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# TARGETING THE POOR FOR UNIVERSAL HEALTH COVERAGE PROGRAM INCLUSION:

## EXPLORING A MORE EFFECTIVE PRO-POOR TARGETING STRATEGY

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This publication was produced for review by the United States Agency for International Development.
It was prepared by (Hossain Zillur Rahman, Mohammad Abdul Wazed) for the Health Finance and Governance Project.

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**DISCLAIMER**

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# ACRONYMS

| | |
|---|---|
| **BBS** | Bangladesh Bureau of Statistics |
| **DDM** | Department of Disaster Management |
| **DGHS** | Directorate General of Health Services |
| **DSF** | Demand-Side Financing |
| **DORP** | Development Organization of the Rural Poor |
| **EGPP** | Employment Guarantee for the Poorest Program |
| **FGD** | Focus Group Discussion |
| **GOB** | Government of Bangladesh |
| **GSK** | Gano Shasthaya Kendra |
| **HEU** | Health Economics Unit |
| **HFG** | Health Finance and Governance |
| **HIES** | Health Income and Expenditure Survey |
| **ID** | Identification |
| **MOHFW** | Ministry of Health and Family Welfare |
| **NHD** | National Household Database |
| **NGO** | Non-Governmental Organization |
| **NSSS** | National Social Security Strategy |
| **OOP** | Out-of-Pocket |
| **PIO** | Project Implementation Officer |
| **PPRC** | Power and Participation Research Centre |
| **PMT** | Proxy Means Testing |
| **PSC** | Poverty Score Card |
| **SAE** | Sub Assistant Engineer |
| **SDG** | Sustainable Development Goal |
| **SSK** | Shasthaya Shurokkha Karmashuchi |
| **SSNP** | Social Safety Net Program |
| **UHC** | Universal Health Coverage |
| **UMT** | Unverified Means Testing |
| **UNO** | Upazila Nirbahi Officer |
| **UPHCP** | Urban Primary Health Care Project |
| **USAID** | United States Agency for International Development |
| **VGF** | Vulnerable Group Feeding |

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# EXECUTIVE SUMMARY

## Background

Bangladesh has rich experience in implementing a large number of social safety net programs (SSNPs) that rely on targeting as a key operational tool. One priority, which remains significantly under-addressed, is the poverty risk associated with high out-of-pocket (OOP) expenditure on healthcare. With the adoption of the Sustainable Development Goals (SDGs) that prioritize Universal Health Coverage (UHC) as Goal 3.8, new programming initiatives must ensure inclusion of the poor to help achieve UHC. However, targeting the poor presents both design and implementation challenges for programs. It is thus very timely that the Power and Participation Research Centre (PPRC) with support from USAID's Health Finance and Governance (HFG) project undertook a qualitative study exploring a more effective pro-poor targeting strategy with the end-goal of informing new program initiatives about better inclusion of the poor for UHC. The study was a qualitative review of targeting approaches used in six selected programs covering both health and non-health sectors, and implemented by both government and non-government organizations (NGOs). The qualitative review was supplemented by a brief literature review and a summary look at the Government's new initiative to establish a national household database for assisting better targeting by SSNPs.

## Insights from the Literature

### *Why Targeting?*

Targeting in the context of social protection refers to the social objective of concentrating resources on those who need them – mainly the poor and vulnerable. Such an objective becomes necessary when resources are not adequate to cover the entire population, or when the service in question is not needed universally (e.g., services targeting seasonal employees in earth-work, or food rations for food insecure households).

### *Who can be a target?*

Targets could be: i) all of the poor in a 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).

### *Targeting errors*

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

### *Understanding targeting performance*

Targeting performance can be understood either as effective (i.e., minimizing inclusion errors) or efficient (i.e., effective and cost-efficient 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 faced by program managers.

***Targeting methods***

There are five major categories of targeting methods:

i) *Means testing* based on household income—a cut-off income level is prescribed against which eligible households are determined;
ii) *Proxy means testing (PMT)* based on easier-to-collect income proxy variables—a cut-off mark for the composite proxy variable is prescribed against which eligible households are determined;
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., wage employment in onerous earth-work) ensures that only the intended target (e.g., rural extreme poor) will apply; and
v) *Geographic targeting* whereby program coverage is focused on spatial concentrations of poverty identified using poverty maps or direct observations.

Each targeting method has its advantages and disadvantages, and choosing one or the other will depend on the specific purpose. For effective targeting, there are also other relevant contextual factors to be considered, including: 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.

# Methodology for Review of SSNPs

PPRC undertook a qualitative review of the targeting strategies used by selected operational SSNPs. Initially a core expert group was convened to brainstorm on targeting and how a review exercise would best be 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. These included four health programs: Gano Shashthaya Kendro (NGO), Sajeda Foundation (NGO), maternal health voucher/demand-side financing (DSF) scheme (government), and the Urban Primary Healthcare Project (UPHCP – government, local government, and NGO). The remaining two were a workfare program, Employment Guarantee for the Poorest Program (EGPP), and the food assistance project, Vulnerable Group Feeding (VGF). Both of these are government programs implemented through rural local governments.

The review focused on the following questions:

vi) What are the main features of the targeting approaches?
vii) What are the rationales behind a specific targeting approach?
viii) What actions are taken during implementation of targeting?
ix) What are the gaps in targeting approaches and what are the recommendations to overcome them?

The purpose of the review was not to assess the performance of the SSNPs, but to learn about and draw lessons for effective targeting in order to inform new programming initiatives for UHC in Bangladesh. Data was collected at both head offices and field offices of the selected programs by an experienced field research team from PPRC. The research included focus group discussions (FGDs), key informant interviews, and targeting-related program document reviews.

# Key Lessons

- 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 PMT) impacts on the program scope and duration.
- At the program level, an information campaign among the target population is a crucial complimentary investment to ensure optimal inclusion rates and program coverage.

- Targeting methods, such as means testing or PMT, may be suitable for contexts characterized by chronic poverty but are unsuitable for contexts with transient poverty, i.e., where households may be poor for part of the year, or when households newly fall into poverty. Such circumstances are particularly significant in urban areas.
- 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 - e.g., while housing was a strong poverty correlate up to the 1990s, it is much less so now.
- Many programs provide identification (ID) cards to beneficiaries that serve as entitlement or discount cards for defined services provided by the institution. Such cards are a promising entry point for popularizing health insurance, as well as for targeting, provided supply-side factors do not become critical bottlenecks.
- Health services targeting the urban poor, particularly for mother and child healthcare services, are often delivered through informal 'satellite clinics'. In reality, such 'satellite clinics' without dedicated space or privacy - and often using beneficiary household space - have proven to be largely ineffective and therefore undermine the potential benefits of targeting.
- Both national and global experience is mixed on the success of targeting approaches.
- Targeting mechanisms need not be mutually exclusive. While firm 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 for targeting include: i) clarity on the target population; ii) well-chosen, effective, and efficient eligibility criteria matching the program content; iii) application of an independent eligibility verification system; iv) deployment of a monitoring and accountability framework of the implementation process; and v) credible engagement of community actors.

## Potential of the National Household Database for Targeting

The Government of Bangladesh (GOB) has developed a National Household Database (NHD) using a PMT formula to improve targeting in SSNPs. Such databases, also known as social registries, are being used in several countries with the support of the World Bank. However, challenges with their use include but are not limited to: an inefficient data collection process; ineffective management of information; and system challenges for feasible and cost-efficient monitoring, verification, and updating to minimize under-coverage (exclusion errors) or leakage (inclusion errors).

The overall objective of the NHD in Bangladesh is to support effective implementation of the National Social Security Strategy (NSSS, 2015), the goal of which is "reducing poverty by better targeting beneficiaries and improving the management of about 145 government social safety net schemes". The specific objective is to prepare a NHD to establish a register of poor households.

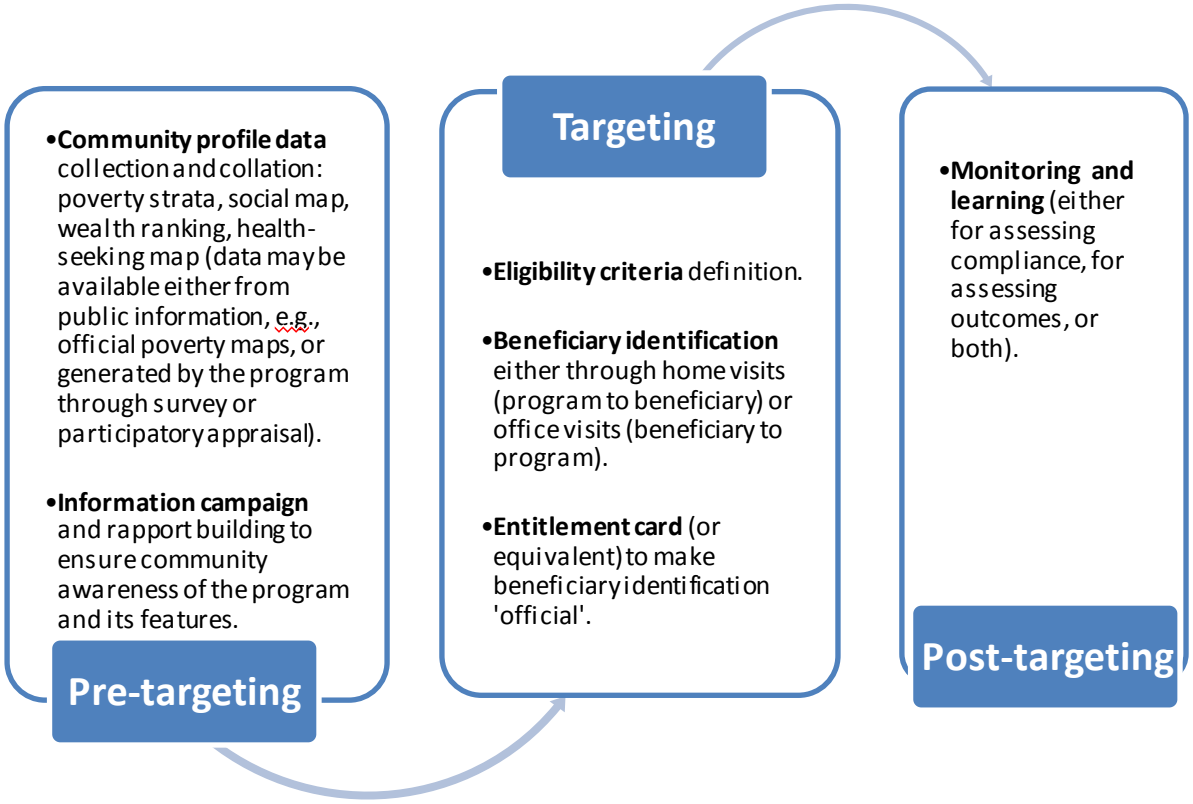
PPRC undertook a brief review of the current status of the NHD initiative to supplement its qualitative review of selected SSNPs. The brief review indicates that NHD can contribute to targeting if the following conditions are met: i) the NHD is updated at regular intervals (e.g., every three years) to adjust for mobility within and across the poverty line; ii) each of the public safety net schemes, possibly using the national ID number, are linked to the NHD; iii) NHD is linked with the beneficiary management information system being developed at the Department of Disaster Management (DDM); and iv) explicit beneficiary consent for making personal information public is built into the survey form—no form has been administered to collect such consent to date, and its inclusion would avoid any ethical issues in the use of data for program implementation.

# Recommendation

**Table E1: List of Recommnedations based on findings from the review**

| Key Lessons from the Review | Recommendation |
|---|---|
| *An effective targeting approach is built, not only on sound conceptual principles, but also on sound operational considerations.* | • Undertake an information campaign to ensure buy-in from the target community and thus increase inclusion. |
| | • Ensure proximity to the facility providing services; this is a key consideration for the poor, particularly in urban contexts where distance entails both costs and unfamiliarity. |
| | • Use a fee-based entitlement card to clarify beneficiary expectations on services and costs, and empower beneficiaries by giving a measure of 'identity' to their transactions with the service provider. None of the available entitlement cards have yet passed the test of universal acceptance, and new programs will require piloting and field-based testing. |
| *All targeting approaches have their strengths and weaknesses. An optimal approach will build on insights from the program review.* | • Combine geographic targeting with participatory approaches to leverage the common phenomenon of spatial concentration of poverty and ensure an element of social accountability, while also avoiding heavy upfront cost burdens of a detailed survey. This approach requires a robust verification system to avoid inclusion and exclusion errors based on corruption and discrimination. |
| *There are two serious drawbacks in the utilization of the NHD for new program-level targeting. Firstly, it is yet to be completed and tested. Secondly, current legal provisions prevent use of the data, as explicit beneficiary consent was not built into the survey form. Pending the resolution of these issues, the NHD is not likely to be relevant for program-level targeting for the next three years.* | • To ensure that the completed NHD becomes relevant for targeting in the future, the following are recommended:<br>• Update the NHD at regular intervals (e.g., every three years) to adjust for mobility within and across the poverty line;<br>• Link the NHD to each of the public SSNPs, possibly using the national ID number;<br>• Link the NHD with the management information system of beneficiaries being developed at the Department of Disaster Management; and<br>• Ensure beneficiary consent to making their personal information public is built into the survey forms to avoid any ethical concerns in the use of the data for program implementation. |
| *A targeting strategy should involve, not only the use of specific approaches, but also monitoring of targeting outcomes with learning for adaptation.* | • Deploy a "Three-Stage Cycle" targeting strategy that incorporates pre-targeting, targeting, and post-targeting monitoring with learning – see Figure 1 (Conceptualization: Hossain Zillur Rahman, 2018). This strategy should include a community-based approach to reduce both errors of exclusion and inclusion, bringing the added benefit of better understanding of the challenges involved in ensuring targeting success. |

**Figure E1: Proposed Three-Stage Targeting Cycle**




## Conclusions

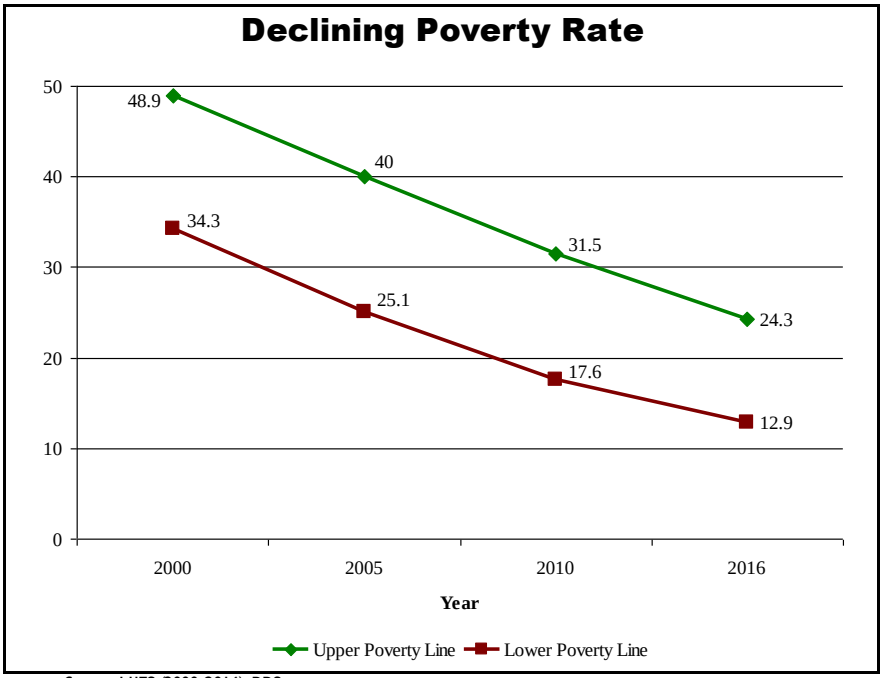
Targeting is widely used in development to ensure the benefits of interventions flow to those most in need. With renewed emphasis on equity in the SDGs, a strategic re-examination of targeting as a strategy is particularly apt for newer areas of application, such as UHC. To be meaningful, such a re-examination entails not only distilling the analytical debates on targeting, but also using learnings from a range of program experiences where targeting is used. This review combined analytical 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, the review recommends a community-based approach combined with geographic targeting while ensuring targeting efficiency to minimize both errors of inclusion and exclusion.

# 1. INTRODUCTION

## 1.1 Poverty Context and Role of Safety Nets

Although there has been a significant decline in both poverty and extreme poverty in Bangladesh, data from the latest Household Income and Expenditure Survey (HIES, 2016) shows one in four people still live below the poverty line, and one in eight remain below the extreme poverty line, as defined by the Bangladesh Bureau of Statistics (BBS) - see **Figure 1**. Not only does poverty continue to be a significant challenge, it is compounded by additional vulnerabilities due to natural disasters, climate change, and unplanned urbanization.

**Figure 1: Poverty Trends in Bangladesh**




**Absolute number of poor is still very large:**

- 39 million out of a population of 160 million live below the poverty line.
- 12.9% were extreme poor in 2016 – although a significant decline from 34.3% in 2000, this is still 20 million people.

*Source*: HIES (2000-2016), BBS

The GOB is committed to the fight against and addressing vulnerabilities to poverty; 23 of its ministries implement 145 public safety net programs designed to mitigate the impact of poverty over the long-term. This substantial program portfolio has addressed the extremes of poverty and provided a crucial cushion, ensuring disaster resilience. However, there are areas that remain unaddressed, specifically the poverty risk associated with high OOP expenditure on healthcare. With the adoption of the SDGs, which prioritize UHC as Goal 3.8, there is a challenge for new programming initiatives to focus on inclusion of the poor in social protection to help achieve UHC.

There is increasing recognition by the GOB and other stakeholders of the need to improve equity, efficiency, and transparency in SSNPs. The urgency is not only to increase coverage of existing programs but focus new programs on achieving UHC. The National Health Accounts (2015) calculate OOP expenditure at 67% of total health expenditure – at present, 5.2 million people in Bangladesh are at risk of being pushed into poverty due to OOP health spending (WHO, 2017).

Expanding coverage of SSNPs per se is not the priority, but ensuring programs are targeted primarily towards the poor. Such targeting is a widely-practiced policy goal. However, targeting the poor

presents challenges in the design of effective instruments and in implementation strategies that can yield desired results. Other issues that need to be addressed adequately include targeting the right people, overlapping coverage, corruption, leakages, and lack of coordination. This qualitative study, undertaken by the PPRC with support from USAID's HFG project, is therefore very timely. It explores and seeks to identify a more effective pro-poor targeting strategy, which is relevant not only for achieving the SDGs in general, but for newer programming areas such as UHC in particular. UHC emphasizes reaching every person in the country including the poor, vulnerable, and the marginalized; without effective targeting, programs may miss precisely those who are most in need of services.

## 1.2 Rationale and Objectives of the Study

In 2015, USAID's health financing assessment identified the need to define clear approaches for targeting the poor in health insurance schemes (Cavanaugh, et al., 2015). The literature and experiences in Bangladesh in general focus more on anti-poverty than health insurance – health insurance schemes focused on the poor is a relatively new concept. However, there is growing recognition of the poverty risks associated with high OOP expenditure on health and the concomitant need to explore new programming which can address such risks. As Bangladesh scales up both new and existing UHC-related safety net initiatives, including those focused on relatively under-addressed areas such as health finance risk mitigation, the time is right for a rapid qualitative study to distill key lessons from existing targeting experiences and identify more effective targeting strategies. This is very relevant for the GOB, as well as other stakeholders, including development partners and NGOs. Qualitative research instruments are particularly appropriate for examining process realities and implementer perspectives. This study was initiated to identify lessons on targeting that could be drawn from experiences of SSNPs covering both health and non-health sectors to inform the design of initiatives to protect the poor from the burden of OOP expenditure on health.

This study had four objectives:

- To distill conceptual and operational lessons from the literature on the nature and use of targeting approaches, including factors determining success and best practices;
- To assess the potential of the government's NHD/poverty register initiative for new social protection programming;
- To undertake a rapid qualitative review of six selected SSNPs to understand targeting approaches in operation; and
- To develop recommendations for an improved and operationally effective targeting strategy for UHC-related programs in Bangladesh.

# 2. SCOPE AND IMPLEMENTATION OF THE QUALITATIVE STUDY

## 2.1 Scope

The main purpose of the study was to qualitatively assess current targeting approaches and experiences of selected programs to explore effective pro-poor targeting strategies for UHC-related program design. Programs for the review were selected by an expert group, a meeting of which was convened by PPRC in consultation with HFG in June 2017. The selection was subsequently finalized through internal reviews at PPRC. The expert group meeting recommended inclusion of both government and non-government programs, as well as programs covering both health and non-health, to ensure wider understanding of targeting strategies.

Six programs were selected. Two important initiatives – the Ministry of Health and Family Welfare's (MOHFW's) Shasthaya Shurakkha Karmashuchi (SSK) project and the Smiling Sun program supported by USAID – were excluded from this study following advice from USAID and HFG as they were being assessed separately by their respective sponsoring institutions. Table 1 lists the six selected programs.

**Table 1: Selected Programs for Review**

| Name of Program | Program Focus | Type of Implementing Organization |
|---|---|---|
| Gano Shashthaya Kendro's (GSK) program | Health | NGO |
| Sajeda Foundation's program | Health + micro-finance | NGO |
| Maternal Health Voucher/Demand Side Financing (DSF) program | Health | MOHFW |
| Urban Primary Health Care Project (UPHCP) | Health | Ministry of Local Government and Rural Development (MLGRD) + City Corporation/Pourashava + NGO |
| Employment Generation Program for the Poorest (EGPP) | Workfare | DDM + UPAZILA NIRBAHI OFFICER (UNO) + Union Parishad |
| Vulnerable Group Feeding (VGF) program | Humanitarian assistance | DDM + UNO + Union Parishad |

## 2.2 Design

The study was not a traditional impact assessment, and its design did not allow for direct interviews with beneficiaries due to legal restrictions around confidentiality and consent. The approach was instead a qualitative review of targeting strategies adopted by selected programs and how they were being implemented in practice. The assessment was undertaken using three research instruments, summarized in Table 2.

**Table 2: Review Instruments and Purpose**

| Instruments | Purpose |
|---|---|
| • Desk review | To establish a description of the targeting approach adopted by the program and its policy antecedents (if available). |
| • In-depth interviews | To obtain an understanding of the policy rationale for the targeting approach and expected program outcomes, as well as to what extent targeting was a priority concern for program managers and independent views. |
| • FGDs | To obtain an understanding of how the targeting approach was working in practice, to identify gaps if any and the necessity for revision. |

## 2.3 Subjects and Sampling

Table 3 describes the interview and FGD participants for each of the selected programs4

**Table 3: Participants for Interviews and FGDs**

| Name of Program | In-depth Interviews | FGDs |
|---|---|---|
| GSK program | • Institutional Head<br>• Program Manager | • Field managers<br>• Service center worker |
| Sajeda Foundation's program | • Institutional Head<br>• Health Program Manager | • Field managers<br>• Service center worker |
| Maternal health voucher/DSF program | • Ministry-level policy actor<br>• Program Manager at the Directorate General, Health Services (DGHS)<br>• Chairman, Department of the Rural Poor (DORP, NGO) | • Field managers<br>• Service center worker |
| UPHCP | • Ministry-level policy actor<br>• Project Director<br>• City Corporation Chief Health Officer/Mayor<br>• Development partner (African Development Bank) | • Field managers<br>• Service center worker |
| EGPP | • Project Director<br>• Ministry-level policy actor<br>• Department-level Program Specialist | • UNO + associates<br>• Union Parishad Chair + associates |
| VGF program | • Director, VGF | • UNO + associates<br>• Union Parishad Chair + associates |

For the interviews, one interviewee from each category was chosen, and the interviews were conducted individually. For the FGDs, the number of participants from each subject type ranged from three to five. Participants were identified during a reconnaissance visit to the programs prior to the actual FGDs. The list of interviewees and FGD participants is provided in the Annex to this report.

## 2.4 Data Collection

### 2.4.1 Guide for In-depth Interviews

**Table 4: Interview Guide**

| Key Consideration | Questions |
|---|---|
| 1. ***Rationale for the choice of targeting criteria*** | a. What is the service or services provided by the program?<br>b. What is the catchment area of a service center? How many people or households does each service center cater for?<br>c. Are there sufficient resources to deliver benefits to everyone who needs them?<br>d. Is the service targeted at a particular group of people? Who is in the target group for each of the services provided?<br>e. What are the targeting criteria?<br>f. Why have these criteria been chosen? How were they developed?<br>g. How do you identify the targeted individuals or households? Do you use data? What data sources are used to apply the targeting criteria? How often is the data updated?<br>h. Please describe how the targeting strategy is implemented. |
| 2 ***.Key policy challenges*** | a. Are there any gaps in the targeting policy? What are the gaps?<br>b. Have there been any changes in the targeting policy?<br>c. Are there any challenges in implementing the targeting strategy in the field?<br>d. Have you been able to address the challenges? How?<br>e. Does the target population have access to a grievance redressal mechanism?<br>f. If not, do you think one should be set up? What is the most feasible grievance redressal mechanism in your context? |
| 3. ***Areas for improvement*** | a. Does the targeting policy require improvement?<br>b. Does implementation of targeting need improvement?<br>c. If yes, in what specific areas? |

### 2.4.2 Guide for Focus Group Discussions with Implementers

**Table 5: Guide for FGDs with Implementers**

| Key Consideration | Questions |
|---|---|
| 1. ***In your experience, how well is the targeting strategy working in practice?*** | a. Are there specific guidelines for selecting or targeting service seekers?<br>b. Are those guidelines relevant, adequate, and useful?<br>c. Are there problems of including people who do not qualify (inclusion error) or excluding people who should have been included (exclusion error)? Any examples where you have noticed these errors?<br>d. Is there any supervision or monitoring to ensure effective implementation of the targeting strategy?<br>e. How important is grievance redressal for beneficiaries? Does grievance redressal work effectively? How can it be made more effective?<br>f. Are there specific barriers or difficulties to implementing the targeting strategy?<br>g. How adequate are the data sources required for implementing the targeting strategy?<br>h. Are there differences in how the targeting strategy is laid out in policy and how it is implemented in practice?<br>i. Are there capacity weaknesses in implementing the targeting strategy? If yes, what are these weaknesses? |
| 2 ***Areas for improvement*** | a. Does the targeting strategy require improvement?<br>b. If yes, in what specific areas?<br>c. If you were to change one thing to improve targeting outcomes, what would you chose? |

Separate instructions were provided to the field researcher to ensure that interviewees and FGD participants understood the purpose of the study and were given assurance of privacy/confidentiality.

### 2.4.3 Data Collection and Management

An experienced team of four field researchers from PPRC undertook the data collection following a full-day's training. The first training session focused on the purpose of the study and an analytical discussion about the issue of targeting, and the second session reviewed the guides for the in-depth interviews and FGDs. Dr. Hossain Zillur Rahman and Dr. Md. Abdul Wazed facilitated the training sessions.

The interview guides were pre-tested during the reconnaissance visit to selected programs. Relevant project documents were also collected during the reconnaissance visit for the desk review.

During data collection, each group was given a brief orientation on the purpose of the interview/FGD and its likely duration, and given an assurance of privacy/confidentiality.

Care was taken to protect human subjects. The interviews and FGDs were only conducted after a proper consent process was applied. Privacy and confidentiality were maintained both during data collection and data management with only authorized personnel handing data.

## 2.5 Limitations

Some of the interviewees and FGD participants in both government and non-government programs were reluctant to voice any critical opinions about targeting approaches or their implementation. While this was acknowledged as a possible limitation of the study, the field research team was able to establish the required rapport and ensure a robust discussion on the issues due to their long experience in research.

# 3. INSIGHTS FROM THE LITERATURE

## 3.1 What is Targeting

Targeting in the context of social protection refers to the objective of concentrating resources from programs (for example, for food insecurity, disaster relief, health, education, or employment) on those who need them most - mainly the poor and vulnerable (The World Bank, 2005). Such an objective becomes necessary when resources are not adequate to cover the entire population (i.e., universal coverage is not possible), or when there is not a universal need for the service in question (e.g., off-season employment in earth-work, or food support for food insecure households). An important objective of targeting is to maximize the impact of the program with the least delivery cost. However, targeting has both advantages and costs. For example, high delivery costs can take resources away from programs and impact on coverage. In addition, there are multiple methods of implementing targeting, none of which are foolproof, and targeting itself can present implementation challenges (Slater and Farrington, 2009). The key objective in effective targeting is to minimize inclusion of non-target populations while avoiding unwarranted exclusion of the target population.

## 3.2 Key Conceptual Insights

### 3.2.1 Who Can Be a Target?

A crucial issue in targeting is clarity on who can be a target. Target populations can be economic, social, geographic, or demographic in nature (Coady, et al., 2004; Gawtkin, 2000). Programs with a wide scope can target all the economically poor among a population, while other programs may target specific segments, e.g. the urban poor. Targets can also be geographically determined, e.g. poverty-prone geographic pockets or hard-to-reach remote locations. Moreover, targets can be demographically determined, i.e., specific vulnerable population segments, such as women, children, or the disabled.

### 3.2.2 Typical Targeting Errors

Global experience of targeting shows the need to be aware of two typical targeting errors (Gawtkin, 2000; Garcia-Jaramillo and Mirati, 2014). The first is leakage and/or under-coverage, which results in the inclusion of non-target populations in the program. This can happen for reasons of design (e.g., unclear or poorly-defined eligibility criteria), or reasons of governance (e.g., lack of transparency and accountability). Inclusion errors are a widespread problem but can be addressed or minimized through better design and greater attention to governance issues. The second category of targeting errors is exclusion, which results in the exclusion of the intended target population from the program. This can happen for reasons of poor design, or budget inadequacy. However, exclusion can also occur due to reasons of social discrimination against specific eligible but marginalized social groups, or the use of program resources for non-target groups.

### 3.2.3 Understanding Targeting Performance

The literature highlights two performance-related concepts, the first of which is subsumed in the second (García-Jaramillo and Miranti, 2014) – see Table 6. The first is effectiveness – targeting is deemed effective if its implementation succeeds in minimizing both inclusion and exclusion errors, i.e. it ensures that non-target populations are not included in the program and eligible beneficiaries are not excluded. However, it is not enough to only minimize errors; targeting must also be cost-efficient.

Thus, the second performance concept is efficiency – targeting is efficient when it simultaneously minimizes inclusion errors and ensures the cost of delivery is kept to a rational minimum.

**Table 6: Conceptual Indicators of Targeting Performance**

| Conceptual Indicator on Targeting Performance | Explanation |
|---|---|
| • Effectiveness | • Minimize inclusion error |
| • Efficiency | • Minimize inclusion error + ensure cost-efficient program delivery |

In reality, there is usually a compromise between improving effectiveness and improving efficiency (Slater and Farrington, 2009). Over-elaborate targeting (to increase effectiveness) may increase administrative costs, thus reducing resources available for program coverage. This is a typical dilemma faced by program managers. Targeting efficiency is therefore the larger goal rather than the narrower goal of targeting effectiveness.

## 3.3 Key Operational Insights

### 3.3.1 Methods

Targeting methods encompass eligibility criteria as well as implementation approaches. Eligibility criteria can include economic, social, demographic, or spatial factors.

The literature indicates five major categories of targeting methods (PPRC and UNDP, 2011):

i. Means testing based on household income – a cut-off income level is prescribed against which eligible households are determined. This method pre-supposes availability of robust household income data.

ii. PMT based on easier-to-collect income proxy variables – a cut-off mark for the composite proxy variable is prescribed against which eligible households are determined.

iii. Participatory targeting based on target identification through guided participation of beneficiary community, again using various income proxies as deemed relevant by the community.

iv. Self-selection whereby the very nature of the benefit (e.g., wage employment in onerous earth-work) ensures that only the intended target (e.g., rural extreme poor) will apply.

v. Geographic targeting whereby spatial concentrations of poverty are identified using poverty maps or direct observations.

### 3.3.2 Proxy Means Test Methodology

The term "proxy means test" is used to describe a situation where "information on household or individual characteristics correlated with welfare levels is used in a formal algorithm to proxy household income, welfare, or need" (Grosh and Baker, 1995). PMT involves using observable and verifiable household or individual characteristics, which are selected based on their ability to predict welfare as measured by, for instance, consumption expenditures of the households. PMT can distinguish chronic poverty, making it an appropriate targeting option where the depth and severity of poverty are relatively high (Grosh and Baker, 1995).

Sophisticated means testing, such as assessing the financial or economic status of an individual or family for the purposes of determining their eligibility for government assistance, presents bureaucratic and administrative difficulties. For example, precise measurements of income or consumption are often unavailable or difficult to obtain. It is often burdensome to assess how much

a family earns or spends every month – in Bangladesh, only a few hundred thousand people receive personal income statements. In addition, household members themselves might not be able to report family consumption as they seldom maintain detailed records. In such situations, it may be possible to use other household characteristics as proxies for income (The World Bank, 2005). For example, a family living in a brick-walled house will likely be wealthier than a family living in a house made of clay. The type of wall is the "proxy" because it can be used to approximate the level of household income or consumption. Naturally, using only one proxy value will render the estimations very imprecise—there is still great variability in incomes, even between families living in houses made of clay. The "wealthy" living in brick-walled houses might also own livestock, such as cattle, and therefore "livestock ownership" can be added as another proxy variable. Other layers of proxy variables may be added until a PMT model is defined that includes a set of variables and weights associated with them to accurately predict the welfare of each household. In practice, most PMT models use more than a dozen different variables.

### 3.3.3 Information Types and Collection Options

Information relevant to targeting usually falls into two types: i) information about the area or community; and ii) information about the beneficiary, whether an individual or a household. Beneficiary information can be collected either actively by the program (i.e., program workers visit beneficiaries at their home or workplace), or passively (i.e., by making the beneficiaries responsible for informing the program of their eligibility). The former increases program costs while the latter increases the risk of exclusion.

### 3.3.4 Contextual Factors

From an operational perspective, there are four key contextual factors with significant bearing on targeting:

- Adequate administrative capacity – such capacity cannot be assumed as administrative capacity is rudimentary in many developing countries, and insufficient to implement an ambitious targeting approach. The choice of targeting approach therefore needs to align with the available administrative capacity.
- Availability and quality of public information about target populations – in the absence of such information, programs may need to generate their own data for targeting. This may result in a cost burden for programs and impact on program coverage.
- Community/beneficiary willingness to participate – this also cannot be assumed and may require information campaigns.
- Responsibility for the financial cost of targeting – this may not be borne by public resources. Clarity about who bears the fiscal responsibility for the cost of targeting is essential, as lack of clarity can affect program sustainability.

## 3.4 Advantages and Disadvantages of Targeting Methods

The literature brought out the advantages and disadvantages of each of the major targeting approaches (Grosh, 2008). These are summarized in the Table 7.

**Table 7: Advantages and Disadvantages of Targeting Methods**

| Method | Features | Advantages | Disadvantages | Contexts for Application |
|---|---|---|---|---|
| **Means testing** | • Assessment of household income against a threshold or cut-off point. | • Accurate. | • Requires high levels of literacy and documentation of income.<br>• Administratively demanding.<br>• May induce work disincentives. | • High administrative capacity.<br>• Reported income is verifiable.<br>• Benefits to beneficiaries sufficient to justify costs of administration. |
| **PMT** | • Household "score" based on a small number of easily observable characteristics with a weight obtained from analysis of household data, and comparing "score" against a pre-determined cut-off point. | • Easily observable and verifiable household characteristics.<br>• Poverty correlates must be relevant and robust proxies for income. | • Requires large body of literate and computer-trained staff, as well as access to technology.<br>• Inherent inaccuracies at household level, although good on average.<br>• Insensitive to quick changes in welfare and mobility, such as in urban slums. | • Programs meant to address chronic poverty in stable situations.<br>• A large program or several programs to maximize return on investment. |
| **Community targeting** | • Program arranges for community leaders and beneficiary groups to establish social maps and wealth ranking. | • Depends on the accuracy of existing information, such as poverty maps.<br>• Performs poorly where poverty is not spatially concentrated. | • Local actors may have other incentives besides robust targeting of the program.<br>• May continue or exacerbate patterns of social exclusion.<br>• Diverse local definitions of welfare may make evaluation more difficult | • Where local communities are clearly defined and cohesive.<br>• Small-scale programs.<br>• Where a large administrative presence is not feasible. |
| **Geographic targeting** | • Eligibility for benefits determined by location of residence.<br>• Choice of locations based on existing information, | • Administratively simple.<br>• Easy to combine with other methods | • Depends on the accuracy of existing information, such as poverty maps.<br>• Performs poorly where poverty is not spatially concentrated. | • Where considerable variations exist in living standards across regions.<br>• Where delivery of an intervention will use a fixed site, such as a school, |

| Method | Features | Advantages | Disadvantages | Contexts for Application |
|---|---|---|---|---|
| | such as poverty maps. | | | clinic, or local government office. |
| **Demographic targeting** | • Eligibility determined by demographic characteristics, such as age or gender. | • Administratively simple.<br>• Low stigma.<br>• Often politically popular.<br>• Works well when combined with community targeting. | • Inaccurate where demographic characteristics are poor correlates of poverty. | • Where registration of vital statistics or other demographic characteristics are extensive.<br>• Where a low-cost targeting method is required. |
| **Self-selecting** | • A program, good, or service that is open to all but designed in such a way that take-up will be much higher among the poor than the non-poor e.g., workfare programs. | • Administrative costs of targeting likely to be low.<br>• Unlikely to induce labor disincentives. | • There may be social stigma associated with a self-selecting program, good, or benefit. | • Where there is great demand for such opportunities e.g., extreme poverty pockets.<br>• Settings where individuals are moving rapidly in and out of poverty. |

## 3.5 Country "Best Practice" Examples

Two examples are described below from the literature review that merit attention as potential "best practices". The first is Pantawid Pamilyang Philipino Programme, or "4Ps" from the Philippines, and the second is the Bolsa Familia program from Brazil. The case studies provide a brief overview of the salient features of these programs and a brief analytical listing of key factors which underlie their depiction as best practices.

**Case Study 1**
***Pantawid Pamilyang Philipino Programme (4Ps), Philippines***

**Key Features**

- Started in 2007, and continued under a Parliamentary Act since 2010, 4Ps is a conditional cash transfer program and is currently the largest SSNP in the Philippines.
- The program is intended to: i) reduce extreme hunger and poverty; ii) achieve universal primary education; iii) promote gender equality and empowerment of women; iv) reduce child mortality and improve nutrition; and v) improve maternal health (Section 3 of the Act).
- Benefits as cash are directly transferred to the respective bank accounts of beneficiary households. Failure by the beneficiary household to comply with conditions set by the program, or if the household no longer meets the eligibility criteria, warrants suspension and/or removal from the program.
- The program combines multiple targeting methods: PMT + geographic targeting + community engagement.
- Benefits are variable depending on the number of children in the household.

**Why best practice?**

- **Scale**
- **Addresses multi-dimensional poverty**
- **Combines multiple targeting methods**
- **Effective implementation; and**
- **Evaluation provides credible evidence of intended outcomes.**

## Case Study 2
## *Bolsa Familia, Brazil*

**Key Features**

- Started in 2003, Bolsa Familia integrated four previous SSNPs to provide cash grants to beneficiaries on condition of their complying with prescribed education and health-related actions.
- The program aims to both reduce short-term poverty through direct cash transfers, and fight long-term poverty by increasing human capital among the poor through conditional cash transfers.
- Brazil has developed its unified registry, Cadastro Unico, based on data collected using Unverified Means Testing (UMT) to select families for eligibility in Bolsa Familia and other SSNPs.
- Using UMT, data collected on self-reported household incomes is compared to pre-determined eligibility criteria. However, use of self-determined incomes risks mismeasurement and fraud due to seasonal, informal, or in-kind earnings. To overcome this, most municipalities use geographic tools, such as local area poverty or vulnerability maps. Thus geographically poor or poverty pockets are given priority for registration.

**Why best practice?**

- **Merges several pre-existing programs**
- **Addresses multi-dimensional poverty**
- **Combines multiple methods to overcome cost-heavy income survey**
- **Evaluation provides credible evidence on intended outcomes**

# 4. QUALITATIVE REVIEW OF TARGETING APPROACHES IN SIX SAFETY NET PROGRAMS

## 4.1 Brief Overview of Selected Programs and Research Design

Programs were selected for the qualitative review through a process of stakeholder consultations and in-house brainstorming. As already mentioned, the choice of programs was guided by the desire to ensure diversity in focus (health/non-health) and implementer (government/non-government). Four of the six selected programs were health-focused, one was employment focused, and one was food support focused. The field research for the qualitative review was undertaken both with headquarter and field staff in their field locations. Table 8 provides a brief overview of the programs and the research design.

**Table 8: Overview of Programs and Research Design**

| Name of Program | Program Focus | Nature of Implementing Organization | Research Strategy | Research Questions |
|---|---|---|---|---|
| GSK | • General healthcare | NGO | • FGDs and key informant interviews<br>• Both HQ and field office staff | • Targeting features<br>• Targeting rationale<br>• Targeting in action<br>• Gaps and recommendations |
| Sajeda Foundation | • General healthcare | NGO | | |
| Maternal Vouchers (DSF) | • Healthcare for pregnant women | MOHFW | | |
| UPHCP | • Mother and child healthcare for urban poor | MLGRD + City Corporations/ Pourashavas + NGOs | | |
| EGPP | • Eighty days guaranteed employment for rural extreme poor | Department of Disaster Management + Union Parishads | | |
| VGF | • Food support | Department of Disaster Management + Union Parishads | | |

## 4.2 Target Group and Eligibility Criteria

Each of the selected programs employed targeting approaches. Table 9 provides an overview of the target group and eligibility criteria used by each of the selected programs.

**Table 9: Target Group and Eligibility Criteria**

| Program and Focus | Target Group | Eligibility Criteria |
|---|---|---|
| **GSK:** General healthcare with special focus on maternal and child health | • Rural population of the catchment area of an Area Office and its sub-centers | • Households are grouped into six categories and provided with color-coded health cards:<br>• Group A (extreme poor/poor): i) no fixed residence, and ii) depend on others for living.<br>• Group B (lower middle class): i) monthly income between Tk. 3-5 thousand, and ii) mainly labor occupations.<br>• Group C (upper middle class): i) monthly income between Tk. 5-10 thousand, and ii) mainly marginal farmers/petty business.<br>• Group D (less rich): i) monthly income between Tk. 10-20 thousand, ii) service/business occupations and also surplus agri production, and iii) can pay zakat.<br>• Group E (rich): i) monthly income between Tk. 20-30 thousand, ii) multiple occupations, and iii) vehicle owner.<br>• Group F (very rich): i) monthly income above Tk 30 thousand, ii) multiple income sources, iii) multiple houses, and iv) socially identified as rich. |
| **Sajeda Foundation:** General healthcare with special focus on maternal and child health | • Urban and peri-urban poor | • All those who pay annual fee of Tk. 150 are eligible for a health card either for an individual or a family.<br>• Micro-credit borrowers of Sajeda Foundation are eligible for a card against annual fee.<br>• Sajeda Foundation does not have an explicit eligibility criteria to identify 'poor'; patients who walk-in and have obtained a card may be assessed subjectively by the attending physician to determine whether they are eligible for a discount. |
| **DSF:** Maternal care for poor pregnant women | • Poor pregnant women in selected high-poverty upazilas | • Functionally landless (owning less than 0.15 acres of land).<br>• Earning extremely low and irregular income or no income (less than Tk. 2,500 per household per month).<br>• Owning no productive assets, such as livestock, orchards, rickshaw, or van. |
| **UPHCSDP:** Maternal and child health (MCH) care for urban poor | • Urban poor of selected pourashava/city corporations | • Information is collected on the following indicators: 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 disabled member.<br>• The collected information is processed by the implementing institution to arrive at an individual 'score' for the intending beneficiary household.<br>• Scoring procedure is explicitly spelt out.<br>• Only those scoring below 20 in major city corporations, below 15 in other city |

| Program and Focus | Target Group | Eligibility Criteria |
|---|---|---|
| | | corporations, and below 10 in municipalities, are eligible for free services for defined ailments in a defined health facility in the locality. |
| **EGPP:** Off-season employment | • Rural extreme poor | • Land-ownership below 10 decimals.<br>• Monthly family income below Tk. 4,000.<br>• Primary occupation: wage labor.<br>• No ownership of livestock or fishing ground. |
| **VGF:** Post-disaster or festival occasion Food support | • Rural poor | • Any four of the following 12 criteria have to be met:<br>• Landless except for homestead;<br>• Main occupation: wage labor;<br>• Female-headed household;<br>• Dependent on begging, do not enjoy two meals a day for significant part of the year;<br>• No adult earner;<br>• Children sent to work instead of school due to poverty;<br>• No income-generating asset;<br>• Divorced or abandoned woman;<br>• Household head is poor freedom fighter;<br>• Household head disabled;<br>• No access to micro-credit; and<br>• Food-insecure due to disaster. |

## 4.3 Targeting in Operation: Findings from the Qualitative Review

The selected programs reported various challenges for targeting in operation and the findings from the qualitative review of implemneting targeing approches are summarized in the **Table 10** below.

**Table 10: Overview of Programs and Research Design**

| Program and Detailed Focus | Implementers | Coverage | Beneficiary Identification and Services |
|---|---|---|---|
| **GSK:** Defined healthcare services through an informal health insurance scheme with variable annual fee as determined by poverty status | Area Hospital Manager + Field Worker | • 50,000-100,000 rural population, or about 20,000 households in the catchment area of a sub-center.<br>• Total of 42 area offices across Bangladesh | • All households in the catchment area are surveyed using a brief socio-economic data form undertaken by Field Workers assigned to the sub-center.<br>• Information is collected on three main indicators – reported income, housing, and occupation.<br>• Based on classification, households are issued color-coded health cards with the following premium chart:<br>  ◦ Group A : extreme poor/poor: no premium<br>  ◦ Group B: lower middle class: Tk 300 per year<br>  ◦ Group C: upper middle class: Tk. 350 per year |

| Program and Detailed Focus | Implementers | Coverage | Beneficiary Identification and Services |
|---|---|---|---|
| | | | • Group D: less rich: Tk. 400 per year<br>• Insurance covers medical consultation for all groups.<br>• For extreme poor, additional facility of 10% discount on medicine.<br>• Ready-Made Garments industry female workers are provided with 50% discount on cesarean cost. |
| **Sajeda Foundation**<br>General healthcare but with a major focus on maternal and child health | Area office | • Urban poor localities | • There is no prior survey of the catchment area population.<br>• Individuals who walk into the area office/hospital are asked to complete a brief card containing demographic data. This card is a discount card and the person must pay an annual fee of Tk. 150.<br>• The discount card offers certain entitlements against a fee chart, which is described in a brochure and also publicly displayed.<br>• Poor beneficiaries are not separately identified, but if a patient seeks an additional discount, this is a discretionary decision of the doctor based on visual assessment of the poverty status of the patient. |
| **DSF:**<br>Antenatal, delivery, and postnatal care for poor pregnant women through the provision of entitlement vouchers | Union Parishad + Resident Medical Officer (upazila health complex) | • Selected high-poverty upazilas<br>• Total number of beneficiaries, as well as their distribution into upazila-specific quotas, is fixed centrally at the ministry level | • Union Family Welfare Assistants linked to Union Health Sub-Center identify poor neighborhoods through visual observation and enquire about the presence of pregnant women.<br>• Information about identified pregnant women is collected using a prescribed form.<br>• Union DSF Committee review the collected forms annually, and prepare an initial list of beneficiaries using eligibility criteria prescribed for the program.<br>• The list is finalized by the upazila DSF committee against the number of beneficiaries centrally allocated for the upazila. |
| **UPHCSDP:**<br>Maternal and child health care in low-income urban neighborhoods of selected municipalities and city corporations | Project Director (Local GovernmentDivision) + Municipality/City Corporation + selected NGOs | • Urban poor of low-income neighborhood of selected pourashava/<br>• city corporation for which an NGO service deliverer has been selected. | • NGO field workers identify poor neighborhoods, i.e. low-income settlements, through visual observation and further identify poor households in low-income settlements through visual observation.<br>• The identified households are asked to provide information using a prescribed form.<br>• On the basis of the information collected, identified households are assigned scores and classified. |

| Program and Detailed Focus | Implementers | Coverage | Beneficiary Identification and Services |
|---|---|---|---|
| | | | • Classified households that conform to the two poorest categories are issued separated color-coded cards against which benefits are availed. |
| **EGPP:** Off-season employment for rural extreme poor | Department of Disaster Management + Upazila administration + Union Parishad | • National coverage number is centrally fixed.<br>• National coverage with proportionately higher coverage of high-poverty upazilas.<br>• Upazila-specific allocations is fixed at ministry level | • Ward Committee identifies a list of eligible beneficiaries on an annual basis based on both verbal requests by potential beneficiaries and the Ward Committee's assessment of the applicant against prescribed eligibility criteria.<br>• The number of beneficiaries is determined based on a quota limit, which is set centrally based on the Ministry's available budget.<br>• Once a list has been prepared, the Ward Committee collects socio-economic data relevant to the eligibility criteria for each of the listed individuals.<br>• The data and list is sent first to the Union and then to the upazila for final approval. The beneficiary list is then finalized. |
| **VGF:** Post-disaster and event-specific food support to food-insecure rural households | Department of Disaster Management + Upazila administration + Union Parishad | • National coverage with proportionately higher coverage of high-poverty upazilas.<br>• Upazila-specific allocation – number centrally fixed at ministry level.<br>• At least 33% of beneficiaries have to be female. | • Ward Committee identifies a list of eligible beneficiaries based on both verbal requests of potential beneficiaries and the Ward Committee's assessment of the applicant against the prescribed eligibility criteria. Such listing occurs before every disbursement which may occur several times a year depending on disaster occurrence and government policy on providing festival-time food support.<br>• The number of beneficiaries is determined based on the quota limit set centrally based on available budget and poverty maps prepared by the Bangladesh Bureau of Statistics.<br>• Once a list has been prepared, the Ward Committee collects some socio-economic data relevant to the eligibility criteria for each of the listed individuals.<br>• This data and list is sent first to Union and then to upazila for final approval against the beneficiary list is finalized. |

## 4.4 Targeting: Program-specific Field Realities

The details of findings by each question and sub-question explored are given below (in Table 11a to Table 11f) for each of the selected programs reviewed.

### 4.4.1 GSK

**Table 11a: Detail Findings from GSK**

| Question | Sub-questions | Insights from FGDs and Interviews |
|---|---|---|
| **How well is the targeting strategy working in practice?** | • Are there specific guidelines for targeting beneficiaries? | • Yes |
| | • Are the guidelines correct, adequate, and useful? | • Yes |
| | • Any examples of inclusion or exclusion errors? | • Program has approx. 15% inclusion error due to pressure from the three upper groups listed by the program. |
| | • Is there a monitoring system to ensure targeting? | • There is a flexible monitoring system that avoids narrowly prescribed formats. A monthly monitoring report is sent to the central research cell. |
| | • Is there a grievance redressal system? Does it work? | • No formal system. Some verbal complaints. |
| | • Are there specific barriers to implementing targeting? | • Upper groups are unwilling to participate in the survey.<br>• Households categorized as 'lower middle class' always put pressure to be listed as 'poor'. |
| | • How adequate are the data sources? | • Adequate |
| | • Any capacity weakness in implementing targeting? | • Shortage of field level health workers.<br>• Multiple workload of field workers and low salary for doctors often leads to high turn-over of personnel. |
| **Recommendations on improvement** | • Does the targeting strategy require improvement? | • More health workers.<br>• Better salary. |
| | • If one change to targeting strategy was to be made, what would it be? | • No additional suggestions. |

### 4.4.2 Sajeda Foundation

**Table 11b: Detail Findings from Sajeda Foundation**

| Question | Sub-questions | Insights from FGDs and Interviews |
|---|---|---|
| **How well is the targeting strategy working in practice?** | Are there specific guidelines for targeting beneficiaries? | • No specific guidelines |
| | Are the guidelines correct, adequate, and useful? | • Not applicable |
| | Any examples of inclusion or exclusion errors? | • Since the hospital has no specific targeting strategy beyond a general strategy of targeting poorer localities, the issue of inclusion or exclusion errors does not apply. |

| | | |
|---|---|---|
| | Is there a monitoring system to ensure targeting? | • There is a strong monitoring system for overall service delivery but not for targeting as such. |
| | Is there a grievance redressal system? Does it work? | • There is a complaint box in the service centers, but there have been no written complaints. Complaints were mostly verbal.<br>• More serious follow-up compared to other programs. Many complaints are actually suggestions. |
| | Are there specific barriers to implementing targeting? | • Poor road infrastructure hampers proper delivery of services, including movement of ambulances. |
| | How adequate are the data sources? | • Data is not a particular focus since targeting is not a priority. |
| | Any capacity weakness in implementing targeting? | • Lack of specialists is a general weakness but not relevant to the issue of targeting. |
| **Recommendations on improvement** | Does the targeting strategy require improvement? | • No. |
| | If one change to targeting strategy was to be made, what would it be? | • Stronger information campaign to make local people aware of the service |

### 4.4.3 DSF

**Table 11c: Detail Findings from DSF project**

| Question | Sub-questions | Insights from FGDs and Interviews |
|---|---|---|
| **How well is the targeting strategy working in practice?** | Are there specific guidelines for targeting beneficiaries? | • Yes. The beneficiary quota is distributed among Unions proportionate to population size. |
| | Are the guidelines correct, adequate, and useful? | • Generally acceptable, but the eligibility criteria of a monthly income of Tk. 3100 is set too low. |
| | Any examples of inclusion or exclusion errors? | • Move from universal coverage to a quota has led to exclusion errors (under-coverage).<br>• Some inclusion errors were noted. Selected beneficiaries are finalized by the Union Parishad chairman with the help of a health assistant and family planning assistant. |
| | Is there a monitoring system to ensure targeting? | • Four-stage monitoring system: i) Union Parishad health workers verify beneficiary information; ii) ward member also verifies beneficiary information; iii) Union Parishad chairman approves the list; and iv) upazila DSF committee representative distributes voucher book among beneficiaries. |
| | Is there a grievance redressal system? Does it work? | • No specific grievance redressal system but there is a complaint box in the upazila health complex.<br>• No written complaints received, but several verbal complaints. Upazila DSF committee has raised the issue with |

| Question | Sub-questions | Insights from FGDs and Interviews |
|---|---|---|
| | | Director, DSF cell at ministry-level but no attention yet. |
| | Are there specific barriers to implementing targeting? | • Every year the quota is declining, which means exclusion errors are rising.<br>• There is pressure for inclusion from economically sound families.<br>• Delays in allocation from the ministry. |
| | How adequate are the data sources? | • Data weaknesses are serious. |
| | Any capacity weakness in implementing targeting? | • No additional manpower has been provided for this program.<br>• Nepotism by local government officials. |
| **Recommendations on improvement** | Does the targeting strategy require improvement? | • No. |
| | If one change to targeting strategy was to be made, what would it be? | • Women who have miscarried in their first and second pregnancies are excluded under the current rule. This may be changed. |

### 4.4.4 UPHCSDP

**Table 11d: Detail Findings from UPHCSDP project**

| Question | Sub-questions | Insights from FGDs and Interviews |
|---|---|---|
| **How well is the targeting strategy working in practice?** | Are there specific guidelines for targeting beneficiaries? | • Yes |
| | Are the guidelines correct, adequate, and useful? | • Yes. |
| | Any examples of inclusion or exclusion errors? | • No examples |
| | Is there a monitoring system to ensure targeting? | • Yes: i) field worker collects and verifies beneficiary information; and ii) supervisor verifies the information to assign an economic classification to the household. |
| | Is there a grievance redressal system? Does it work? | • No formal system. Complaints box for written complaints but no complaints received. Usually verbal complaints. Follow-up is at the discretion of the supervisor. |
| | Are there specific barriers to implementing targeting? | • There is neither a dedicated space nor the budget for satellite clinics.<br>• Lack of privacy hampers proper service provision for pregnant women. |
| | How adequate are the data sources? | • Data is adequate for the purpose. |
| | Any capacity weakness in implementing targeting? | • Lack of information campaign about the service for the community.<br>• No full-time gynecology specialist service available. |

| | | |
|---|---|---|
| **Recommendations on improvement** | Does the targeting strategy require improvement? | • No. |
| | If one change to targeting strategy was to be made, what would it be? | • Provide fund for dedicated space for satellite clinics. |

### 4.4.5 EGPP

**Table 11e: Detail Findings from EGPP**

| Question | Sub-questions | Insights from FGDs and Interviews |
|---|---|---|
| **How well is the targeting strategy working in practice?** | Are there specific guidelines for targeting beneficiaries? | • Yes. |
| | Are the guidelines correct, adequate, and useful? | • Yes. |
| | Any examples of inclusion or exclusion errors? | • Implementers and community representatives estimate inclusion and exclusion errors at around 10% due to nepotism of local government. |
| | Is there a monitoring system to ensure targeting? | • Formal monitoring system is in place but implementation is not strong. |
| | Is there a grievance redressal system? Does it work? | • Formal grievance redressal system but few written complaints.<br>• Many verbal complaints are sometimes frivolous in nature and are of poor merit. |
| | Are there specific barriers to implementing targeting? | • Eligibility criteria of 60 year age limit excludes many potential beneficiaries.<br>• Nepotism of local government officials. |
| | How adequate are the data sources? | • No scope for verifying self-reported information except through community meeting. |
| | Any capacity weakness in implementing targeting? | • Newly elected local government members take time to acquaint themselves with the task |
| **Recommendations on improvement** | Does the targeting strategy require improvement? | • Raise age limit to 65 years.<br>• Make landownership criteria of 10 decimals flexible since it is not a robust correlate of poverty in many localities. |
| | If one change to targeting strategy was to be made, what would it be? | • Make landownership eligibility criteria flexible. |

### 4.4.6 VGF

**Table 11f: Detail Findings from VGF project**

| Question | Sub-questions | Insights from FGDs and Interviews |
|---|---|---|
| **How well is the targeting strategy working in practice?** | Are there specific guidelines for targeting beneficiaries? | • Yes. |
| | Are the guidelines correct, adequate, and useful? | • Yes. |
| | Any examples of inclusion or exclusion errors? | • Both inclusion and exclusion errors are up to 10% due to nepotism of local government. |
| | Is there a monitoring system to ensure targeting? | • Formal monitoring system is in place. |
| | Is there a grievance redressal system? Does it work? | • Formal grievance redressal system but there have been few written complaints.<br>• Many verbal complaints are frivolous in nature and are of poor merit. |
| | Are there specific barriers to implementing targeting? | • Some beneficiaries without tokens must be accommodated due to political pressure or pressure from assembled beneficiaries.<br>• Full weight of food entitled is sometimes not followed due to corruption. |
| | How adequate are the data sources? | • Adequate |
| | Any capacity weakness in implementing targeting? | • No. |
| **Recommendations on improvement** | Does the targeting strategy require improvement? | • No. |
| | If one change to targeting strategy was to be made, what would it be? | • Food ration should be distributed in pre-packed bags to prevent leakage. |

## 4.5 Inclusion Errors

PPRC carried out a major evaluation of SSNPs in Bangladesh in 2011 (PPRC and UNDP, 2011). An important focus of that study was the degree of inclusion errors in the ten surveyed programs. Key findings from the 2011 study relating to inclusion errors are summarized in Table 12.

**Table 12: Degree of Inclusion Error in Major Safety Net Programs**

## Degree of inclusion error: PPRC study of 10 major safety net programs

(source: PPRC/UNDP, 2011, Social Safety nets in Bangladesh: Volume 2: Ground Realities and Policy Challenges)

| Program | Eligibility criteria | % of Inclusion error |
|---|---|---|
| Old age | 65 years of age | 16.9 |
| Widow | Widow<br>Destitute (land below 10 decimals) | 0<br>20.8 |
| VGD | Less than 15 decimals of land | 6.3 |
| EGPP | Dependent on labor occupation | 23.5 |
| Secondary stipend | Less than 50 decimals of land | 10.9 |
| SHOUHARDO | Less than 10 decimals of land | 7.9 |
| CLP | Landless | 20.1 |
| REOPA | Less than 10 decimals of land | 13.6 |
| VGDUP | Less than 10 decimals of land | 24.6 |
| TUP | Less than 10 decimals of land | 19.8 |
| *Average inclusion error for all programs* | | *16.4* |

# 5. LESSONS LEARNED

## 5.1 Lessons from the Qualitative Review

- Targeting advantages must be balanced with the costs – overly elaborate eligibility criteria and large investment in beneficiary household data-collection (e.g., means testing or PMT) can impact on the program scope and duration.
- An information campaign among the target population is a crucial complimentary investment to ensure better inclusion rates and program coverage.
- Targeting methods, such as means testing or PMT, may be suitable for contexts characterized by chronic poverty but are unsuitable for contexts with transient poverty, i.e., where households may be poor part of the year or when households newly fall into poverty. Such circumstances are particularly significant in urban areas.
- 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, it is much less so now.
- Many programs provide ID cards to beneficiaries, which serve as entitlement or discount cards for defined services. Such cards provide promising entry point for popularizing health insurance, as well as for targeting, provided supply-side issues do not become bottlenecks.
- Health services targeting the urban poor, particularly mother and child healthcare services, are often delivered through informal 'satellite clinics'. However, satellite clinics which do not have a dedicated space or offer privacy have proven to be largely ineffective and therefore undermine targeting.
- Both national and global experience is mixed on the success of targeting approaches.
- Targeting mechanisms need not be mutually exclusive. While firm 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.

## 5.2 Success Factors in Targeting

Both the qualitative review and the literature review highlighted five critical success factors for targeting:

- Clarity in defining the target population;
- Well-chosen, effective, and efficient eligibility criteria matching the program content;
- Independent eligibility verification system;
- Monitoring and accountability framework in place; and
- Credible engagement of community actors.

# 6. OVERVIEW OF THE NATIONAL HOUSEHOLD DATABASE PROJECT (FORMERLY POVERTY REGISTER INITIATIVE)

## 6.1 Background

GOB through 23 of its ministries implements a large number of public SSNPs. There are issues around targeting the right people, nepotism among local government officials, overlapping coverage, corruption, leakages, and lack of coordination that need to be addressed. Therefore, GOB with financial and technical support from the World Bank has undertaken a project to prepare a countrywide database, the NHD (initially named the Poverty Register).

A key objective of the NHD is to contribute to better targeting. It is expected that the NHD will be used by all the SSNPs implemented by the various GOB agencies. The database was developed using a PMT formula. This involves using observable and verifiable household or individual characteristics in a formal algorithm to proxy household welfare. Though PMT has been argued to improve targeting efficiency (Grosh and Baker, 1995; Sharif, I., 2012), numerous implementation challenges remain which include but are not limited to an inefficient data collection process, ineffective management of information, and challenges with a feasible and cost-efficient monitoring, verification, and updating system to minimize under-coverage (exclusion errors) and leakage (inclusion errors).

## 6.2 Objectives and Key Features

Preparing an NHD using PMT is a significant step forward towards improving targeting in SSNPs and other resource transfers for the poor. The objectives and key features of the NHD are summarized below:

- The overall objective of NHD is to assist with effective implementation of the NSSS (2015) goal of "reducing poverty by better targeting beneficiaries and improving the management of about 145 government social safety net schemes."
- The specific objective is to prepare an NHD to establish a register of poor households.
- The project is being implemented by the BBS and is one of the components of the GOB's Safety Net Systems for the Poorest Project supported by the World Bank. This project also supports the five SSNPs – EGPP, Cash-for-Work, Test Relief, VGF, and Gratuitous Relief – implemented by the DDM.
- Surveyed households are assigned a poverty score card (PSC) using a PMT formula. The score is used to identify the poor by comparing their PSC against a cut-off mark.
- A total of 34 million households are being surveyed in three phases, with two phases completed at the time of writing.
- NHD will generate two databases: i) a PSC census; and ii) an upazila level list of poor and non-poor households based on their PSC.
- The project is currently two years behind schedule due to implementation challenges.

## 6.3 Can the National Household Database Contribute to Targeting?

NHD can contribute to targeting if the following conditions are met:

- The NHD is updated at regular intervals (e.g., every three years) to adjust for mobility within and across the poverty line;
- Each of the public SSNPs is linked to the NHD, possibly using the national ID number;
- NHD is linked with the management information system of beneficiaries being developed at the DDM; and
- Beneficiary consent to making their personal information public is built into the survey forms. This will avoid any ethical concerns in the use of the data for program implementation.

Beneficiary consent in making their personal information public is both a legal and an ethical issue. According to Section 12 (2) of the Statistics Act 2013, the BBS is obliged not to publish any data collected for a survey or census. Subsection 3 of Section 12 does provide scope for publication of data with the consent of the person involved. However, during data collection of the completed two phases, no form was administered to collect such consent.

# 7. RECOMMENDATIONS

The qualitative review of targeting approaches demonstrates that programs have developed targeting approaches based on program design and available resources (Table 13). 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, the following recommendations (Table 14) merit attention from GOB and other stakeholders for designing and implementing a targeting strategy for any SSNP, with clear relevance for programs designed to support UHC.

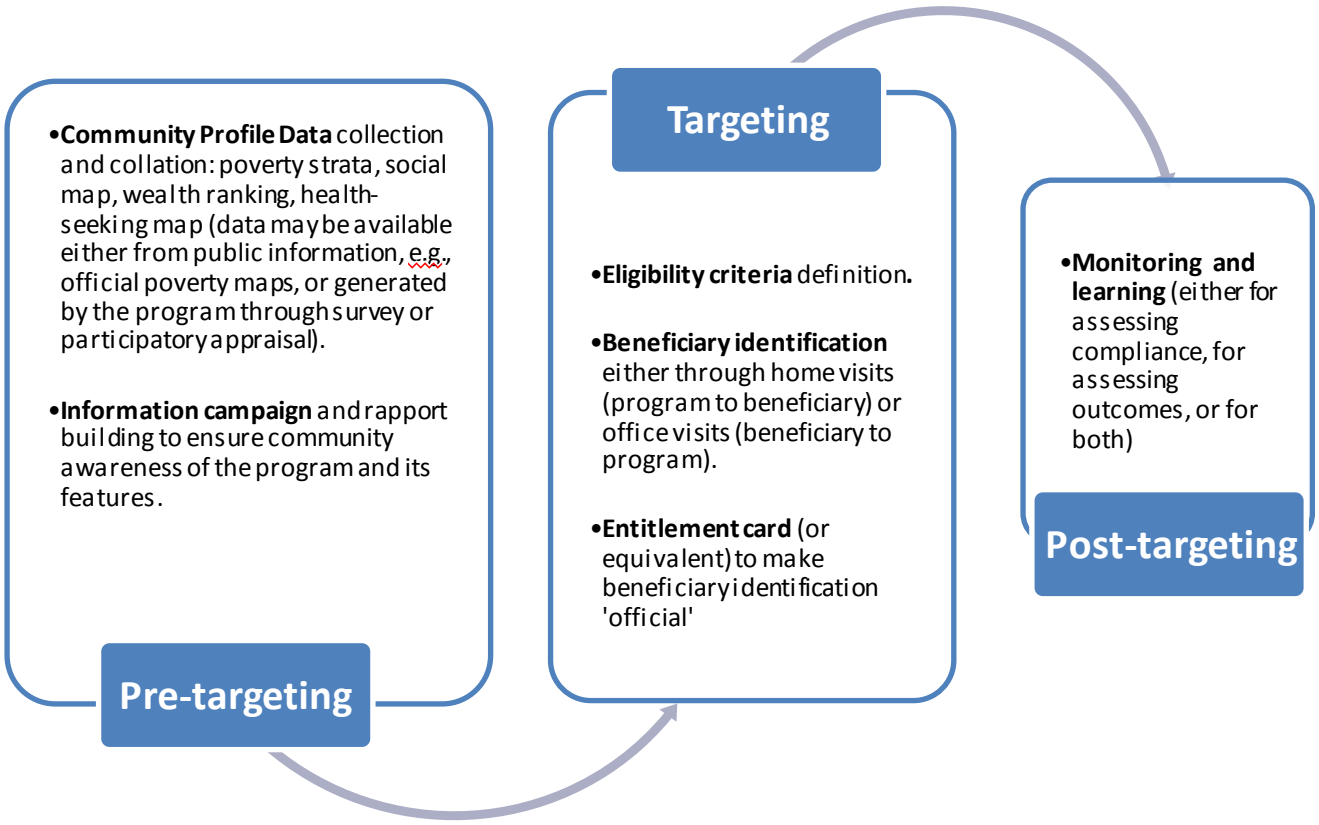
**Table 13: Summary of Findings and Suggested Recommendations**

| Question | Sub-questions | Insights from FGDs and Interviews |
|---|---|---|
| **How well is the targeting strategy working in practice?** | Are there specific guidelines for targeting beneficiaries? | • Yes. |
| | Are the guidelines correct, adequate, and useful? | • Yes. |
| | Any examples of inclusion or exclusion errors? | • Both inclusion and exclusion errors are up to 10% due to nepotism of local government. |
| | Is there a monitoring system to ensure targeting? | • Formal monitoring system is in place. |
| | Is there a grievance redressal system? Does it work? | • Formal grievance redressal system but there have been few written complaints.<br>• Many verbal complaints are frivolous in nature and are of poor merit. |
| | Are there specific barriers to implementing targeting? | • Some beneficiaries without tokens must be accommodated due to political pressure or pressure from assembled beneficiaries.<br>• Full weight of food entitled is sometimes not followed due to corruption. |
| | How adequate are the data sources? | • Adequate |
| | Any capacity weakness in implementing targeting? | • No. |
| **Recommendations on improvement** | Does the targeting strategy require improvement? | • No. |
| | If one change to targeting strategy was to be made, what would it be? | • Food ration should be distributed in pre-packed bags to prevent leakage. |

**Table 14: Matrix on Recommendations**

| Review finding | Recommendation |
|---|---|
| *An effective targeting approach is built not only on sound conceptual principles but also sound operational considerations.* | • Undertake an information campaign to ensure buy-in from the target community and thus increase inclusion. |
| | • Ensure proximity to the facility providing services; this is a key consideration for the poor, particularly in urban contexts where distance entails both costs and unfamiliarity. |
| | • Use a fee-based entitlement card to clarify beneficiary expectations on services and costs, and empower beneficiaries by giving a measure of 'identity' to his/her transactions with the service provider. None of the available entitlement cards have yet passed the test of universal acceptance, and therefore new programs will require a piloting and field-based testing. |
| *All targeting approaches have their strengths and weaknesses. An optimal approach will build on insights from program review.* | • Combine geographic targeting with participatory approaches to leverage the common phenomenon of spatial concentration of poverty and ensure an element of social accountability, while also avoiding heavy upfront cost burdens of a detailed survey. This approach requires a robust verification system to avoid inclusion and exclusion errors based on corruption and discrimination. |
| *There are two serious drawbacks in the utilization of NHD for new program-level targeting. Firstly, it is yet to be completed and tested. Secondly, current legal provisions prevent the use of the data as provision for explicit beneficiary consent was not built into the survey forms. Pending the resolution of these drawbacks, the NHD is not likely to be relevant for program-level targeting for the next three years.* | • To ensure that the completed NHD becomes relevant for targeting in the future, the following are recommended:<br>• Update the NHD at regular intervals (e.g., every three years) to adjust for mobility within and across the poverty line;<br>• Link the NHD to each of the SSNPs, possibly using the national ID number;<br>• Link the NHD with the management information system of beneficiaries being developed at the Department of Disaster Management; and<br>• Ensure beneficiary consent to making their personal information public is built into the survey forms. This will avoid any ethical concerns in the use of the data for program implementation. |
| *A targeting strategy should involve not only the use of specific approaches, but also monitoring of targeting outcomes with learning for adaptation.* | • Deploy a "Three-Stage Cycle" that incorporates pre-targeting, targeting, and post-targeting monitoring with learning – **see Figure 2** (Conceptualization: Hossain Zillur Rahman, 2018). This strategy should include a community-based approach with an objective to reduce both exclusion and inclusion errors, and brings the added benefit of better understanding of the challenges involved in ensuring targeting success. |

**Figure 2: Proposed Three-Stage Targeting Cycle**



# 8. CONCLUSION

Targeting is one of the most widely used strategies in development aimed at ensuring that the benefits of interventions flow to those most in need. With renewed emphasis on equity in the SDGs, a strategic re-examination of targeting as a strategy is particularly apt for newer areas of application, such as UHC. To be meaningful, such a re-examination entails not only a distilling of the analytical debates on targeting, but also using learnings from a range of program experiences where targeting is used. The preceding review combines analytical and experiential learnings to suggest a three-stage cycle incorporating pre-targeting, targeting, and post-targeting monitoring with learning for adaptation. Specifically for new UHC programming, the review suggests a community-based approach in combination with geographic targeting while ensuring targeting efficiency to minimize both errors of inclusion and exclusion.

# ANNEX A: LIST OF PARTICIPANTS

**Power and Participation Research Center**

**Targeting Project**

| Organization | Name of FGD Participants | Name of Interview Participants |
|---|---|---|
| Gonoshasthyo Kendro (GK) | • Dr. Mokter Hossain, Duty Doctor, Barobaria GK Sub Center, Dhamrai.<br>• Md. Jewlur Rahman, Supervisior, Barobaria GK Sub Center, Dhamrai.<br>• Tania Akter, Paramedic, Barobaria GK Sub Center, Dhamrai.<br>• Rafiqul Islam, Field Worker, Barobaria GK Sub Center, Dhamrai.<br>• Amena Begum, Paramedic, Barobaria GK Sub Center, Dhamrai.<br>• Md. Taimur Ali, Senior Health Assistant, GSK | • Dr. Mizanu Rahman, Director GSK<br>• Dr. Kamal Uddin, Physiotherapist GSK |
| UPHCSDP | • Farjana Akter, Female Welfare Volunteer, UPHCSDP, Kishoregonj<br>• Hafiza Akter, Service Provider, UPHCSDP, Kishoregonj<br>• Momotaj Parveen, Service Provider, UPHCSDP, Kishoregonj | • Md. Abdul Hakim Majumder, Project Director, UPHCP<br>• Md. Moniruz Jaman Morol Project Manager, Kishoregonj<br>• Md Rahamat Ali Mondal, Field Supervisor, Kishoregonj |
| DSF | • Syed Moshrraf Hossain, Health Inspector, Kishoregonj<br>• Md. Delower Hossain, Health Inspector, Kishoregonj<br>• Shahanaj Parveen, Assistant Health Inspector, Kishoregonj<br>• Md. Sayem Uddin Assistant Health Inspector, Kishoregonj<br>• Monjurul Mukit, Assistant Health Inspector, Kishoregonj<br>• Afroza Begum, Assistant Health Inspector, Kishoregonj | • Dr. Badrul Hasan, Regional Medical Officer, Kishoregonj, Upazila Health Complex<br>• Dr. Md. Mustafizur Rahaman , Medical Officer, Kishoregonj, Upazila Health Complex |
| Sajeda Foundation | • Dr. Qaisur Rabbi, Coordinator, Sajeda Hospital, Keranigonj<br>• Md. Harun-or-Rashid, Hospital Manager, Sajeda Hospital, Keranigonj<br>• Nadira Yesmin, Administrative Officer, Sajeda Hospital, Keranigonj<br>• Md. Ziaur Rahman, Accounts Officer, Sajeda Hospital, Keranigonj<br>• Dr. Md. Mesbhauddin , Duty Doctor, Sajeda Hospital, Keranigonj<br>• Ranjita Boral, Nurse, Sajeda Hospital, Keranigonj<br>• Jesmin Akter, Nurse, Sajeda Hospital, Keranigonj | • Dr. Shamsher Ali Khan, Senior Director, Sajeda Foundation |
| DORP | | • AHM Nouman , Chief Executive Officer and Executive Director, DORP |

| | | |
|---|---|---|
| EGPP | • Md Younus Mia, Project Implementation officer (PIO), Devidwer Upazila<br>• Md. Habibur Rahman, Assistant Rural Development Officer (Tag Officer), Devidwer<br>• Md. Ashraful Islam, Sub Assistant Engineer (SAE), EGPP, Devidwer | • Rabindra Chakma, Upazila Nirbahi Officer (UNO), Devidwar<br>• Mr. Satyendra Kumar Sarkar, Project Director, Strengthening of the Ministry of Disaster Management & Relief (MoDMR) Program Administration Project, Department of Disaster Management<br>• Muhammad Aminul Islam, Program Specialist, Department of Disaster Management |
| VGF | • Md. Moynal Hossain Chairman, Dhamti UP, Devidwar<br>• Md Md, Al-Amin Chowdhury, Union Parishad member<br>• Md. Jamal Hossain, Union Parishad member,<br>• Md. Mostafizur Rahman, Secretary | • Mr. Satyendra Kumar Sarkar, Project Director, Strengthening of the MoDMR Program Administration Project, Department of Disaster Management<br>• Muhammad Aminul Islam, Program Specialists, Department of Disaster management |

# ANNEX B: BIBLIOGRAPHY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