

MISEREOR health care sector portfolio evaluation: summary of results

Abridged evaluation report
by *evaplan GmbH*, Heidelberg, Germany

This evaluation is the second sector portfolio evaluation to be conducted by Church Central Agencies in accordance with the Guidelines, agreed with the German Federal Ministry for Economic Cooperation and Development (BMZ), 'on objective-oriented and effect-oriented monitoring of performance in the field of the promotion of activities of the Churches which are of special relevance to development'. The sector earmarked for investigation, health care, was jointly selected by the BMZ, the Church Development Service (EED), and MISEREOR. MISEREOR contracted *evaplan GmbH* at the University Hospital of Heidelberg to evaluate its health care sector portfolio between August 2012 and December 2013. The thematic focus was on projects in the field of primary health care that were approved between 2005 and 2007 and completed before the end of 2011.

The objective of this evaluation was twofold: firstly, to contribute to the learning process that MISEREOR strives for in dialogue with its partners and secondly, to contribute to the process of rendering account and ensuring transparency towards the public and the German Federal Ministry for Economic Cooperation and Development (BMZ).

1. Object of the evaluation

In the period 2005–2007, 264 project proposals were approved in the health care sector (126 in Asia, 91 in Africa, 43 in Latin America, and 4 international projects). Of these projects, 119 were selected for evaluation (55 in Asia, 39 in Africa, 25 in Latin America); these selected projects had a comprehensive primary health care approach including structures and measures such as referral services/infrastructure; primary-level facilities (e.g. health centres) as well as secondary-level ones (e.g. hospitals); prevention and treatment of infectious diseases; traditional and alternative medicine.

The volume of the individual measures ranged from €25,000 to €1.2 million. The content ranged from the purchase of a car to comprehensive primary health care programmes, with projects spread over three different continents (18 African, 10 Asian, and 10 Latin American countries). Overall, the analysed and evaluated projects are not entirely comparable; some have different focuses in terms of methodology and content. Nevertheless, the evaluation design used allows general conclusions to be drawn and recommendations to be made. The compiled results can, therefore, provide interesting input for the learning process.

2. Methodological approach

With due regard for technical and methodological standards and in accordance with the terms of reference drawn up by MISEREOR, qualitative and quantitative data was evaluated for a statistical population of 119 primary health care projects. Triangulation was chosen as the strategic approach in order to be able to ensure a high level of result validity by using different methods such as source analyses, interviews, group discussions, and the use of a variety of information sources during the desk and field phases. Important sources of information included the following in particular: MISEREOR policy documents, partner funding requests, project approval documentation, MISEREOR's data acquisition system (which includes project reports, travel reports, and evaluation reports), individual and group interviews with members of staff

working on projects as well as specialised consultants commissioned by MISEREOR, and the analysis of relevant websites. In the field phase, interviews and group discussions were also conducted with partner organisation staff and project beneficiaries in the countries where the projects were being implemented.

The evaluation was designed on the basis of a two-stage approach:

- 1) To begin with, a comprehensive desk study was carried out. This comprised an ex-post investigation that was conducted primarily using data from the defined investigation period and information relating to it. The document review was divided into three steps:
 - a) Basic statistical data was compiled for all 119 projects, and the measures taken were analysed on the basis of approximately 450 project-related and 71 supporting sector documents.
 - b) The second step involved an analysis of the target groups, methodological approaches, and existing information on outcomes and impacts. To this end, approximately two-thirds of the projects (74) were picked at random, albeit in proportion to the continents. This random selection ensured that a cross section was evaluated and that the focus was not specifically on particularly successful or particularly weak projects.
 - c) In a third step, 32 projects were selected. On these, a detailed analysis was carried out in order to establish the kinds of outcomes and impacts they had.

- 2) Based on the findings of the desk study and the selection criteria derived from these findings, ten projects in five different countries were chosen for the field phase. A mixture of methodologies made it possible to address not only specific questions, but also the situations specific to each country, partner, and project. The key questions and basic themes needed for this were developed and defined together by the evaluation team. During the preparation of the field phase, the following methodologies were applied: document analysis, discussions with relevant members of MISEREOR staff, the establishment of contact with partner organisations and the local consultants by e-mail, telephone, or Skype. Parallel to this, the evaluation design and the interview tools for the various partners/groups were developed and the people from whom information was to be obtained and interviewees were identified. During the field phase, data was gathered using surveys built around key questions, discussions with relevant resource people (representatives) of the partner organisation, cooperation partners, health care facility staff, diocesan staff, staff working in the state health care system and in regional and local authorities, and observations made directly in the service facilities of the projects visited. Discussions and interviews with those who used the measures and output (target groups, beneficiaries) also constituted a major part of the data-gathering process. In addition to individual interviews, focus group discussions, and self-evaluation workshops, surveys were conducted on the basis of the 'most significant change' method.¹

The results of the case studies were also analysed on the basis of jointly developed criteria resulting from the given terms of reference and MISEREOR's objectives. In addition to the DAC

¹ In particular for the purpose of evaluation of projects or measures that did not develop any indicators that would allow for a measurement of their outcomes and impacts, MSC-based surveys (MSC = most significant change) are a good way of acquiring a detailed understanding of the causalities of effects and relevant processes. In the context of this cross-sectoral evaluation, the 'most significant change' method was applied in the form of open interviews, 'story-telling' (e.g. what are the three most important changes in the context of .../ would things have developed differently if there had been no project?) with the target groups and relevant players in order to obtain the most comprehensive information possible about the change process in a project environment where no indicators had been identified.

criteria and the questions based on these criteria that sought to dig more deeply into the subject matter, the focus of the analysis was on those factors in particular that help and hinder the success of projects, such as project strategies and approaches, cooperation relationships (integration in national and Church concepts and structures), handling and steering competence, and the partner organisations' planning, monitoring, and evaluation (PME) system.

3. Project partners' areas of activity and strategic orientation

On the basis of the objective 'to improve the health and life situation of the population in a sustainable manner' by focusing on the poor, the marginalised, and women and children as particularly disadvantaged groups, MISEREOR helps a large number of very different partner organisations implement a wide range of projects in the primary health care sector.

MISEREOR has not developed an explicit overarching promotion strategy that provides binding prerequisites for the approval of these projects. However, orientation frameworks, policy papers at national and regional levels, and policy papers on health care do offer pointers. Accordingly, one prerequisite for project approval is that the projects should foster the target groups' own strengths and the corresponding national initiatives and potential within the meaning of sustainable 'help towards self-help' and should contribute to a productive exchange both within and between the individual countries and regions (South–South and South–North exchange). An important aspect of MISEREOR's overarching strategy in recent years has been to intensify the networking and interlinking of sectors, i.e. to promote integrated approaches that overcome sector-specific thinking. For this reason, more comprehensive projects that focus more heavily on networking, lobbying, and advocacy work are viewed as key for countries with a poorly developed health care system because they facilitate the demand for the rights of people in the health care sector ('universal access').

Although there were no overarching guidelines regarding the content of a sector-specific promotion strategy and no binding sector orientation framework for the health care sector in the period under evaluation, the following can be said in summary: there are many common features in the strategic and development policy orientation of many primary health care projects. Accordingly, many of these projects can be allocated to the areas of intervention in the set of cause-and-effect correlations developed by MISEREOR (cf. Annex). This indicates that MISEREOR and its partner organisations have a similar understanding of what primary health care means. MISEREOR strongly supports and promotes this primary health care approach. The considerable differences between the projects (from complex primary health care projects to the delivery of items of equipment) can be viewed as an illustration of the fact that support is adapted to meet needs and to address the problems and the situation specific to the relevant countries.

As far as the issue of gender is concerned, apart from MISEREOR's general 'gender orientation framework', which defines gender as a cross-cutting issue in international cooperation, MISEREOR does not seem to have a binding strategic procedure for supporting projects in terms of more gender justice (e.g. by recommending and promoting gender-differentiated monitoring). This applies both to the partner organisations and to the content, orientation, and implementation of their projects.

4. Assessment of the projects according to DAC criteria

Relevance

The overarching question is: are we doing the right thing? All projects examined during the desk study were deemed to be very relevant. This relevance is reflected primarily in the focus on those target groups that had least access to health care services, in particular women and children. Overall, it can be assumed that the projects' measures correspond to the specific and very

different conditions in the various countries and continents. For example, most projects can be deemed to have planned their objectives on the basis of the relevant core problems and the specific situation in the countries, and that the project approaches correspond to the respective need and the professional standards in the period under consideration. For these reasons, the projects are considered to show a very high level of relevance.

Effectiveness

Overall, the results of the desk study concluded that the effectiveness of the projects was satisfactory to good. The project documentation indicates that as a result of the measures taken the aims of the projects were reached, i.e. the target output was achieved in most of the projects despite the adverse working conditions and a considerable room for improvement often encountered in the state-run health care administration, as it could be observed e.g. in projects in Guatemala, Haiti, or the DR Congo. This cannot be said to the same extent for the full range of objectives which were expressed in the approval documentation in the form of expected outcomes and impacts. One thing can be confirmed: the more simply the objectives were formulated, the more frequently evidence could be provided to show that these objectives had been reached. However, the more sophisticated and more complex the objectives, the more rarely they were achieved or the more often the project reports only contained information about successfully implemented activities but no information as to whether the ambitious objectives were reached. The reasons for this were the frequently unspecific situation analyses with regard to the specific target group and the target group size, a correspondingly lower level of specific objectives, and also the relatively limited resources available (mostly between €25,000 and €150,000), which is not enough when seeking to reach comprehensive objectives such as a reduction in childbirth mortality. According to the results of the desk study, the project documentation generally only provided unspecific information regarding the number of people who availed of the implemented project measures (user rates). In most projects, the target groups were defined as 'the poor' or 'women and children' in the communities or regions within the catchment area of the project. In most projects, the number of people in these catchment areas ranged from 25,000 to 1.5 million. A differentiation between the target population and the target group (i.e. the actual users) was rarely made. The results of the field study, on the other hand, painted a different picture: in the projects evaluated there, the target groups and target group sizes were clearly identified. The user rates for the implemented measures in all projects were recorded using the PME system and largely corresponded to plans, which is another indication of the effectiveness of the implemented project measures.

Efficiency

Efficiency is more difficult to judge than the two previously mentioned criteria because within the framework of the desk study cost-benefit ratios could not be calculated on the basis of the information available. It is only when the results of the field phase were available that more concrete statements could be made. Overall, these results attested that the efficiency of the measures was good: in all evaluated projects, organisational structures that allowed for the efficient implementation of the planned interventions were identified. When the professionalism or the qualifications of the managerial staff are considered, the picture is more nuanced. Only a few projects had a management or structures that made it possible to adapt the project strategies to meet changing needs. Another challenge for many projects was the fact that they—for a number of reasons, including their financial situation—had at best only one outstanding manager and no qualified deputies or well-trained middle management. The high fluctuation in staff was another challenge faced by many projects. Another point worth noting is that only a few projects both in the period under evaluation and now had/have a functioning PME system that allows outcomes and impacts to be monitored. Nevertheless, it was established that most partner organisations and staff had a clear understanding of the factors that favoured/endangered the success of the project and the outcomes and impacts that were achieved or potentially could be achieved.

Impacts: overarching developmental effects

Measuring overarching ('indirect') effects in the health care sector is generally difficult because health care services do not operate under controlled conditions. There is general consensus that health—both that of the individual and that of the community—is in itself of great value. There is also adequate scientific evidence to back this up.

The overarching effects or impacts, as outlined in the set of cause-and-effect correlations, are addressed in the plans for most projects, and one can assume that the projects really do make a contribution on this overarching developmental level.

However, corresponding evidence was only found in relation to the ('direct') outcomes of the projects evaluated in the field phase. In this context, the effects can be said to be satisfactory to good.

Because of the existing data, which lacked reference figures, allocation to impacts was only possible in a limited number of cases in the desk study phase. In contrast to this, overarching effects were noted for all projects examined in the field phase. Even though explicit effects indicators could not be examined in any of the projects in the period under evaluation, it was possible to identify changes as a consequence of the interventions implemented between 2005 and 2008 with the help of project documentation and because of the time that has passed in the intervening period of up to eight years. In this respect, it is important to emphasise that changes can never be traced exclusively to the interventions supported by MISEREOR. It can, however, be proven that the evaluated projects made a considerable contribution to the identified effects (corresponding to the impacts and outcomes of the set of cause-and-effect correlations). Moreover, several projects can be deemed to have created structures and had a broad impact on the health care system in the project region (e.g. projects in Liberia, India, El Salvador, and in the Philippines), and can even be viewed as exemplary in this respect.

Sustainability

According to the results of the WHO Commission on Macroeconomics and Health², effective investments in health reduce poverty and promote economic growth. Consequently, it can be assumed that the projects evaluated here, which overall demonstrate good effectiveness and identifiable effects, can also show that they made a corresponding contribution to sustainable development. This assessment is backed up by the results of the field phase, which also confirms the assumptions from the desk study regarding structural and financial sustainability.

A sustainable improvement in services (structural sustainability) was identified in all of the projects that were examined. In addition, the improved qualification of health care staff in many cases also led to changes in attitude and hence to a reduction of the stigma attached to disadvantaged population groups and their discrimination. Networking among partners that receive support from MISEREOR is generally good and contributes to improved structural sustainability in the medium term. Among the positive examples are 'solidarity funds' and support for disadvantaged sections of the population and individuals. It must also be added that MISEREOR's socially committed approach was hampered or made more difficult in many countries such as India, Guatemala, Haiti, or DR Congo by the fact that commitments made by the health administrations (e.g. payment of salaries, materials, supplies of medication, etc.) were not honoured and—in the case of Haiti or DR Congo—the provision of health services was almost entirely delegated to religious, non-governmental, and international organisations.

² WHO, Report of the Commission on Macroeconomics and Health. Geneva, World Health Organisation, 2001.

As far as financial sustainability is concerned, we can in summary say that most of the health care facilities or projects supported by MISEREOR still depend on external financing and support. However, with regard to the evaluated projects, it can also be said that there is an increasing diversification of donors and, therefore, decreasing dependence on only one donor (e.g. MISEREOR). In terms of 'phasing out' or an 'exit strategy', no difference was noted between projects that were financed by MISEREOR and those that were financed through KZE, the Catholic Central Agency for Development Aid (i.e. BMZ resources).

5. Conclusions and lessons learned

Strategic and development policy orientation

For MISEREOR and its partners, the high strategic and developmental significance of the health sector portfolio is undisputed. This significance is clearly reflected in the evaluated project approaches, even if it is not consistently reflected in the allocation of resources. The fundamental strategic and development policy principles of MISEREOR's project support can be found to varying degrees in all of the examined projects: sustainable help towards self-help, reinforcing the potentials and strengths of selected and relevant target groups and partner organisations, strong networking with other sectors, and networking and lobby work.

Cooperation and promotion of networking

Close networking with national Church-based legal holders and local communities is a defining feature of Church health-related development work. The high value of networking for MISEREOR in terms of closeness to the grassroots level is discernible throughout, even though it is not highlighted and described in all of the projects examined.

Promoting partners' competence to act and steer

In all of the evaluated projects, the selection of the implementation approaches, inputs and tools applied proved fundamentally appropriate for the strategic orientation of the project measures. Deficits were noted in the interlinking of consultancy content, the services offered, coordination processes with state institutions or other national/international institutions active in the same areas, and in PME systems, most of which were not working adequately. In these areas, a need for support was identified.

Good practice approaches, knowledge management

Lessons to be learned and knowledge management constitute an important area in the strategic orientation of development cooperation. In some countries or partner organisations, good practice approaches that contain potentially important lessons for other projects too (e.g. in India and El Salvador) were documented during the field phase. These exemplary project approaches or project components are characterised by innovativeness and effectiveness, a participatory and empowerment-based approach, gender sensitivity, a focus on outcomes and impacts, a reasonable cost-effectiveness ratio, sustainability, and transferability.

Recommendations

The unique feature of MISEREOR—strong participatory support for local partners and a demand-oriented focus on themes close to the grassroots—should continue to be a guiding principle of key importance in MISEREOR's cooperation with its overseas partner organisations.

Country strategies should be developed and updated on a regular basis, and specific, strategic orientations should be discussed (e.g. closer cooperation with other sectors that are relevant to health care, greater support for formal training projects, or greater inclusion of cross-cutting issues such as gender and the right to health).

Good project experiences (good practices) should be documented in a more consistent manner and should be made available to other projects so that lessons can be learned. In general, it seems particularly important to strengthen partners' management competence and steering skills by intensifying dialogue with them and ensuring continual backstopping, especially with regard to translating a focus on effects into their reality of planning, monitoring, and evaluation (PME). Good evaluation reports that focus on outcomes and impacts, sound baseline surveys and data collection can help partners draw attention to their work, thereby in turn allowing them to get good results from their education, advocacy and lobbying activities. The securing and continuing development of effective services (lessons learned from other projects) in health care facilities should play a greater role in project planning and support measures.

The improvement of management skills should go hand in hand with a consistent strengthening of the competence of those affected and their organisations (continuing appropriate training, increased participation in programme steering and participation activities).

In order to achieve long-term successes, more thought must be given to self-supporting financing models, budget planning, and a greater diversification of donors or sources of income. This also includes using more systematically the potential for synergy in cooperation with both Church and governmental networks.

Authors: evaplan GmbH/PD Dr Michael Marx (team of expert consultants: Jane Bañez-Ockelford, Valerie Broch-Alvarez, Pinaki Ranjan, Dr Svetla Loukanova, Dr François Zioko Mbenza, Maria Margarita Palacios Monroy, Angelika Pochanke-Alff, Dr Winfried Zacher)

Follow-up

by MISEREOR

The report on the synthesis phase was analysed with the evaluation team from evaplan in two stages: firstly at a meeting with the MISEREOR work group in charge of accompanying the evaluation and secondly with the BMZ. The following important aspects were identified as requiring further internal discussion:

- Health is an important part of MISEREOR's mission. For this reason, an explicit strategic orientation of this sector portfolio is important. However, this orientation must be appropriate for the different general conditions in the various countries and to MISEREOR's responding-to-proposal principle (i.e. a flexible orientation of support to proposals from partners). The question as to how and in what form strategic principles of the sector portfolio can be specified is expected to be discussed and clarified.
- One positive result of the evaluation was that Church organisations often succeed in building up a good relationship with people and adapting services to meet people's real needs. However, there is a contradiction between the desire to reach poor sections of the population and the aspiration to make services financially sustainable. In this respect, partner organisations should develop strategies that will allow them to improve coordination and cooperation with governmental entities and to tap into new opportunities

for financing. Intensifying the discussion of sustainability issues with partners and further clarifying its own position will also be a task to be tackled by MISEREOR in the future.

Following the debriefing meetings, the MISEREOR work group in charge of accompanying the evaluation, which comprises MISEREOR staff whose field of specialisation is the health sector and a number of continental department staff, drew up concrete proposals for further follow-up activities. Work on the implementation of these proposals has begun.

*Translation from the German by
Aingeal Flanagan, M.A., Cologne,
and MISEREOR Language Services
11/2014*

