanism, at least in reducing errors of inclusion.

Success Factors in Targeting
- **Key success factors include:**
  - **Clarity on the target population;**
  - **Well-chosen and pragmatic eligibility criteria matching the program content;**
  - **Independent eligibility verification;**
  - **Monitoring and accountability framework in place; and**
  - **Credible engagement of community actors.**

7. Review of Poverty Register Initiative / National Household Database

The NHD project (initially named the Poverty Register Initiative) is being implemented by the Bangladesh Bureau of Statistics. It is one of the components of GoB's Safety Net Systems for the Poorest project (supported by the World Bank). Under this project, surveyed households are assigned a poverty score card (PSC) using a proxy means test formula. A total of 34 million households are being surveyed in three phases. The output will be a database of poor and non-poor households based on their PSC result. However, the project is running two years behind schedule and is expected to be completed in 2020.

NHD might contribute to targeting in Bangladesh, if the following issues are addressed:
- The NHD is updated at regular intervals (e.g., every three years) to adjust for mobility within and across the poverty line;
- The NHD is linked to each of the public safety net schemes, possibly using the national identification number;
- NHD is linked with the management information system of beneficiaries being developed at the Department of Disaster Management; and
- Provision for explicit beneficiary consent is built into the survey forms – this will avoid any ethical and legal concerns in the use of the beneficiary data for program implementation.

8. Recommendations

Table 2 demonstrates that each of the reviewed SSNPs has developed its own targeting approach based on program design and available resources. A range of targeting approaches have evolved covering all five categories listed in Section 3 (above). Bangladesh now needs a national standard for targeting to reduce duplication and program specific costs, as well as to improve benefits to target populations. While the move towards a national standard will take time, this brief provides recommendations for designing and implementing a targeting strategy for any SSNP, with clear relevance for programs designed to support UHC.

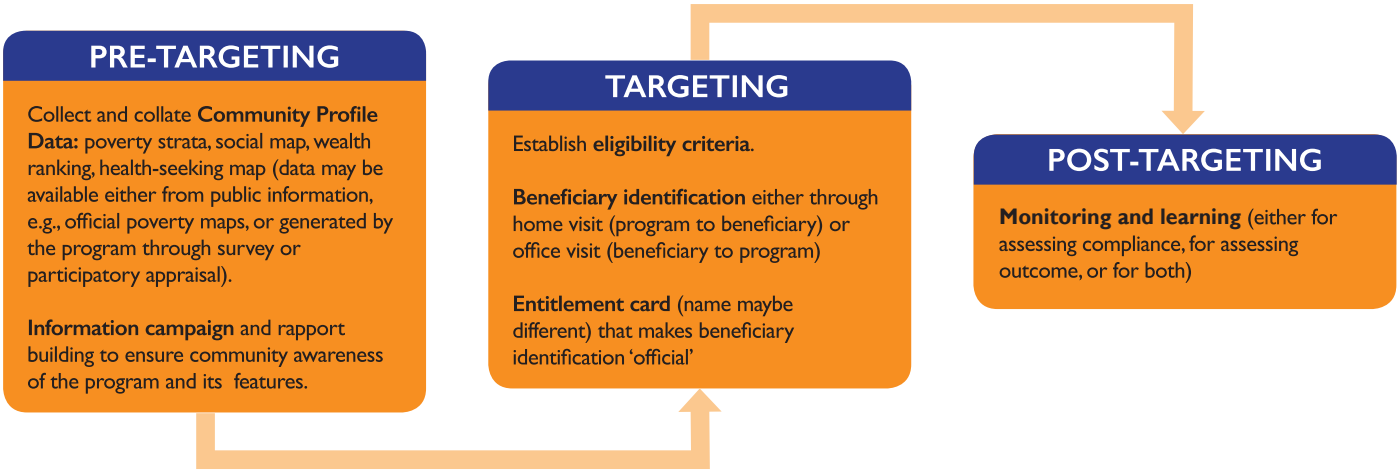
- An effective targeting approach should be built not only on sound conceptual principles but also on sound operational considerations. The review identified three operational priorities that merit attention:
  - *An information campaign* to ensure buy-in from the target community;
  - *Proximity to the facility providing services*, which is a key consideration for the poor, particularly in urban contexts where distance entails both costs and unfamiliarity; and
  - *A fee-based entitlement card*, which can clarify beneficiary expectations on services and costs, and empower beneficiaries by giving a measure of 'identity' to their transactions with the service provider. However, none of the available entitlement cards have passed the test of universal acceptance, and new programs will require a reality check.

- Insights from program implementation suggest targeting approaches should combine geographic targeting with participatory approaches. All targeting approaches have their strengths and weaknesses. A combined approach would leverage the common phenomenon of spatial concentration of poverty and builds in an element of social accountability, while also avoiding heavy upfront cost burdens of detailed surveys.

- The Poverty Register Initiative or NHD should not yet be used for targeting. There are two serious drawbacks to its the utilization for new program-level targeting. Firstly, it is yet to be completed and tested. Secondly, current legal provisions stand in the way of using this data, as provision for explicit beneficiary consent was not built into the survey forms. Pending the resolution of these drawbacks, the NHD is unlikely to be relevant for program-level targeting for the next three years.

- A targeting strategy should incorporate monitoring of targeting outcomes with learning for adaptation. From this perspective, a targeting strategy can be visualized as a Three-Stage Cycle that incorporates pre-targeting, targeting, and post-targeting monitoring with learning (Conceptualization: Hossain Zillur Rahman, 2018) – see Figure 1. This proposed strategy includes a community-based approach, with an objective to reduce both errors of exclusion and inclusion. Such a visualization brings the added benefit of better understanding of the challenges involved in ensuring targeting success.

Figure 1: Proposed Three-Stage Targeting Cycle



9. Conclusion

Targeting is a widely used strategy in development aimed at ensuring that the benefits of interventions flow directly to those in greatest need. With renewed emphasis on equity in the context of SDGs, a strategic re-examination of targeting is particularly apt for nascent areas, such as UHC. To be meaningful, such a re-examination entails not only distilling the analytical debates about targeting, but also specific learnings from a range of program experiences. This review combines analytic and experiential learnings to recommend a three-stage cycle incorporating pre-targeting, targeting, and post-targeting monitoring with learning for adaptation. Specifically for new UHC programming, a community-based approach combined with geographic targeting that ensures efficiency to minimize both inclusion and exclusion errors is recommended.

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The Health Finance and Governance (HFG) project works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. Designed to fundamentally strengthen health systems, the HFG project improves health outcomes in partner countries by expanding people's access to health care, especially to priority health services. The HFG project is a five-year (2012-2017), $209 million global project funded by the U.S. Agency for International Development under Cooperative Agreement No: AID-OAA-A-12-00080.
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