Internal Ex-Post Evaluation for Technical Cooperation Project

conducted by Bangladesh Office: December, 2022

Country Name	**Safe Motherhood Promotion Project**
People's Republic of Bangladesh	**Safe Motherhood Promotion Project(Phase 2)**

I. Project Outline

Background	In Bangladesh, maternal and child health indicators remained poor. One of the reasons for the high maternal and infant mortality rates were difficulty to detect and treat abnormal pregnancies due to the low maternal health checkup rate, which caused the delays in the treatment. Also, only about 12% of deliveries were made at health facility or with birth attendant having birth attendance training. Under such circumstance, a technical cooperation project was implemented to develop an effective model for improvement of Maternal and Child Health (Phase 1 project). In order to apply the model, a succeeding project was implemented (Phase 2 project).		
Objectives of the Project	Through strengthening of safe delivery service system, establishing Community Support System (CmSS)/groups, identification of good practices of Maternal and Neonatal Health (MNH) services and consolidation of it in national strategies, etc, the Project aimed at expanding the approaches to improve MNH services quality and utilization, thereby contributing to improvement in MNH.		
	<Phase 1> 1. Overall Goal: Approaches of Reproductive Health (RH) services extracted from the Project are standardized and applied to other districts. 2. Project Purpose: Health status of pregnant and post-partum women and neonates improves in the target district. <Phase 2> 1. Overall Goal: Maternal and neonatal health status is improved in Bangladesh. 2. Project Purpose: The approaches to improve MNH services quality and utilization in line with Health, Population, and Nutrition Sector Development Program (HPNSDP) are expanded in Bangladesh.		
Activities of the Project	1. Project site: <Phase 1>Narsingdi district <Phase 2>Narsingdi, Jessoreand Satkhira districts 2. Main activities: <Phase 1>(i) strengthening of safe delivery service system, (ii)establishing CmSS/groups, etc. <Phase 2>(i) identification of good practices of MNH services and consolidation of it in national strategies, (ii) developing a package of MNH interventions under Upazila Health System (UHS), etc. 3. Inputs (to carry out above activities) Japanese Side <Phase 1> 1) Expert: 7persons 2) Training in Japan:13 persons 3) Training in the third country: 4 persons (India) 4) Equipment: Equipment related to Emergency Obstetric Care (EmOC) and neonatal care services, renovation of health facilities. 5) Local Cost: local staff, contract with NGOs, hospitals, consultants <Phase 2> 1) Experts:11 persons 2) Training in the third countries: Sri Lanka, Tanzania and Kenya 3) Equipment: Equipment for neonatal care, etc. 4) Operation cost: Contract with CARE Bangladesh Bangladeshi Side <Phase 1> 1) Staff allocated: 30persons 2) Land and facilities: project office 3) Local Cost: Partly borne by the Bangladesh side (Medical equipment, drug, consumable supplies, materials and operation cost for project office) <Phase 2> 1) Staff allocated: persons: 34 persons 2) Land and facilities: Office premises, provision of building, etc.		
Project Period	<Phase 1> (ex-ante) April 2006-March 2010 (actual) July 2007-June 2011 (Extended period: July 2010-June 2011) <Phase 2 > (ex-ante) July 2011 -June 2016 (actual) July 2011-June 2016	Project Cost	<Phase 1> (ex-ante) 396 million yen (actual) 404million yen <Phase 2> (ex-ante) 492 million yen (actual) 440 million yen
Implementing Agency	Ministry of Health and Family Welfare (MoHFW)		
Cooperation Agency in Japan	-		

II. Result of the Evaluation

<Constraints on Evaluation>

- Due to the restriction under COVID-19, information was collected through collecting a questionnaire and telephone interviews.

< Special Perspectives Considered in the Ex-Post Evaluation >

- As the Phase 1 and Phase 2 projects share the common goal, the indicators for the Phase 2 project are verified to check the level of achievement of the Project Purpose and the Overall Goal.
- Continuation status of the project effects are analyzed as factors to achieve the Overall Goal.

1 Relevance

<Consistency with the Development Policy of Bangladesh at the Time of Ex-Ante Evaluation >

The projects were consistent with the development policy of Bangladesh.

In the Health Nutrition and Population Sector Program (HNPSP) (fully operational in 2005), the improvement of Maternal and Child Health, especially antenatal and postnatal maternal and reproductive health conditions was addressed as a priority issue. Also, the "National Strategy for Accelerated Poverty Reduction II" (2009-2011) aimed at solving the problems in the area of maternal and child health through the measures of quantitative expansion of skilled birth attendants, expansion of Postnatal Cares (PNC), and expansion of Emergency Obstetric Care (EmOC) services. Health, Population and Nutrition Sector Development Program (HPNSDP) (2011-2016) continued to prioritize improvement of Maternal and Neonatal Health.

<Consistency with the Development Needs of Bangladesh at the Time of Ex-Ante Evaluation >

The projects were consistent with the development needs of Bangladesh on Maternal and Child Health. The Maternal and Child Health indicators remained poor partly because of low maternal health checkup rate as well as high percentage of delivery without proper birth attendance.

Even after improvement of the Maternal and Child Health indicators in the country, challenges remained: weak coordination of function at the central level, necessity of promotion of Primary Health Care (PHC) service delivery at the community level, which was necessary to support Maternal and Child Health activities, lack of Comprehensive Emergency Obstetric Care (C-EmOC) services in health facilities, lack of Postnatal Care (PNC) services, lack of neonatal care, problems of access to health facilities in some areas, lack of skilled birth attendants, and lack of services for the poorest.

<Consistency with Japan's ODA Policy at the Time of Ex-Ante Evaluation>

The projects were also consistent with Japan's ODA policy to Bangladesh. The Country Assistance Program to Bangladesh, which was being revised as of December 2005 prioritized social development and human security which includes health.

<Evaluation Result>

In light of the above, the relevance of the project is high.

2 Effectiveness/Impact

<Status of Achievement of the Project Purpose at the time of Project Completion>

Under the Phase 1 project, the Narsingdi Model, a model that showed how to strengthen the relationship between pregnant women and maternal and child health service providers by organizing community support groups for pregnant and nursing mothers, was developed. In order for the Government of Bangladesh to reflect some of the findings and measures obtained from the Norsindhi Model in the HPNSDP for nationwide implementation, Phase 2 was implemented aiming to further improve the model and strengthen the system for nationwide dissemination.

The Project Purpose of the Phase 2 was achieved at the time of the project completion. All the 5S-CQI-TQM[1] hospitals in Satkhira and Narsingdi achieved over 75% on 5S at MNH services areas which was above the target of 70%(Indicator 1), the percentage of Community Support Groups (CSGs) functional in Satkhira was 82% relative to the target of 70% (Indicator 2), the proportion of women with complications using EmOC in Satkhira district and Kalaroa Upazila was 80.9% which was just over the target of 80% (Indicator 3), the proportion of deliveries assisted by skilled personnel in Satkhira and Kalaroa districts increased to 54.8% and 68.1% respectively against the target of 50% (Indicator 4), almost all Community Clinics (CCs) in Bangladesh established CSGs (Indicator 5), and the number of TQM pilot hospitals expanded to 106 (Indicator 6).

<Continuation Status of Project Effects at the time of Ex-post Evaluation>

The project effects have continued after the project was completed. As mentioned above, the continuation status of the project effects is analyzed as factors to achieve the Overall Goal of Phase 2. The 5S-CQI-TQM and CSG concepts have been taken in the policy and implemented country-wide. This implied the effectiveness of the concept has been highly evaluated and incorporated to the policy in MOHFW.

<Status of Achievement for Overall Goal at the time of Ex-post Evaluation>

The Overall Goal of Phase 2 has been achieved. There has been no consistent data on Maternal Mortality Raito (MMR) from MoHFW at both national and district levels), and data on MMR seemingly worsened (it was 194 in 2010 and became 196 in 2016[2], with no relevant data published in 2019). However, according to the World Bank, the MMR decreased from 258 (2010) to 173 (2017), showing a 30% reduction. This is a significant improvement compared to the overall goal of 26% reduction from 194 to 143. Additionally, since the Ministry does not have consistent data and referred to the World Bank's figures, Neonatal Mortality Rate (NMR) decreased from 32.4 (2007) to 19.1 (2019). This data up to 2019 was deemed a 41% reduction, almost achieving the overall goal of a 44% reduction from 37 to 21 in the NMR. Both MMR and NMR have improved; therefore, the indicators are deemed "achieved."

The Government of Bangladesh has committed to improving the country's maternal and neonatal health situation, and as a result, the targets for the attainment of MMR and NMR were achieved. Other data indicate that there has been a significant improvement in the maternal health process indicators during the period from 2010 to 2019, such as uptake of Ante-Natal Care (ANC) (from 71.2% to 75.2%), delivery by skilled providers (from 26.5% to 59.0%), institutional delivery (from 23.4% to 53.4%) and Post-Natal Care (PNC) (from 22.5% to 66.7%), and so on[3].

[1] 5S means "Set, Sort, Shine, Standardize, Sustain", CQI means "Continuous Quality Improvement" and TQM means "Total Quality Management".
[2] Source: Bangladesh maternal mortality survey (BMMS) 2010, BMMS2016
[3] Source: MOHFW

Since many other organizations (including the government) have had MNH interventions in the country, it is not possible to disaggregate the contribution of the project to the change in maternal and neonatal health indicators from national data. However, considering the following situation, it can be said the project somewhat has contributed. At the target sites, improvement of quality of services due to the introduction of 5S-CQI-TQM at hospitals and CSGs at the community level were believed to have contributed to the improvement in the utilization of hospital services such as ANC, PNC, delivery, and neonatal care. Besides, 5S-CQI-TQM and CSG concepts have been taken in the policy, and implemented country-wide and with the support of other development partner agencies.

The strategy for Quality Improvement (QI) was first introduced in Bangladesh by the project and subsequently adopted by the government. The government established the Quality Improvement Secretariat (QIS) at the Health Economics Unit (HEU) under the MoHFW in 2015, and QIS developed the national plan for QI, which was being revised at the time of ex-post evaluation. The strategy adopted 5S-CQI-TOM. QI committees have been formed at the divisional and district levels, as well as within Medical College Hospitals to implement and monitor the QI activities in all the districts. Work Improvement Teams (WITs) have also been formed at the district hospitals, where 5S was introduced. The staff of several district hospitals have been trained on 5S and PDCA (Plan, Do, Check, and Act) by QIS. Other development partners such as Save the Children, UNICEF and UNFPA have adopted this strategy (5S & PDCA) to improve the quality of services at their project districts.

As for CSGs, considering the success and effectiveness of the CmSS, MoHFW adopted the CmSS model as an approach for community mobilization and replicated the model country-wide as Community Support Groups (CSG) through its existing grass-root level service facilities called Community Clinics (CC). Using the experiences of the project (implemented by CARE Bangladesh), MoHFW established three (03) CSGs under each of CC catchment areas for creating awareness, mobilizing local resources, promoting accountability, facilitating effective referrals, and developing other required supports for the poor women in accessing timely maternal and child health services.

<Other Impacts at the time of Ex-post Evaluation>

No negative impacts on the natural environment have been observed. There has been no land acquisition or resettlement.

<Evaluation Result>

Therefore, the effectiveness/impact of the project is high.

Achievement of Project Purpose and Overall Goal（Phase 2）

Aim	Indicators	Results	Source
(Project Purpose) The approaches to improve MNH services quality and utilization in line with Health, Population, and Nutrition Sector Development Program (HPNSDP) are expanded in Bangladesh.	Indicator 1: The proportion of all the TQM hospitals in Satkhira and Narsingdi achieved 70% or more on 5S at the MNH service areas (ANC/PNC corner, delivery room, operation theater and female ward)	Status of the Achievement: achieved (continued) (Project Completion) All the 5S-CQI-TQM hospitals in Satkhira and Narsingdi achieved over 75% on 5S at MNH services areas. (Ex-post Evaluation) The exact indicator data in Satkhira and Narsingdi has not been obtained due to the restriction of covid19 period. However, the concept of 5S-CQI-TQM is considered as an essential aspect of the quality of MCH health services at the hospital, which is already incorporated in the policy. Compared with the achieved goal that "Approaches of Reproductive Health (RH) services extracted from the Project are standardized and applied to other districts," the indicator has been achieved.	JICA documents
	Indicator 2: The percentage of CSGs functional in Satkhira is increased to 70% or more.	Status of the Achievement: achieved (continued) (Project Completion) The percentage of CSGs functional in Satkhira was 82% (540 CSGs out of total 657 CSGs). (Ex-post Evaluation) The CSG concept has been incorporated in policy and implemented nationally, which means CSGs are functional. The indicator is considered as achieved.	JICA documents
	Indicator 3: The proportion of women with complication using EmOC services increases to 80% or more in Satkhira and Kholaroa	Status of the Achievement: achieved (not verifiable) (Project Completion) The proportion of women with complications using EmOC in Satkhira district and KalaroaUpazila was 80.9%. (Ex-post Evaluation)Although data showed that birth delivery by skilled personnel and institutional birth delivery has a rising trend nationwide, this does not necessarily mean that the proportion of women with complications using EmOC services continues to be 80%. It was challenging to collect enough information to conclude due to the restriction of Covid19 at the evaluation time, so it was concluded as "not verifiable."	JICA documents
	Indicator 4: Proportion of deliveries assisted by skilled personnel (C-SBA, SSN/FWV with midwifery training, MBBS	Status of the Achievement: achieved (continued) (Project Completion) The proportion of deliveries assisted by skilled personnel in Satkhira district increased to 54.8% as of the terminal evaluation (baseline: 37.4%), and in Kalaroa, it increased to 68.1% (baseline: 45.6%) (Ex-post Evaluation) Despite that the Birth delivery by skilled personnel increased from 26.5% to 59.0%, and institutional birth delivery rose from 23.4% to 53.4% nationwide between 2010 and 2019 in Bangladesh, which does not necessarily mean that the proportion of deliveries assisted by skilled personnel in the areas is more than 50%. On the other hand, the indicator can be assumed to improve in parallel with the	JICA documents

	doctor) *increases to 50% or more * (i) C-SBA: Community based Skilled Birth Attendant, (ii) SSN/FWW: Senior Staff Nurse/Family Welfare Volunteer, (iii) MBBS: Bachelor of Medicine & Bachelor of Surgery	increment on skilled birth attendant and institutional birth delivery of the nationwide data. The indicator has been achieved at the end of the project, and we can assume it remains achieved now.	
	Indicator 5: The proportion of established CSGs reaches to 100% in Bangladesh	Status of the Achievement: achieved (continued) (Project Completion) According to the CBHC documents, the number of established CSGs was 39,240 in Bangladesh (99.4% of the target: 40,149 as of June 2015). In 2013, RCHCIB issued the government order that all CCs should create CSGs as per the guideline. (Ex-post Evaluation) The Precise data on the CSG establishment number has not been collected due to the restriction by COVID-19. Still, CSG has been incorporated at the Policy level, and CCs have expected to formulate the CSG; thus, the indicator is deemed achieved.	JICA documents
	Indicator 6: TQM pilot hospitals expands to more than initial four hospitals (baseline: 3)	Status of the Achievement: achieved (continued) (Project Completion) The number of pilot hospitals was 106 in Bangladesh. (Ex-post Evaluation) The concept of 5S-CQI-TQM has been incorporated in the policy and implemented nationally. It is regarded as achieved.	JICA documents
(Overall Goal) Maternal and neonatal health status is improved in Bangladesh.	Indicator 1: MMR is reduced from 194 (2010) to under 143	(Ex-post Evaluation) achieved There has been no consistent data on Maternal Mortality Raito (MMR) from MoHFW at both national and district levels), and data on MMR seemingly worsened (it was 194 in 2010 and became 196 in 2016[4], with no relevant data published in 2019). However, according to the World Bank, the MMR decreased from 258 (2010) to 173 (2017), showing a 30% reduction. This is a significant improvement compared to the overall goal of 26% reduction from 194 to 143. **National level MMR*** 2010: 258 / 2011: 248 / 2012: 238 / 2013: 227 / 2014: 214 / 2015: 200 / 2016: 186 / 2017: 173 / 2018: N/A / 2019: N/A *Data is only available up to 2017.	World Bank
	Indicator 2: NMR is reduced from 37 (2007) to under 21.	(Ex-post Evaluation) achieved Since the MOHFW does not have consistent data and referred to the World Bank's figures, Neonatal Mortality Rate (NMR) decreased from 32.4 (2007) to 19.1 (2019). This data up to 2019 was deemed a 41% reduction, almost achieving the overall goal of a 44% reduction from 37 to 21 in the NMR. Both MMR and NMR have improved. **National level NMR** 2007: 32.4 / 2008: 31.0 / 2009: 29.6 / 2010: 28.3 / 2011: 27.0 / 2012: 25.8 / 2013: 24.8 / 2014: 23.5 / 2015: 22.5 / 2016: 21.6 / 2017: 20.7 / 2018: 19.8 / 2019: 19.1	World Bank

3 Efficiency

Although the project costs for Phase 1 and Phase 2 were within the plan, the project periods exceeded the plan (the ratio against the plan: 95%, 111%, respectively). The outputs were produced as planned. Therefore, the efficiency of the projects is fair.

4 Sustainability

<Policy Aspect>

The concept of 5S-CQI-TQM has become the strategy of QIS, HEU of MoHFW, "Strategic Planning on quality of care for health service delivery in Bangladesh" (2015-2032) to achieve an effective health system that provides the highest quality of care by quality improvement of hospital services. CSG concept is in line with the "Revitalization of Community Health Care Initiatives" project under the MOHFW.

<Institutional/Organizational Aspect>

There has been no change in the institutional/organizational structure to promote the concepts and models introduced by the project. As mentioned above, QIS was established at HEU, MOHFW in 2015. The mandates of the QIS have been to a) develop the QI tools, guidelines, standards, Standard Operating Procedures (SOPs), and policies, etc., b) develop Monitoring and Evaluation (M&E) system for the quality

[4] Source: Bangladesh maternal mortality survey (BMMS) 2010, BMMS2016

of care for health service delivery; c) ensure attainment of national health care standards; and d) coordination with govt. agencies, NGOs, and autonomous bodies.

At the time of ex-post evaluation, the QIS was staffed with a program manager (Joint Secretary), one consultant, and 2 Medical Officers (MO) from the government side. In addition, development partners have supported the QIS with some staff (Save the Children: 2 consultants; UNICEF: 1 MO, UNFPA: 1 MO). The overall activities of the QIS have been led by the Director General (DG) (Additional Secretary), HEU.

QI committees have been formed at the divisional and district levels, as well as within Medical College Hospitals to implement and monitor the QI activities in all the districts. WITs have also been formed at the district hospitals, where 5S is introduced.

<Technical Aspect>

To sustain those skills and knowledge, MoHFW kept the option for training, refresher training in their Operation Plan (OP).

Many materials with regards to QI such as 5S and PDCA have been developed to implement the strategy across the country. As mentioned above, QI committee have been formed to implement and monitor the QI activities. The staff of several district hospitals has been trained on 5S and PDCA by QIS.

<Financial Aspect>

MoHFW has had a sufficient budget for training in different OPs. Those are from the Government of Bangladesh and RPA (Reimbursable Project Aid) by DPs. About 61% of the total budget of the 4th sector program is coming from the Government of Bangladesh The total budget under the 4th sector budget (2017-2022) for HEU was about Tk. 2,218.3 million, of which 7% was allocated for QIS.

<Evaluation Result>

In light of the above, no problem has been observed in terms of the policy, institutional/organizational, technical and financial aspects. Therefore, the sustainability of the project effects is high.

5 Summary of the Evaluation

The projects achieved the Project Purpose, as the targets such as adoption of 5S, functioning of CSGs, using EmOC, deliveries assisted by skilled personnel, establishment of CSGs and the number of TQM pilot hospitals were achieved. The Overall Goal has been achieved, as MMR and NMR have improved, and the project has contributed to this achievement since the concepts of 5S and CSG have been incorporated into the policy. As for efficiency, the project periods exceeded the plan, however, the project costs were within the plan.

Considering all of the above points, this project is evaluated to be highly satisfactory.

III. Recommendations & Lessons Learned

Recommendations for Implementing Agency:

TQM program will strengthen 5S activities and support their dissemination. TQM program has been spread widely through Bangladesh and has been put into practice in many hospitals. It is critical that TQM program should be implemented more actively and the activities should be sustainable Although solid leadership in hospitals is essential for TQM, it could be easily undermined by personnel transfer. Also, obtaining the effectiveness of TQM in quality improvement of health services would take a relatively long time, compared with the fact that people can see the effectiveness of 5S by its appearance and cleanness in the hospital in such a short time. Thus, the quality of TQM would require continuous monitoring and supervision. To improve the quality of TQM program, the Government of Bangladesh needs to promote hospitals to maintain TQM program with PDCA cycle and share good practices with other hospitals.

Lessons Learned for JICA:

From the outset, the Phase 2 project focused on improving and expanding MNH services quality and utilization, which was highly relevant to the health strategies of the government of Bangladesh in line with the "Health, population, and nutrition sector development program 2011－2016". Primarily, the Phase 2 project focused on the linkage between policy formulation and operationalization with the Government of Bangladesh, which is considered one of the critical aspects of this Project's high ratings. This linkage has been established through several approaches, such as field tours and forums organized for the policymakers and development partners, which helped them get a clear picture of 5S-Kaizen-TQM and CSG concepts.

Creating such opportunities to demonstrate project ideas at the practical level is really useful in helping policymakers and development partners get a deeper understanding of the issues and become supportive. In addition, as an approach to policy recommendations in a project, it is necessary to devise ways to incorporate the knowledge gained in the project into a form that is easy for the government to utilize and link this to recommendations and advice with the better understanding of a health system, health policy, and its context in a country. Moreover, early on, a project also brought senior government officials from the Ministry of Health to the site, which facilitated their understanding of the Project. Collaboration with HPNSDP was also accelerated.

Besides, CSG has been incorporated into the policy to create awareness, mobilize local resources, facilitate effective referrals, and develop other required supports for poor women to access timely maternal and child health services, which can be deemed as one contributor to the improvement of MMR and NMR. After the formulation of CSG, its activation needs to be considered to have maximum results. In a limited resource setting of the government health sector in Bangladesh, NGOs played a significant role in facilitating the activities of CSG. On the other hand, recognition of the fact that this could not develop government capacity in the long term if NGOs alternatively play the role of the government health sector itself. This means formulating a project in collaboration with NGOs will need to be carefully considered, including how the government could take over this responsibility.

(Left Photo) Creating and utilizing a community map to identify pregnant women and mothers

(Right Photo) The Project aimed at improving MNH services quality and utilization