Final Evaluation 2012 –

Brief report

Multidisciplinary HIV/AIDS-Program in Chittagong, Rajshahi, Khulna und Sylhet / Bangladesh

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Tabular overview

The evaluation mission

Evaluation period	09/2011 – 06/2012 Debriefing GIZ (SSt 08) and final report: July 2012
Evaluating Institution / Consulting firm	CEval – Center for Evaluation, Saarland University
Evaluation team	M.A. Klaus-Peter Jacoby (international consultant), Ph.D. Rumana Huque (national consultant)

The development measure

Title according to the offer	Multidisciplinary HIV/AIDS-Program in Chittagong, Rajshahi, Khulna and Sylhet / Bangladesh
Number	2008.2108.2 (Phase 1: 2001.2503.9)
Overall term broken down by phases	Phase 1: 06/2004 to 12/2008 Phase 2: 01/2009 to 12/2011, extended until 12/2012
Total costs	German contribution: 6.05 Mio. EUR (Phase 1: 3.55 Mio., Phase 2: 2.5 Mio.) Contribution of the partner: Office infrastructure and personnel for program activities (48 months of health staff in the participating city corporations).
Overall objective as per the offer	„Prevention, diagnosis, counselling and treatment for sexually transmittable diseases (STD) and HIV/AIDS in Chittagong, Khulna, Rajshahi and Sylhet are improved.“
Lead executing agency	Ministry of Local Government, Rural Development & Co-operatives (MoLGRDC)
Implementing organizations (in the partner country)	National level: Ministry of Health and Family Welfare (MoHFW), Local level: City Corporations in the program locations Chittagong, Rajshahi, Khulna and Sylhet
Other participating development organizations	None
Target groups as per the offer	Target groups are all inhabitants potentially at risk of contracting STDs and HIV in the cities of Chittagong (with a population of over 2 million), Rajshahi

	(380.000), Khulna (775.000) and Sylhet (285.000). Priority is given to particular risk groups, such as Injecting Drug Users (IDU), migrant workers, people living with HIV/AIDS (PLWHA) and adolescents from 15 to 24 years. Women are also particularly at risk, due to their socio-economically and culturally disadvantaged situation. Therefore, the program addresses men and women in a gender-specific manner.

The rating

Overall rating *On a scale of 1 (very good, significantly better than expected) to 6 (the project/program is useless, or the situation has deteriorated on balance)*	4
Individual rating	Relevance: 3; Effectiveness: 4; Impact: 5; Efficiency: 4; Sustainability: 3

Executive summary

The *Human Immuno Defficiency Virus* (HIV) was officially registered in Bangladesh for the first time in 1989. Although at present, between 7.700 and 19.000 people are estimated to be infected with HIV/AIDS – according to the United Nations Program on HIV/AIDS (UNAIDS) – the prevalence still remains below 0.1% of the total population and registered infections mostly concentrate on specific *Most-at-Risk-Populations* (MARPs). The national HIV/AIDS initiated as soon as 1985 when the *National AIDS Committee* (NAC) was founded. However, little attention was given – until recently – to the key role of primary health care (PHC) in urban areas and its contribution to the prevention of HIV/AIDS and STD. The city corporations that are in charge of coordinating urban PHC services suffer from a lack of financial and personnel resources and do not have appropriate capacities for assuring equitable access to PHC services. This situation particularly affects poor or otherwise disadvantaged populations (core problem).

Against this background, the German Agency for International Cooperation (*Deutsche Gesellschaft für Internationale Zusammenarbeit – GIZ*) implemented the „Multidisciplinary HIV/AIDS-Program in Chittagong, Rajshahi, Khulna and Sylhet" (MDHAP). The first phase was conducted from 06/2004 to 12/2008. The second phase was intended to end in 12/2011, but was extended to 12/2012. The lead executing agency is the *Ministry for Local Government, Rural Development and Co-operatives* (MoLGRDC) as its competences include the coordination and supervision of the City Corporations. The most important implementing partners are the *Ministry for Health and Family Welfare* (MoHFW) and the City Corporations of the program locations. Target groups are all inhabitants of the program locations that are potentially at risk of being infected with HIV/AIDS and STD, particularly specific risk groups (e.g. migrant workers, adolescents) or populations that do not have appropriate access to primary health care.

The overall objective of the development measure is: „Prevention, diagnosis, counselling and treatment for sexually transmittable diseases (STD) and HIV/AIDS in Chittagong, Khulna, Rajshahi and Sylhet are improved".

The indicators that are specified in the program offer do not represent an appropriate benchmark for evaluating the success of the development measure as the overall picture of donor contributions to HIV/AIDS changed significantly at the beginning of phase 2 and led to a very different scenario for the German technical cooperation (TC). At present, key program components do not focus anymore specifically on HIV/AIDS prevention, but more broadly on the monitoring of PHC services and infectious diseases, as well as on the strengthening of PHC service providers in urban areas. Therefore, the evaluators modified the indicators ac-

cording to the new target areas. The modified indicators are: (1) The health departments of the city corporations report at least once a year monitoring data of urban PHC service providers to the MoHFW; (2a) The organizational capacity of urban PHC service providers – measured by standardized quality standards – haven improved in at least 7 pilot facilities in Sylhet; (2b) The quality standards are scaled up other PHC service providers under the competence of the Sylhet City Corporation (SCC); (3) The percentage of patients of selected PHC service providers which express concern of being discriminated when demanding STD-services, has been reduced by 20% compared to the baseline-survey.

The input of German technical cooperation (aprox. 2.5 Mio. € for phase 2 and 6.05 Mio. € for the overall term of the program) comprised international and national long-term- and short-term-experts, as well as a limited amount of local financial contributions to integrated Public-Private-Partnerships (iPPP). The contributions of the implementing partners mainly consisted in office infrastructure and personnel for program activities. Activities concentrated on the implementation of an urban Health Management Information System (HMIS – Component 1, piloted in Khulna), the implementation of a quality management (QM) for urban PHC service providers, based on a agreed Quality Standards (Component 2, piloted in Sylhet) and a set of several interventions aiming for a more equitable access to PHC for selected vulnerable groups (component 3). The intended outputs were: (a) a technically functional HMIS delivering data on PHC services and infectious diseases, (b) the application of quality standards by urban PHC service providers and (c) models of HIV/AIDS/STD-prevention and improved PHC for vulnerable groups integrated in the organizational routines of implementing partners. As the use of the output it was expected that (a) the city corporations would use HMIS-data in order to respond to the national monitoring system of MoHFW and to take informed and need-oriented decisions with regard to the coordination of urban PHC providers; (b) that PHC service providers – on the basis of the quality standards – would initiate change processes in order to continuously improve their performance; and (c) that implementing partners of component 3 would continue to offer HIV/AIDS/STD-services and/or PHC services for vulnerable groups on an independent and sustainable basis. Altogether, these interventions aimed for the strengthening of urban health management and improving the performance of PHC service providers as a direct effect. As an indirect effect, the development measure intended to contribute to reducing further infections with HIV/AIDS/STD and improving the overall health situation of the selected vulnerable groups. On a highly aggregated level, this should result in a contribution to the health related *Millennium Development Goals* (MDG 4 to 6).

The field phase of the final evaluation took place vom 1st to 19th of april 2012. Data collection comprised qualitative interviews with 61 persons, documentary analysis and the analysis of

available secondary data (including results of the program monitoring and the previous e-VAL-interviews. One international consultant and one national consultant formed the evaluation team. According to the GIZ-guidelines for evaluating the success of development measures, they assessed the criteria of *Relevance, Effectiveness, Impact, Efficiency* and *Sustainability*. Each criterion is rated on a six-level-scale (from level 1 = "very good rating" to level 6 "the development measure is useless") with the exception of the sustainability rating (four-level-scale from level 1: "very good sustainability" to level 4 = "insufficient sustainability").

The evaluation rated the development measure with an overall rating of level 4, i.e. according to the GIZ-guidelines an "**unsatisfactory rating**: negative results predominate despite identifiable positive results". The overall rating is based on the individual assessment of each one of the previously mentioned criteria:

Relevance was **still rated satisfactory (level 3),** due to the compliance of the program concept with the sector policies and strategies of the partner country. As well the HMIS as the Quality Standards for PHC providers are interventions with a potential for contributing to an improvement of PHC in Bangladesh. The MDHAP interventions are also in line with the broader GIZ health sector program, with thematic areas being that similar (MIS, Quality-Management) that it would have been more recommendable to carry out both development measures under the umbrella of one single health sector program. Furthermore, the rating must take into account that the program took a shift away from the overall objective stated in the program offer and now focuses on a more general strengthening of urban PHC than on HIV/AIDS/STD prevention. Although plausible arguments can be made for the re-orientation of the program, the overall objective and its indicators were not sufficiently adapted. Thus, the incongruence between the actual program strategy and the formal objective hinders a better rating for the relevance criterion.

With regard to Effectiveness, both key components (HMIS and QM) are not yet sufficiently consolidated and probably won't reach a satisfactory level until the end of the program in 12/2012. In april 2012, the HMIS (component 1) had just initiated a first data collection (data available for 14 out of 27 NGOs) which means that the intervention is not yet mature enough in order to allow for the intended *use of the output* (→ Indicator 1 only partially achieved). In the case of the QM for urban PHCP providers (component 2), there are 7 pilot clinics which have improved some internal processes and health services – although not fully meeting their expectations (→ Indicator 2a only partially achieved). So far, no steps have been taken towards the scaling up of the underlying quality standards to other PHCP providers in the Sylhet area (→ Indicator 2b not achieved). With regard to the level of discrimination of people

using STD-services (→ Indicator 3), some patient surveys have been carried out by the MDHAP but did not deliver sufficiently specific data, thus, indicator 3 cannot be assessed. The effectiveness of the diverse interventions under component 3 varies strongly. Particularly the more specific HIV/AIDS/STD interventions have not institutionalized by the implementing partners; several of them have already been abolished at the time of the evaluation and thus, cannot deploy any further effects. Only two iPPP-measures in the tea and the ship-building sector (which explicitly exclude HIV/AIDS and STD) have significantly increased workplace security and/or the access of workers and their families to adequate PHC. However, these measures cannot compensate the previously mentioned shortcomings and Effectiveness must be rated **unsatisfactory (level 4)**.

The findings regarding Effectiveness already imply that the contribution of the program to overarching development results (impact) ist necessarily limited and cannot be satisfactory. Neither the HMIS nor the QM-component are sufficiently mature to have any more profound impact at the moment of the evaluation. Furthermore, the high proportion of already abandoned measures in component 3 must also be considered, as no scaling up is possible when even the pilots have not been successfully established. As no systemically relevant results can be observed at the time of the evaluation, Impact is rated as **clearly unsatisfactory (level 5).**

With regard to the Efficiency criterion, the program concept and program structure seemingly meet the requirements for an efficient implementation process. However, neither production-efficiency nor cost-effectiveness actually reached a satisfactory level. The main reasons for this are some discontinuities of the program process (e.g. due to fluctuation of personnel, also within the MDHAP-team) and the lack of coordination/cooperation with other relevant programs, including the health sector program of GIZ. As the efficiency must also be measured against the limited effectiveness of the MDHAP, it also receives an **unsatisfactory rating (level 4).**

The assessment of the program's sustainability is difficult as very different aspects must be considered. Taking into account the unsatisfactory ratings for effectiveness and impact, particularly the difficulties in component 2 and 3, sustainability at the moment of the evaluation is necessarily insufficient, too. A presently positive sustainability has only be achieved by the iPPPs in the tea and the shipbuilding sector where the program had managed to identify intervention areas which became strategic priorities of the partner companies (e.g. as contributions to the stability of the workforce, better access to international markets through the com-

pliance with minimum standards). At the same time, there is a certain potential that some scaling-up of the HMIS as well as for the Quality-Standards for urban PHC if both interventions will be actively advocated for some additional time by the GIZ health sector program. In spite of the generally critical assessment of the program, the assessment of its sustainability also takes into account that several key stakeholders (implementing partners, MDHAP staff) are optimistic that a demand for the HMIS and the Quality Standards can still be generated beyond the present pilot locations. Thus, adopting these components, the GIZ health sector program could still achieve – belatedly – a more positive scenario. Therefore, the program is rated with **sustainability level 3.**

There are several recommendations and lessons learned that can be drawn from the findings of the evaluation. As the technical quality of the products – in spite of their low effectiveness – is positively rated by all interviewees, the GIZ health sector program should engage in the follow up of the key MDHAP-components in order to achieve a limited scaling-up. Recommended follow-up activities are particularly: (a) supporting interested city corporations in formulating project proposals and acquiring resources for the implementation of the HMIS; (b) promoting the dissemination of the quality standards for urban PHC providers in Sylhet and the adaption of the quality standards at the national level (→ formal recognition of the standards by the MoHFW ad the MoLGRDC).

Relevant lessons learned are: (a) the need for a stronger focus on interinstitutional coordination – or coordination between the different levels of public administration - particularly in the case if the dimension of one single development measures represents only a very small share of over donor resources; (b) the need for sensitizing the implementing partners more systematically for the requirements of a sustainable capacity development instead of expecting donors to assume relevant system functions by themselves (e.g. integrating sustainability strategies in each change process).

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Anlage 1: Assessment of the program indicators on basis of the indicatos as modified by the evaluation team.

Multidisciplinary HIV/AIDS-Program in Chittagong, Rajshahi, Khulna and Sylhet
Project-Nr. 2008.2108.2 (Phase 1: 2001.2503.9)

Overall objective according to the present offer: Prevention, diagnosis, counselling and treatment of STD and HIV/AIDS in Chittagong, Khulna, Rajshahi and Sylhet are improved. ***Factual objective according to the present interventions*:** The capacity of city health departments and urban PHC providers has been enhanced.

Indicator 1	**Indicator 2a**
The health departments of the city corporations report at least once a year monitoring data of urban PHC service providers	The organizational capacity of urban PHC service providers – measured by standardized quality standards – haven improved in at least 7 pilot facilities in Sylhet
Data collection has just begun in early 2012. → at 04/2012 14 out of 27 covered. Monitoring data is not yet being used for decision making.	All 7 pilot clinics in Sylhet have achieved relevant improvements, however limited to particular areas of the quality standards only. Changes are not yet fully consolidated.

Indicator 2b	**Indicator 3**
The quality standards are scaled up other PHC service providers under the competence of the Sylhet City Corporation	The percentage of patients of selected PHC service providers which express concern of being discriminated when demanding STD-services, has been reduced by 20% compared to the baseline-survey.
No actions have been taken so far in order to diseeminate the quality standards to other PHC providers.	The indicator cannot be assessed as no reliable data is available.

Cross-cutting issues

Poverty Reduction (SUA)

The programs concept aims for contributing to the improvement of the health situation of poor populations. However, results would take place on a highly aggregated level only and are presently not yet observable.

Gender (G-1)

Gender equality and – more generally – equitable access to discrimination-free health services were addressed by specific program components. The effectiveness remains however limited as several interventions are not being continued by the implementing partners.

Good Governance (PD/GG-1)

As well the HMIS as the QM for urban PHC providers try to improve the capacity of city corporations for coordinating sector stakeholders and properly implement sector policies/strategies. Results on the city governance of health are, however, still very limited.

Indicator achieved | Indicator partially achieved | Indicator not achieved

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