

Report of short evaluation

„ Improving the provision of gynaecological healthcare in Bangladesh: Addressing the significant burden of gynaecological disease on women’s health with high-quality training and mentorship “

**The Centre for Women’s Global Health at the Royal College of Obstetricians and Gynaecologists
(2021_EKHA93)**



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Oct. 2023

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Acknowledgements

A particular gratitude goes to Dr. Sabrina Jabeen, Dr. Md Mahiur Rahman, Dr. Mehedi Hasan of icddr,b and Elizabeth Rafii-Tabar of RCOG who facilitated and supported the evaluation and for all the fruitful discussions during the visit. I like to thank all the other colleagues of icddr,b and RCOG for contributing their time to get interviewed and sharing their knowledge and opinions.

Heinz Henghuber
Oct. 2023

Front Picture: Overcrowded Phulbari hospital (Upazila Health Complex), beds in the hallway (Phulbari, Dinajpur district)
Photo: Heinz Henghuber

List of Acronyms

ANC	Ante-Natal Care
BMMS	Bangladesh Maternal Mortality and Health Care Survey
DALY	Disability Adjusted Life Years
DGHS	Directorate General of Health Services
DGFP	Directorate General of Family Planning
DPM	Deputy Program Manager
EGS	Essential Gynaecological Skills
EKFS	Else-Kröner-Fresenius Stiftung
EPI	Expanded Program of Immunization
GFATM	The Global Fund to fight AIDS, TB, and Malaria
HIV	Human Immunodeficiency Virus
ICDDR,B	International Centre for Diarrheal Disease Research, Bangladesh
MD	Medical Doctor
M&E	Monitoring & Evaluation
MOHFW	Ministry of Health and Family Welfare
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
OGSB	Obstetrical and Gynaecological Society of Bangladesh
PM	Program Manager
PNC	Post-Natal Care
RCOG	Royal College of Obstetricians and Gynaecologists
SDG	Sustainable Development Goal
STI	Sexually Transmitted Infections
TWG	United Nations Population Fund
UHC	Universal Health Coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UK	United Kingdom (Great Britain)
YLD	Years Lived with Disability
WHO	World Health Organization

1 Executive Summary

The Else-Kröner-Fresenius Stiftung supports the Centre for Women’s Global Health at the Royal College of Obstetricians and Gynaecologists (RCOG), and the International Centre for Diarrheal Disease Research, Bangladesh (icddr,b), for the project “*Improving the provision of gynaecological healthcare in Bangladesh: Addressing the significant burden of gynaecological disease on women’s health with high-quality training and mentorship*”. The funding is 199.884 € for 24 months. The Project runs till April 2024 and is in mid-term execution status.

Bangladesh is the most densely populated country in the world with an estimated 167 million inhabitants. The country is ranked 129th on the Human Development Index out of 191 countries. The Bangladeshi health system is enormously scattered and fragmented. Gynaecological services are free in public hospitals, but often not fully provided or even absent. The services of private health facilities are generally of better quality, but expensive and unaffordable for the poor and the marginalised. The overall mortality rates for women aged 15-49 years decreased from 190 per 100 000 in 2001 to 116 per 100 000 in 2016. The three diseases contributing the most to women’s mortality were maternal causes (13-20%), circulatory system diseases (15-23%), and malignancies (14-24%). There was and is a strong focus on maternal health and obstetrics. Other causes of women’s death and gynaecology are somewhat neglected. The absence of basic, essential gynaecological skills among healthcare providers is leading to long-term suffering and disease for many girls and women, particularly from poor and marginalised groups. There exists no formal in-service training for doctors in gynaecological health, and many of the doctors will not be able to treat more complex gynaecological health needs. Underreporting of gynaecological disease and a lack of diagnostic tests is also contributing to a vast burden of preventable disease and disability borne by Bangladeshi women. Bangladesh is still a patriarchalism society. Many women in rural areas for instance often do not come to the hospitals unless they are severely sick, because they are afraid to ask the husband for the money for treatment. In addition, cultural attitudes and perceptions around gynaecological health are barriers for some women to look for treatment. In summary, Bangladesh remains a **very relevant context** to be supported by the EKFS. The large gaps and corresponding needs in gynaecological skills amongst health workers and a corresponding lack of adequate services in women’s health care are **highly relevant too**. The project pilots a training program on essential gynaecological skills paired with corresponding research and impact evaluation with the aim of developing a scalable capacity building solution for further expansion. The project contributes to SDG 3 on good health and well-being particularly to sub goal 3.4 to reduce mortality from NCDs, 3.7 on reproductive health, 3.8 to achieve universal health coverage. It also contributes to SDG 1 on poverty and SDG 5 on gender equality.

The overall aim of the project is to operationalise the existing Essential Gynaecological Skills (EGS) approach at sub-district and district levels of the health system to increase women’s access to high quality gynaecological health services. The EGS curriculum was developed by RCOG in the UK. It was locally adjusted by a selected technical working group. The project followed a training cascade from 13 senior master trainers to train 30 expert trainers, who themselves then trained 76 trainees and do the refresher trainings. The implementation package included the development of a gynaecological data recording system. The pilot EGS

training is accompanied by an impact evaluation. Overall, **effectiveness will be achieved as presented in the project application.** All training outputs are already achieved or will be achieved. How far healthcare providers improved their skill level, the readiness of the selected facilities to provide gynaecological service, the share of women satisfied with their experience of gynaecological health care services and a monthly average utilization rate of the facilities will be consolidated till the end of the funding period within the impact evaluation. It can be stated the complementary combination of RCOG, icddr,b and OGSB was a success factor for effectiveness, particularly for securing the necessary government buy-in.

It is very likely the improved skills of medical staff, the new registers and the guidebooks contributed to a larger number of identified cases (confirmed by interviews) and corresponding treatment. Hence women have better access to gynaecological services. The newly available data can contribute to improved public health decision making. Therefore, it can be assumed the outcomes of the project contribute to a reduction in mortality and morbidity from gynaecological disease. In the first two months after the trainings, about 3.800 women were registered with gynaecological diseases in the four selected health centres.

Generally, capacity building measures have a certain sustainable level, when they lead to changed clinical preparedness, diagnosis, and treatment. Future refresher trainings would help to sustain these capacity improvements. Trained trainers will ease future efforts. The identified “champions” can act as advocates within the broader health system for continued EGS training. A govt. manager of the Maternal Health Program stated, the Ministry intends to put the EGS skills package in the new 5-year National health plan to be extended to more districts. In a nutshell, the impact of the project is **already reasonable and will be high impact, when a scale up of the trainings to other districts will be supported** (and funded) by the government in the future. **The later has a good chance** to materialise given the statements of the MOHFW persons. **A further country wide expansion in the longer term would be an ultimate high impact of this initial pilot.**

The project consists mainly of capacity building measures but has a considerable research part with the study on the impact and the evaluation of activities. The share of cost for personnel are in a reasonable range for a capacity building program. The running cost for office and communication with 2% of the budget are comparably low. Direct project activities incl. related equipment takes 43% of the budget, incl. the M&E and research travel activities (17%) even 60%. In summary, allocation efficiency does not raise any concerns. Regarding production efficiency it needs to be noted, that master and expert trainers worked voluntarily with only a per diem paid. Neither RCOG nor icddr,b charged general overhead (apart from the project management staff). Given the output with the curriculum developed and adjusted, 30 expert trainers and 76 trainees trained incl. an accompanying impact evaluation, the value for money is very reasonable. **The project can be classified as very cost efficient. When the later scalability of the training by the Ministry of Health materialises, as presently discussed, it can be categorised as highly efficient.**

The Accounting Manager of icddr,b explained the accounting set-up and the procedures. Icddr,b runs presently 359 mainly research projects with a funding volume of about 80 million USD. They are using Microsoft Dynamics Navision, a professional Enterprise Resource Planning software. There are no separate bank accounts, but all bookings are categorised with a grant code. An overview of the project expenses can be easily created by fingertip, also with a budget overview. There is a separate team within the Finance department focussing on budget control only. Icddr,b has up to 10 audits per month, given the large number of projects

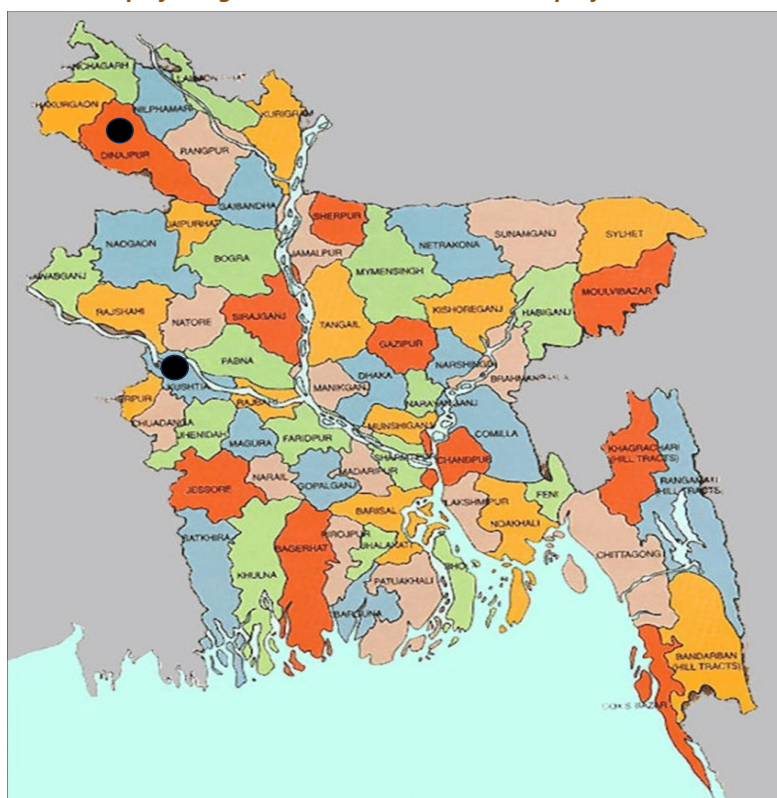
and its institutional donors. The funding is transferred by RCOG by a fixed payment schedule. Icddr,b provides a financial report to RCOG. The project coordinator gets advances for a small petty cash to handle the expenses in the field. Purchases above 100 USD must go through an established supply chain procedure. Two sample checks for receipts were performed. All receipts are scanned and are available easily in the system including approvals and payments. **In summary, the accounting systems and procedures follow high professional standards. There was no indication for any gaps in the accounting.**

2 Background

2.1 Introduction

The Else-Kröner-Fresenius Stiftung (EKFS) supports the *Centre for Women’s Global Health at the Royal College of Obstetricians and Gynaecologists (RCOG)*, and the International Centre for Diarrheal Disease Research, Bangladesh (icddr,b), for the project “*Improving the provision of gynaecological healthcare in Bangladesh: Addressing the significant burden of gynaecological disease on women’s health with high-quality training and mentorship*”. The funding is 199.884 € for 24 months. Icddr,b is executing the project locally. A third important partner is the Obstetrical and Gynaecological Society of Bangladesh (OGSB). The Project runs till April 2024 and is in mid-term execution status.

District map of Bangladesh with the two selected project districts



Source : <https://www.researchgate.net/>

2.2 Methodology

Data collection and analysis

Regarding qualitative methods, semi-structured or individual interviews were performed with seven staff of icddr,b, two from RCOG per video, one master trainer, three expert trainers, two trainees and five further key informants from the Ministry of Health and Family Welfare (MOHFW) and other partners. The evaluator attended a session of the Technical Working Group meeting for the curriculum with the possibility of questions and answers, as well as a large research dissemination event organised by USAID and icddr,b.

For the quantitative analysis, data from the reports and presentations provided, were used. To assess the bookkeeping, the evaluator interviewed the responsible Finance person. The Finance responsible person briefly explained the system and main procedures. Random sample checks of receipts were performed. To evaluate cost efficiency mainly the adjusted budget was used for analysis.

Limitations/restrictions

Only one of the two project districts could be visited. The project is in mid-term and the partner’s own impact evaluation is not yet finalised to be integrated. Only the Accounting department of icddr.b, counting for roughly 3/4 of the budget could be visited. As treatment is not a direct part of the program, no patients were interviewed.

3 Analysis

3.1 Relevance

Bangladesh is the most densely populated country in the world with an estimated 167 million inhabitants.¹ It is twice the population of Germany on 42% of its area. The country is ranked 129th on the Human Development Index out of 191 countries.² With the help of international development assistance, Bangladesh has reduced the poverty rate from 32% of the population in 2009 to 22% in 2018.³ The country achieved the Millennium Development Goals for maternal and child health and made considerable progress in food security since independence in 1971.⁴

The Bangladeshi health system is enormously scattered and fragmented. Another characteristic of the health system is the small coverage of the public providers. The private sector is a major actor in providing delivery services and about a third of all deliveries are taking place in private facilities. Gynaecological services are free in public hospitals, but often not fully provided or even absent. The services of private health facilities are generally of better quality, but expensive and unaffordable for the poor and the marginalised. Public hospitals are overcrowded. The visited district hospital in Dinajpur for instance has officially 250 beds. The reality is that the facility has over 700 admitted patients mostly in makeshift beds. There are essential health care staff shortages. Dinajpur district has 12 Upazilla (sub district) health centres (Upazila Health Complex).

Life expectancy is estimated at 75 years, 77,21 years for female and 72,8 years for male.⁵ Maternal mortality rate is still very high at 165 deaths per 100,000 live births (2019) according to the WHO.⁶ The overall mortality rates for women aged 15-49 years decreased over time,

¹ Est. 2023, CIA world factbook

² UNDP, Human Development Index 2021/22

³ WHO Bangladesh Country Cooperation Strategy: 2020–2024, Jan. 2023

⁴ Idem CIA world factbook

⁵ Idem CIA world factbook

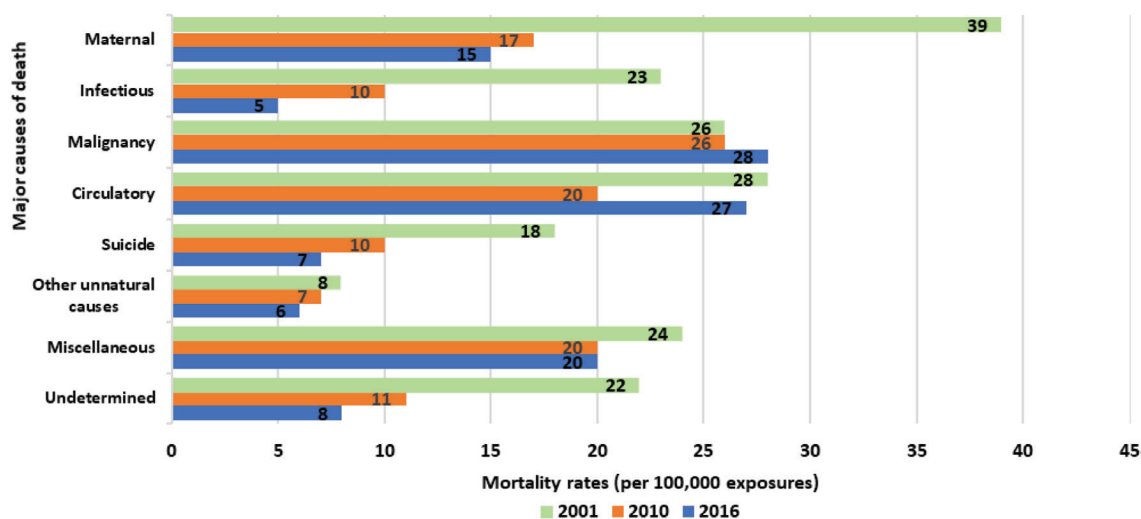
⁶ Idem WHO Bangladesh Country Cooperation Strategy: 2020–2024

from 190 per 100 000 in the 2001 BMMS to 116 per 100 000 in the 2016 BMMS.⁷ The three disease categories contributing the most to women’s mortality were maternal causes (13-20%), circulatory system diseases (15-23%), and malignancies (14-24%).⁸The shares varied over the specific age groups with maternal causes decreasing as contributor with increasing age.

By far, the largest decrease in mortality over the years came from maternal causes (see graph below), whereas other categories, mainly non-communicable diseases (NCDs), such as malignancies and circulatory causes of death increased. Hence there is a significant shift in the importance of causes of death, which reflects indirectly the recent history of public health measures in Bangladesh. There was and is a strong focus on maternal health and obstetrics, assumingly also driven by a selective targeting oriented on the SDGs. Other causes of women’s death and gynaecology are somewhat neglected. This assumption of negligence of gynaecology in comparison to obstetrics was mentioned in all partner interviews and the technical working group on women’s health.

One of the conclusions of a 2023 survey of women’s deaths⁹ was the need to ensure that the health workforce is appropriately trained on essential gynaecological skills (EGS) and equipped to confront rising morbidity and mortality due to NCDs and unnatural deaths.¹⁰

Table: Women’s mortality rates per 100 000 years of observations by major causes of death in the 2001, 2010, and 2016¹¹



Under the miscellaneous category, diabetes, hepatitis, and other liver diseases, renal failure, and chronic respiratory diseases were the main causes of death.

⁷ Nahar Q, Alam A, Mahmud K, Sathi SS, Chakraborty N, Siddique AB, Rahman AE, Streatfield PK, Jamil K, El Arifeen S. Levels, and trends in mortality and causes of death among women of reproductive age in Bangladesh: Findings from three national surveys. J Glob Health. 2023 Aug 25

⁸ Idem. Nahar Q et al

⁹ Idem. Nahar Q et al

¹⁰ Idem. Nahar Q et al

¹¹ Taken from Nahar Q, Alam A, Mahmud K, Sathi SS, Chakraborty N, Siddique AB, Rahman AE, Streatfield PK, Jamil K, El Arifeen S. Levels, and trends in mortality and causes of death among women of reproductive age in Bangladesh: Findings from three national surveys. J Glob Health. 2023 Aug 25

The absence of basic, essential gynaecological skills among healthcare providers is leading to long-term suffering and disease for many girls and women, particularly from poor and marginalised groups, who have no choice in health care. In rural areas, women will likely be seen by inexperienced doctors. There is no in-service training for doctors in gynaecological health, and many of the doctors will not be able to treat more complex gynaecological health needs. Underreporting of gynaecological disease and a lack of diagnostic tests is also contributing to a vast burden of preventable disease and disability borne by Bangladeshi women:

- Cervical cancer is the second most common cancer among women in Bangladesh. Lack of awareness, poor access to healthcare, and limited screening programs contribute to the high incidence of cervical cancer in the country.¹²
- Low uptake of effective, long-acting contraceptives is contributing to unsafe abortion. Family planning is often absent in the hospitals.
- An estimated 20.000 women in Bangladesh live with obstetric fistula, many live with abnormal uterine bleeding. This affects the quality of life and limits economic possibilities of the women.
- An estimated 15% of women of reproductive age are affected by infertility.

The survey performed by icddr,b prior to the training found the following gaps, which were confirmed with the interviews of external partners:

- A lack of skills, experience, and confidence among health workers to deal with gynaecological conditions, translating into delays for patients and worsening health outcomes.
- A lack of data collection for gynaecological conditions.
- Poor attitudes among health providers towards gynaecological care.
- A tendency among women to present to higher level hospitals rather than their local facility.

In summary, Bangladesh remains a very relevant context to be supported by the EKFS. The large gaps and corresponding needs in gynaecological skills amongst health workers and a corresponding lack of adequate services in mother and child health care **are highly relevant too.** The project pilots a training program on essential gynaecological skills (EGS) paired with corresponding research and impact evaluation with the aim of developing a scalable capacity building solution for further expansion.

The project contributes to SDG 3 on good health and well-being particularly to sub goal 3.4 to reduce mortality from NCDs, 3,7 on reproductive health, 3.8 to achieve universal health coverage and 3.c on training the health work force. It also contributes to SDG 1 on poverty and SDG 5 on gender equality.

3.2 Effectiveness

The overall aim of the project is to operationalise the existing Essential Gynaecological Skills (EGS) approach at sub-district and district levels of the health system to increase women’s access to high quality gynaecological health services.

¹² Uddin AFMK, Sumon MA, Pervin S, Sharmin F. Cervical Cancer in Bangladesh. South Asian J Cancer. 2023 Feb 25;12(1):36-38. doi: 10.1055/s-0043-1764202. PMID: 36851938; PMCID: PMC9966158.

In detail health care professionals should be better able to:

- prevent gynaecological disease,
- identify and manage gynaecological disease at early stages,
- ensure that women receive comprehensive gynaecological healthcare services that best meets their needs, and
- confidently tackle cultural barriers to accessing gynaecological healthcare.

The planned phases of the project are as following:

Phase	Activity	Funding
Stage 1	Creating new EGS Expert Trainers	EKFS
Stage 2	Expert Trainers deliver EGS training to staff in Kushtia and Rajbari districts	
Stage 3	Creation and support for EGS “champions” at health centres	
Stage 4	Expert Trainers and "Champions" provide supportive supervision and mentorship to health care providers for implementation of EGS approach into daily practice	
Stage 5	EGS advocacy workshops run by "Champions" to encourage behaviour change	
Stage 6	Monitoring and lesson learning, icddr,b will lead on research activities	
Stage 7	Monitoring and programme learning (provision of EGS training).	Global Affairs Canada (some publications within EKFS budget)
Stage 8	Advocacy for health care delivery (provision of EGS training) innovations towards national scale-up.	
Stage 9	Research paper development, led by Bangladesh health providers	

The project is in mid-term execution and the last 5 months of the 2-year program have just started. The situation of the defined indicators as of Oct. 2023 is as following:

Table: Objectives and indicators – Status at end of 2022, updated with info from the visit

Project Matrix		
OVERALL GOAL	Indicators	Comment evaluation
Improved women’s health and quality of life in Bangladesh	Reduction in mortality from gynaecological disease and reduction in morbidity from gynaecological disease	The undoubtful project’s <u>contribution</u> to reduction in mortality will not be measurable.
OUTCOMES	Indicators	
To operationalise the EGS approach at sub-district and district levels of the health system, increasing women’s	1. % of healthcare providers with improved knowledge level 2. % of healthcare providers with improved skill level	The project is accompanied with an impact evaluation and corresponding research. Detailed results can be

<p>access to high quality gynaecological health services</p>	<p>3. Readiness of the facilities to provide gynaecological service 4. % of women satisfied with their experience of gynaecological health care services 5. Monthly average utilization rate of the facility</p>	<p>expected around February 2024.* Baselines were recorded. (The evaluation period for the health systems will be the 6 months after the trainings)</p>
<p>OUTPUTS</p>	<p>Indicator Target</p>	<p>Comment Evaluation, status as per Oct. 2023</p>
<p>TRAINED STAFF New pool of highly skilled teachers (Expert Trainers) established who cascade training and motivate staff at selected facilities in order to improve the quality of gynaecological health services on offer.</p>	<p>1) 30 Expert Trainers established, having attained level of competency required, and each delivered at least one EGS training by end May 2022. 2) Approximately 75 health care providers (nurses and doctors) trained and have attained a level of competency in EGS priority topics by end May 2022 (when all training has been delivered).</p>	<p>13 master trainers were identified (1 RCOG, 12 from Bangladesh), of which 1 male, 12 female. 30 expert trainers are trained, (27 female, 3 male) 76 trainees are trained (38 in Dinajpur, 38 in Kushtia; 33 MDs and 43 Nurses. The refresher training has just finished. ⇒ Indicator achieved. The expert trainers came from public and private facilities. A database for the trainers is established.</p>
<p>MENTORS & CHAMPIONS Mentors and champions identified and assigned for all HCPs trained.</p>	<p>1) 1 or 2 EGS “champions” established at each facility (15 champions in total) by June 2022, and at least 3 examples recorded of them publicly championing the EGS approach to gynaecological services by December 2022. 2) All Expert Trainers & Champions demonstrate examples of leadership in gynaecological health care training by December 2022.</p>	<p>6 EGS champions are identified in Kushtia (all female, 3 on district level 3 on upazilla level). 6 EGS champions are identified in Dinajpur (4 female, 2 males; 3 are on district level 3 are on upazilla level). So far 4 “champion” meetings were held in Dinajpur and 5 in Kushtia district.</p>
<p>Government buy-in Health decision-makers at health centre, regional and MOH level express support EGS through commitments and planning.</p>	<p>1) Staff at health care facilities buy-in to the EGS approach to gynaecological service delivery. 2) MOH and DG representatives are</p>	<p>Staff at health facilities is buying in, confirmed by interviews. Two Govt. employees, a deputy program manager and</p>

	<p>participating as members of project Steering Committee, from September 2021 until end of the project.</p> <p>3.) Health facilities show plans for incorporating EGS training into existing CPD sessions by September 2022.</p>	<p>program manager are co-investigators of the protocol and part of the technical working group (met during evaluation visit).</p> <p>EGS training was incorporated.</p>
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*The average satisfaction score levels of the 76 trainees were close to “very satisfied” on all category levels including the facilitators and the course content (avg. score from 4,34 to 4,95 with 5 as the maximum on a 1 to 5 scale). The nurses rated throughout all aspects slightly higher than the non-specialised doctors. Only the training environment got a “satisfied” score only with the doctors. The satisfaction score on upazilla level was slightly higher than on district level with similar results of being “very satisfied”.

The non-specialised doctors improved their knowledge score (pre-test to post-test) from 7.79 to 8.24; whereas the nurses’ knowledge improved stronger from a score of 6.09 to 7.74.¹³

The two districts Dinajpur and Kushtia were chosen, because Iccdr.b was well connected there and had already some structure in place from other projects.¹⁴

The EGS curriculum was developed by RCOG in the UK. It was locally adjusted by a selected technical working group consisting of members from MOHFW, WHO, UNICEF, UNFPA, Save the Children, Ipas and icddr,b. The group had split up the modules and adjusted for cultural differences, but also by availability and capacity of the Bangladeshi health system. There was a strong buy-in observed by the partners, while meeting with the technical working group.

The 11 modules of the EGS curriculum addressed the following topics:

- Basic reproductive sciences and clinical skills
 - History taking, gynaecological examination, good medical practice.
- Contraception
 - Contraception for teenager, local methods, counselling around less reliable methods
- STIs and HIV
 - Prevention, symptomatic presentation, sexual history taking.
- Emergency gynaecology and management of the acutely ill woman
 - Resuscitation, use of early warning scores, triage, and prioritisation
- Abnormal uterine bleeding
 - Management of fibroids, postmenopausal bleeding, local attitudes
- Cervical cancer
 - Identifying normal/abnormal cervix and basic treatment, prevention, cervical cancer, and palliative care
- Early pregnancy loss
 - Manual vacuum aspiration (x2), aftercare following early pregnancy loss.
- Subfertility

¹³ Dr. Sabrina Jameen, Improving the provision of Essential Gynaecological Healthcare in Bangladesh: Addressing the significant burden of gynaecological disease on women’s health, PowerPoint Presentation for the board meeting, June 22, 2023

¹⁴ Bangladesh has 64 districts (Bengali: zila) and approximately 500 sub-districts (Bengali: upazilla).

- Female and unexplained infertility, local beliefs, ovulatory and tubal disease
- Urogynaecology
 - Obstetric fistula, prolapse.
- Improving standards: an introduction to clinical audit
 - Developing an audit pro forma, data management, sharing audit findings
- Gender based violence.
 - Medical management, frontline psychosocial support, manifestations of GBV

The training contained 11 modules, 2 out of 13 original modules were left out before the training. The guidebooks were translated in Bangla for the nurses, who don’t speak all well English and the Bangladesh Government prefers to have the Bangla version of all the National documents. The guidebooks will be further improved with the experience of the pilot training. Originally planned online trainings were cancelled as presence trainings were favoured (after Corona).

The project followed a training cascade common for Bangladesh:

Identified 13 senior master trainers => trained 30 expert trainers (3 days) => who then trained 76 trainees (4 days) and do the refresher trainings (2 days).

Challenges

A main challenge reported was to take out the trainers and trainees from their daily work to the trainings. The hospitals in the districts are chronically understaffed. Taking out staff for trainings is therefore very difficult. Most doctors, particularly the senior doctors (and professors) from doctors work partly or fully in private health facilities or practices. They accept a considerable income loss when they volunteer to teach or participate. There is also a hesitance to leave Dhaka for the province reported.

Another challenge was the ambitious timing. It needed time to get the government on board and keep them connected and involved, which depended a lot on government schedules. It took also considerable time to bring the technical working group together and to adjust the guidebooks and curricula. Nevertheless, this time invested secured the buy-in of the partners.

Other achievements

The implementation package included the development of a gynaecological data recording system, which did not exist in the health facilities prior to the project in a standard and pre-defined form. This contains an outpatient gynaecological register, referral notes, a supervision check list, and a monthly reporting form. A job aid with the most used information was prepared to benefit the healthcare providers (both Bangla and English). In total 14 standard documents were created. Some interviewed nurses reported the registers save time as for some entries it is just ticking small boxes instead of writing as before, which can be done more rapidly.

4 refresher trainings were held already, 2 in Kushtia (6 expert trainers, 19 trainees) and 2 in Dinajpur (5 expert trainers and 18 trainees).

All trainings were performed with a mix of teaching methods: theoretical sessions, hands on training on mannequins (imported from UK), storytelling/experiences and discussion sessions,

as well as take home manuals. The interviewed participants particularly mentioned the breakout sessions as very useful.

The pilot EGS training is accompanied by an impact evaluation following WHO guidelines¹⁵, with the objectives of:

- tracking the development of people’s knowledge and skills;
- finding out whether the training was appropriate to the trainee and whether the learning is being applied;
- identifying gaps and future needs in training - for future scalability;
- finding out if the investment in training was worthwhile or whether alternative methods to improve performance are needed instead;
- obtaining information on which to base future training plans and strategies.

Overall, **effectiveness will be achieved as presented in the project application**. All training outputs are already achieved or will be achieved. How far healthcare providers improved their knowledge level (pre-test/post-test), improved their skill level, the readiness of the selected facilities to provide gynaecological service, the share of women satisfied with their experience of gynaecological health care services and a monthly average utilization rate of the facilities will be consolidated till the end of the funding period (end of March 2024). Although the project is on schedule, the study results and their dissemination may take a month longer¹⁶ as planned and the partners may ask for one month of no-cost extension.

It can be stated the complementary combination of RCOG, Icddr,b and OGSB was a success factor for effectiveness. The high reputation of icddr,b and OGSB in Bangladesh and their advocacy efforts based on long term experience helped securing the necessary government buy-in so far.

3.3 Sustainable Impact

The outcome objectives of the project are as following:

- To demonstrate that EGS training offers a model for improving gynaecological health outcomes that addresses identified needs with a good value for money and to advocate for national scale-up of EGS training in the health care system of Bangladesh.

It is very likely the improved skills of the medical staff, the new registers and the guidebooks contributed to a larger number of identified cases and corresponding treatment. Hence women will have better access to gynaecological services. The newly available data can contribute to improved public health decision making. Therefore, it can be assumed the outcomes of the project contribute to a reduction in mortality and morbidity from gynaecological disease, although this attribution will not be measurable.

In the first two months after the trainings alone, about 3.800 women were registered with gynaecological diseases in the four selected health centres. They are benefitting from the improved service readiness. There are no prior records to compare with, although some non-standardised records exist. However, all interviewed doctors and nurses reported they

¹⁵ WHO, Evaluating Training in WHO. 2010

¹⁶ Mainly due to lengthy government monitoring and approval procedures

identify more cases as before as they are more confident with diagnosing now and will ask different questions from the beginning. The visited two hospitals reported they identified more gynaecological cases and explicitly mentioned more cervical cancer cases are identified. A further impact is the improved networking within the hospitals and between the hospitals. For instance, the doctors discovered that some injections used for family planning can stop bleeding and can be used in other departments. The trainings will support task-shifting basic elements of gynaecological service delivery to frontline health workers and away from specialized gynaecologists, who are further up in the referral structure. Referrals come with additional cost for the patient and the time consumed without treatment may deteriorate the patient’s conditions.

The trained expert trainers, trainers and hospital managers responded during the interviews on the question of strong points:

- ↑ The trainings served the neglected gynaecologic gap (cervical cancer, family planning, SGBV) outside obstetrics.
- ↑ The training was comprehensive.
- ↑ The trainees were provided with the capacity to work.
- ↑ The breakout sessions and scenarios were particularly useful. They give more confidence to the medical doctors and nurses. There was good mix of teaching methods.
- ↑ The networking effect of the trainings is favourable for the services. There is better coordination in the health facility. The list of available medicines was shared.
- ↑ Compact EGS package could become a standard.
- ↑ First the facility managers were reserved, now ANC and gynaecology was combined. In some facilities male and female patients were given treatment from the same service point.
- ↑ There was a structured implementation plan for the project.
- ↑ Standard registers will reduce the time for data recording.
- ↑ Data quantity and quality has improved. Before the stats were not available for gynaecology. This has led to better decision making.
- ↑ Now the data is standardised, before it was scattered.
- ↑ Now we have a separate room for gynaecology, which empowers the patients.
- ↑ Stakeholders were integrated from the beginning.
- ↑ The doctors can recognise the conditions better and identify more cases, particularly during outdoor clinics. Clinical diagnosis has improved. More cases get treated accordingly.
- ↑ More cervical cancer cases are detected.
- ↑ The facility services’ readiness has improved.
- ↑ The staff was motivated after the training.
- ↑ Patients get better service.
- ↑ A higher number of gynaecology patients asks for contraceptives.
- ↑ Strong complementary partnership of the three partners: RCOG, icddr,b and OGSB.

On weak points responses were:

- ↓ The master trainer pool was scattered, and it was difficult to plan with them.
- ↓ The government level is not prepared for gynaecology.
- ↓ The facilities are weekly prepared, and they are low equipped.
- ↓ Shortage of consumables and equipment.
- ↓ Rotation of doctors in government service all 3 years, losing persons trained relatively quickly.
- ↓ Some doctors had a “we know all this” attitude in the beginning.

- ⇓ Some trainers lacked pedagogic talent.
- ⇓ It is difficult to sensitize the population.
- ⇓ Data is not digitalised, Directorate General of Family Planning (DGFP) and DHIS2 needs data recording (shared patient ID would be useful)
- ⇓ The expert trainer trainings need decentralisation. Travelling to Dhaka is time consuming.

Risks

From the anticipated risks at the beginning of the project only a potential turnover of expert trainers and trainees has somewhat materialised. Doctors within the public system must rotate all 3 years within the country. Two identified trainees had to move to other parts of the country. Still, the capacity is kept within the country from a wider impact lens if a trained person has to move.

The short timing was an issue in the first year as going through the government discussion and the approval processes take time. Nevertheless, the project is on schedule in October 2023. All other risks could be avoided or mitigated by corresponding counteracting.

Sustainability

Generally, capacity building measures have a certain sustainability, when they lead to changed clinical preparedness, diagnosis, and treatment. Future refresher trainings would help to sustain this capacity improvements. Particularly the newly established uniformed data recording will need refresher trainings.

Trained trainers will ease future efforts. The identified “champions” can act as advocates within the broader health system for continued EGS training.

A future scale up and expansion to other districts was aimed for from the beginning. With the results of the accompanying study and the impact evaluation icddr,b can be able to secure the government buy-in to extend the EGS training to other districts. In the meeting of the technical working group a govt. manager of the Maternal Health Program stated, the Ministry intends to put the EGS skills package in the new 5-year National health sector plan from 2024 to 2029 to be extended to more districts. OGSB and icddr,b will advocate for EGS to get national accreditation, as a formal step within the training’s incorporation into the next National Health Plan produced by the Government of Bangladesh.

The impact (and sustainability) of the project can be categorised in three potential steps.

Table: Impact scenarios

Scenarios	Impact result	Probability	Comments
1) Capacity building in 4 health facilities in 2 districts	Reasonable to considerable impact	achieved	This is already achieved.
2) Expansion of the capacity building program to few other districts (potentially up to 20 out of 64) with funding from MOHFW – developed guidebooks and training curricula are used for other districts	High impact	high	MOHFW may include the expansion to other districts in its 5-year national health sector plan 2024 to 2029
3) Further country wide expansion of the capacity building program. The	High impact	Reasonable, but uncertain at present.	Has a good chance when step 2 can happen.

training guidebook becomes a national standard package.			
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In a nutshell, **the impact of the project is already reasonable and will be high impact**, when a scale up of the trainings to other districts will be supported (and funded) by the government in the future. The later has a good chance to materialise given the statements of the MOHFW persons. A further country wide expansion in the longer term would be an ultimate high impact of this initial pilot. The rating is reasonable impact for the intermediate status, as the pilot project without a later scaling up while the EGS package becoming more widely used would remain a stand-alone measure.

Table: Recommendations on impact and sustainability

Subject	Issue	Recommendations
Advocacy and buy-in from the government	To achieve further scaling up a continued buy-in from the government is needed	It is recommended to further advocate government deciders, but also all other influencers for a possible scale up of the project. It will be key to convince the <u>new</u> Director Maternal and Child Health/DGHS. (icddr,b and RCOG are conscious of this).
Publishing research on the pilot project	Evidence gained will be useful beyond Bangladesh	It is recommended to publish the results of this project widely. Some other countries could benefit from this experience. (icddr.b and RCOG are aware of this).
Refresher trainings	Sustaining the knowledge and skills	Future refresher trainings beyond the current project may be necessary to maintain the gained knowledge and skills, and the corresponding improvement in the health systems.

3.4 Efficiency

The evaluation of allocation efficiency¹⁷ is based on the budget. The project consists mainly of pilot capacity building measures but has a considerable “research part” with the study on the impact and the evaluation of activities. The share of cost for personnel with 39% of the total are in a reasonable range for a capacity building program, even when the travel of the M&E and study team is added (+17% points). The running cost for office and communication with 2% of the budget are comparably low. Direct project activities incl. related equipment take 43% of the budget, incl. the M&E and research travel activities (17%) even 60%. Equipment included “mannequins”, which had to be imported from UK -transported by the international Master trainer. The mentorship sessions take up 9% of the total budget.

In summary, allocation efficiency does not raise any concerns.

Table: Slightly regrouped revised budget incl. relative share

Category	sub category	Amount	%ages
PERSONNEL	Project Management ROCG	28.939 €	14%
	Project Management icddr,b	26.285 €	13%
	sub total	55.224 €	28%
	Travel/transport for staff	21.807 €	11%
	sub total	77.031 €	39%
RESEARCH, STUDY; M&E, travel	RESEARCH, STUDY	33.102 €	17%
PROJECT ACTIVITIES (trainings, material)		81.553 €	41%
Equipment (e.g.mannequins)		3.786 €	2%
	sub total	85.339 €	43%
RUNNING COST (office and communication)		4.414 €	2%
	GRAND TOTAL	199.886 €	100%

Regarding production efficiency¹⁸ it needs to be added, that master and expert trainers worked voluntarily with only a per diem paid. Many of the Bengali doctors work till 14h in public health facilities and in the afternoon, they work in private facilities. Hence teaching a course means an often-considerable loss of income, particularly for the very senior trainers from Dhaka. Neither RCOG nor icddr,b charges general overhead (apart from the project management staff).

Given the output with the curriculum developed and adjusted, 30 expert trainers and 76 trainees trained incl. mentorship session and the accompanying study with a considerable impact evaluation **the cost/benefit or the value for money is very reasonable. The project**

¹⁷ Allocation efficiency: The project’s use or allocation of resources is appropriate regarding achieving the project’s objectives.

¹⁸ Production efficiency: The project’s use of resources is appropriate regarding the outputs achieved.

can be classified as very cost efficient. When the later scalability of the training by MOHFW materialises as presently discussed, it can be categorised as highly efficient.

3.5 Particularities and Coherence

It can be stated, the complementarity of the triangle of the three partners was a success factor for the project.

The Royal College of Obstetricians and Gynaecologists (RCOG) is a professional association based in the UK. The college has over 16,000 members in over 100 countries, of which some also in Bangladesh. RCOG was the initiator of the preceding survey on gynaecological health and provided the international curriculum and the training handbooks. Both was later adapted to the local context.

The Obstetrical and Gynaecological Society of Bangladesh (OGSB) is a National forum of Obstetricians and Gynaecologist of Bangladesh with 2.164 members within the country.¹⁹ Some OGSB members are also members of the RCOG. OGSB provided most master trainers, which were selected by both RCOG and OGSB. OGSB has also a strong role to play while advocating with the government and bringing the Ministry of Health and Family Welfare (MOHFW) on board due to their established reputation and political connectedness.

Icddr,b is a large scientific research institute, which works also in other middle-income countries outside Bangladesh. They are specialised in developing, testing, and assessing the implementation of interventions specifically designed for resource-poor settings. Their present funding is about 80 million US\$ and comes mainly from international donors (incl. USAID, CDC, the GFATM and the Gates foundation) and they currently run 359 projects. Icddr,b was the implementing and coordinating partner on ground. They are also very well connected with the government, and they are well experienced and conscious of the political advocacy needed to transform evidence-based solutions into policy and subsequent system implementation. Icddr,b provided the platform for the project. They accompanied the project with a monitoring and study team following the WHO guidelines on evaluating training.²⁰

Gender

Bangladesh is still a patriarchy society. Many women in rural areas for instance often do not come to the hospitals unless they are severely sick, because they are afraid to ask the husband for the money for treatment. In addition, cultural attitudes and perceptions around gynaecological health are barriers for some women to look for treatment. Given these cultural sensitivities around gynaecological health problems, women will expect to be seen by a female healthcare provider; in many places, this will mean being seen by a nurse. The project focussed on women’s health.

¹⁹ https://www.ogsb.org/web_admin/page/welcome

²⁰ WHO, Evaluating Training in WHO. 2010

3.6 Accounting

The Senior Manager, Grants, and compliances of Iccdr,b explained the accounting set-up and the procedures. Iccdr,b administers roughly 75% of the total budget (199.886 €)²¹. The rest is administered by RCOG.

Iccdr,b runs presently 359 mainly research projects with a funding volume of about 80 million USD. They are using Microsoft Dynamics Navision, a professional Enterprise Resource Planning System for mid-size organisations.

There are no separate bank accounts, but all bookings are categorised with a grant code on one bank account. The access of the bank account is highly restricted.

An overview of the project expenses can be easily created by fingertip, also with a budget overview. The project has two budget codes. There is a separate team within the Finance department focussing on budget control only. Iccdr.b has up to 10 audits per month, given the large number of projects and its institutional donors.

The funding is transferred by RCOG by a fixed payment schedule. Iccdr,b provides a financial report to RCOG.

The project coordinator gets advances for a small petty cash to handle the expenses in the field. Purchases above 100 USD must go through an established supply chain procedure.

Two sample checks for receipts were performed. All receipts are scanned and are available easily in the system including approvals and payments. There is a separate storage room for the physical receipts.

In summary, the accounting systems and procedures follow high professional standards. There was no indication for any gaps in the accounting.

²¹ The budget is not fully separated between the cost borne at iccdr,b and RCOG.

4 ANNEX

Schedule of Field Mission

Date/Day	Activity	Remarks
Sun, 29th Oct. 2023	Flight from Berlin to Dar-es-Salaam via Istanbul	Leaving home 2 am, arriving in Dar-es- Salaam 10.30 pm
Mon, 30rd Oct. 2023	Early arrival in Dhaka, later meeting with ICDDR research team, revisiting schedule, first key staff interview	Hotel in Dhaka
Tue, 31st Oct. 2023	Interviews with Master and Expert trainers, interview with Senior Manager, Grants and compliances (Finance/ Accounting), meeting with technical working group, focus group discussion (Government and other stakeholders), further interviews	Hotel in Dhaka, ICDDR and EPI building
Wed, 1st Nov. 2023	Research for Decision Makers dissemination event, interview WHO, flight to Dinajpur (Saidpur Airport), meeting with ICDDR field team	Event at Hotel Intercontinental, Saidpur to Dinajpur 45 min, overnight at BRAC guesthouse
Thu, 2nd Nov. 2023	Meeting with the Civil Surgeon of Dinajpur, meeting with the Hospital Superintendent of Dinajpur District Hospital, interviews with expert trainers and trainees, field team, meeting with UHFPO of Phulbari Health Center, departure for Dhaka	45 min drive to Phulbari one way, 45 min Dinajpur to Saidpur, flight back to Dhaka, at hotel 23h
Fri, 3rd Nov. 2023	Interview with the principal investigator of the study/ICDDR and further staff interviews, debriefing, working on notes	ICDDR, Hotel in Dhaka
Sat., 4th Nov. 2023	Flight from Dhaka to Berlin via Istanbul, arrival home at 20.15h	Departure from Dhaka 06:35h

Main documents as basis for the evaluation

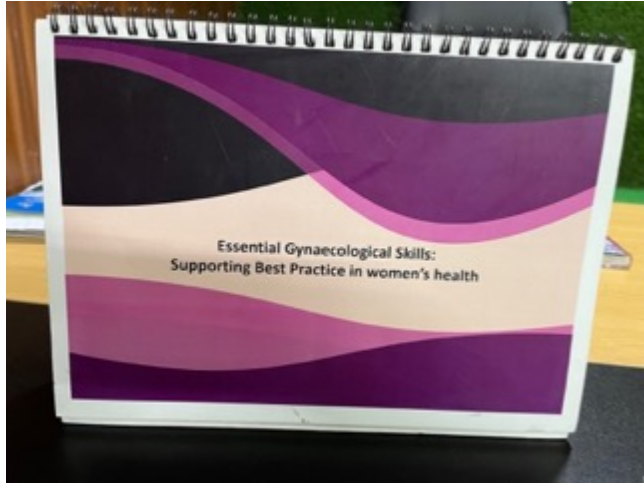
- 1) RCOG, project application “*Improving the provision of gynaecological healthcare in Bangladesh: Addressing the significant burden of gynaecological disease on women’s health with high-quality training and mentorship*”, Sept. 2021
- 2) RCOG, interim progress report April 2022-March 2023 “*Improving the provision of gynaecological healthcare in Bangladesh: Addressing the significant burden of gynaecological disease on women’s health with high-quality training and mentorship*”, April 2023
- 3) WHO, Assessment of Healthcare Providers in Bangladesh 2021
- 4) WHO, WHO Bangladesh Country Cooperation Strategy: 2020–2024, Jan 2023
- 5) Nahar Q, Alam A, Mahmud K, Sathi SS, Chakraborty N, Siddique AB, Rahman AE, Streatfield PK, Jamil K, El Arifeen S. Levels, and trends in mortality and causes of death among women of reproductive age in Bangladesh: Findings from three national surveys. *J Glob Health*. 2023 Aug 25;13:07005. doi: 10.7189/jogh.13.07005. PMID: 37616128; PMCID: PMC10449030.
- 6) WHO, Evaluating Training in WHO. 2010
- 7) Dr. Sabrina Jabeen, *Improving the provision of Essential Gynaecological Healthcare in Bangladesh: Addressing the significant burden of gynaecological disease on women’s health*, PowerPoint Presentation for the board meeting, June 22, 2023

List of contacts (Interviews, focus group discussion)

Name	Organisation & Function	Date
Elizabeth Rafii-Tabar	RCOG, Senior Global Programmes Manager	Video interview 10 th Oct. 2023
Dr Santanu Acharya	RCOG, Clinical Lead for the programme	Video interview 11 th Oct. 2023
Dr. Sabrina Jabeen	Icddr,b, Project Co-Principal Investigator (Assistant Scientist, Maternal and Neonatal Health Maternal and Child Health Division)	Interview 1 st Oct 2023
Prof. Dr Shahin Rahman	Master trainer EGS prog and RCOG Clinical lead in Bangladesh; Professor and Head of the department of Holy Family Hospital	Interview 2 nd Oct 2023
Dr. Naushaba Tarranum Mahtab	Expert trainer EGS prog, Assistant Professor of Obstetrics, and gynaecology, BIRDEM	Interview 2 nd Oct 2023
Dr. Md. Hafizul Islam	UNICEF, National MNCAH Officer	Interview 2 nd Oct 2023
Technical Working Group meeting with 9 persons	DGHS/MoHFW, DPM (ERD & influenzas Control), 4 persons from DGHS/MoHFW, UNICEF, 1 OGSB, 1 WHO, 1 Ipas NGO, 1 Save the Children	Interview 2 nd Oct 2023 TWG meeting with focus group discussion, 2 nd Oct 2023
Mohamed Shafiqul Kabir	Icddr,b, Senior Manager, Grants, and compliances (Finance)	Interview 2 nd Oct 2023
Dr. Md. Nurul Islam Khan	WHO, Reproductive, Maternal, Newborn, and Child Health	Interview 3 rd Oct 2023
Dr. AHM Borhan-UI-Islam Siddiki	Civil Surgeon, Dinajpur District	Interview 4 th Oct 2023
Dr. Ashutosh Deb Sharma	Senior consultant, Dinajpur District hospital, Expert trainer of EGS	Interview 4 th Oct 2023
Dr. Md Mashiur Rhaman	Upazilla health and family planning officer, Trainee of EGS	Interview 4 th Oct 2023
Dr. Farjana Irin	Junior Consultant/Gynaecologist Upazilla Health Centre Phulbari, Expert trainer of EGS	Interview 4 th Oct 2023
Dr. Seikh Forgans Skinin	Senior consultant, Dinajpur District hospital, Expert trainer of EGS	Interview 4 th Oct 2023
Dr. Md. Fazlur Rahman	Hospital Superintendent, Hospital Director Dinajpur District Hospital	Interview 4 th Oct 2023
Dr. Alamgir Kabir	Asst. Surgeon Phulbari hospital, Trainee of EGS	Interview 4 th Oct 2023
Mosammat Shirain Akter	Senior Staff Nurse, Phulbari hospital, Trainee of EGS	Interview 4 th Oct 2023
Md. Al-Mahmed	Icddr,b, Field Research Officer	Interview 4 th Oct 2023
Md Sanaullah Miah	Icddr,b, Senior Field Research Officer	Interview 4 th Oct 2023
Dr. Mehedi Hasan	Icddr, b, Project research physician, Maternal and Child Health Division	Interview 5 th Oct 2023
Dr. Ahmed Ehsanur Rahman	Icddr, b, Scientist, Project Principal Investigator, Maternal and Child Health Division	Interview 5 th Oct 2023
Dr. Md Mahiur Rahman	Icddr, b, Study Physician, Maternal and Child Health Division	Interview 5 th Oct 2023

Images of the project from the project visit (photos by H. Henghuber)

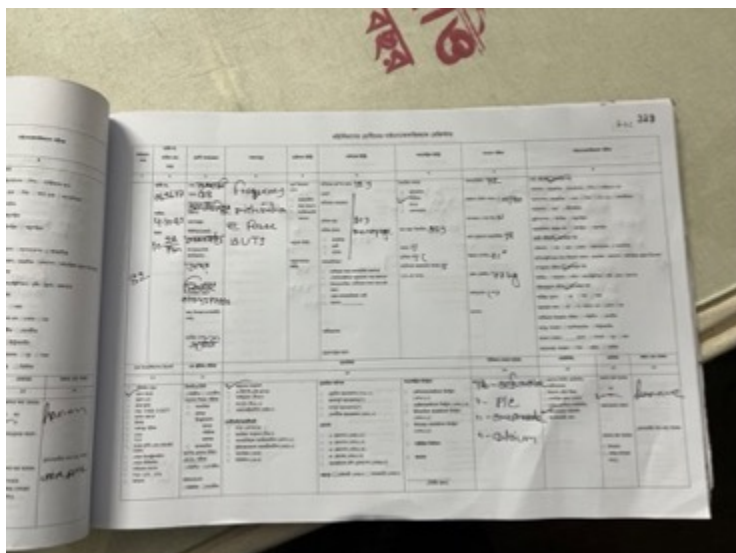
Desk guide for training participants on Essential Gynaecological EGS skills



ESG desk guide: content example



Gynaecological register, introduced by the project (before either a non-standard register or no register at all)



Crowded patient queues at Dinajpur District Hospital



NCD corner at Phulbari hospital



Research dissemination event in Dhaka (USAID, icddr,b)



Terms of Reference

Evaluation form for the project

(a) **Relevance (Does the project do the right thing?)**

Development policy reference:

- Have national and / or local health strategies or policies been adequately considered in project planning?
- Is there a plausible explanation of how the project contributes to the development of the partner institution and the target region through its technical and regional orientation?
- Does the project contribute to the achievement of SDG3 (Ensuring a healthy life for all people of all ages and promoting their well-being)?

Target group references:

- Does the project address a relevant problem of the local population?
- Does the project ensure that vulnerable groups benefit from the project activities?

Participatory Planning:

- Have the needs of local and German partners been identified together and has the project been planned and designed jointly?
- Have local key actors been involved in the planning of the project?

Rights and Ethical guidelines:

- Are gender aspects (in terms of Do-No-Harm) taken into account in project planning?
- Is project implementation ethically and politically justifiable?

(b) **Effectiveness (Can the goals of the project be realistically achieved?)**

Traceability and impact logic:

- Is the project planning and implementation promising in view of the described needs / problem analysis?
- Is there a clear link between the activities and the objective of the project? That Do the activities appear suitable to achieve the project objective?
- Does the project follow comprehensible impact logic? Are activities and project goals as well as indicators assigned to each other in a meaningful way?
- Are the project goals realistically achievable with the existing staff and expertise?

Measurability and feasibility:

- Are there initial values for the indicators to be measured (baseline)?
- Are suitable measuring instruments chosen to collect data?
- Do the named target values appear realistically achievable?

(c) **Sustainable impact (Are the positive effects of the project likely to be sustainable?)**

Strengthening local structures:

- Will local structures be strengthened in the longer term through their involvement in the project and through cooperation?

Capacity development:

- Does the project contribute to capacity development at the human and institutional level in the partner country?
- Does the project contribute to the optimization of processes?

(d) Efficiency (Are the objectives of the project achieved economically?)

- Do the resources used appear proportionate to the planned services and intended effects?
(For example, is the budget well thought out, are finances planned realistically, is the number of budgeted trips appropriate?)

(e) Particularities

Are there other positive unique selling points of the application that confirm the eligibility?
Special features may include, but are not limited to:

- Does the project contain promising innovations?
- Is there already a well thought out monitoring concept?
- Does the applicant have a positive experience with similar projects?
- Does the applicant have regional experience / experience in low or low - income countries?
Middle income?
- Are the learning outcomes and improvements that the project aspires to be potentially in one?
- Larger context transferable (up-scaling)?
- Is the local partner particularly interesting and promising?
- Are questions dealt with that are of particular relevance to German development cooperation?
- Are gender aspects, vulnerable groups and inclusion particularly taken into account?
- Is the project following a multi-sector approach?
- Is a triangular cooperation implemented in the project?

(f) Accounting

- What is your impression of accounting and local financial management?