

Ex post evaluation – Cameroon

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Sector: Basic health infrastructure 12230
Programme/Project: Sectoral Programme Health II (BMZ No. 2000 65 391*),
 Accompanying measure (BMZ No. 2001 70 001),
 Basic and advanced training measure (BMZ 2004 308)
Implementing agency: Cameroon Ministry of Health



Ex post evaluation report: 2015

| | | BMZ No. 2000 65 391 (Planned)** | BMZ No. 2000 65 391 (Actual)** |
|---------------------------|-------------|------------------------------------|-----------------------------------|
| Investment costs (total) | EUR million | 8.34 | 9.35 |
| Counterpart contribution | EUR million | 0.00 | 0.98 |
| Funding | EUR million | 8.34 | 8.37 |
| of which BMZ budget funds | EUR million | 8.34 | 8.37 |

*) Random sample 2015

**) Amount including personnel support BMZ No. 2001 70 001 (EUR 1.26 million), 2004 308 (EUR 0.25 million) as well as residual funds totaling EUR 0.03 million from Phase I, BMZ No. 1994 66 095

Summary: According to the programme appraisal report, the Health sectoral programme (Phase II) in Cameroon was designed as a cooperative programme (CP) with the Gesellschaft für Internationale Zusammenarbeit to help improve the health of the population in initially 6 out of 40 health districts in the Littoral, North West and South West provinces. In light of the much greater need for rehabilitation, however, the focus was placed on only five health districts, and contrary to plans, only four (instead of up to six) district hospitals and six (instead of up to 15) local health centres were renovated or newly built and equipped. The maintenance of the equipment was to be ensured by means of a maintenance fund. The staff at the institutions supported in both phases of the sectoral programme received advanced training as part of an accompanying measure.

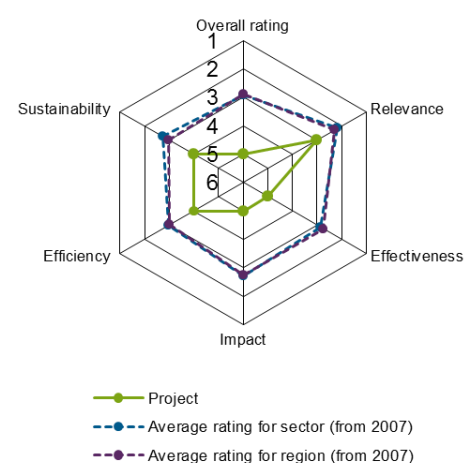
Objectives: The ultimate objective of the second phase of the Health sectoral programme was to help improve the health of the population in the supported districts. The programme objective was to improve the quality and quantity of health care in the beneficiary districts by creating a range of services of sufficient quality and ensuring their use at the rehabilitated health institutions.

Target group: The target group was the population of the initially six health districts to be supported, totaling roughly 0.7 million inhabitants (demographic information for the five districts ultimately reached is not available)..

Overall rating: 5

Rationale: The results show that use of infrastructure has not increased as planned, and is instead declining consistently. Accordingly, the developmental effectiveness of the programme is also rated as clearly inadequate. Despite significant investment in health infrastructure, no improvement was noted with any of the indicators. Likewise, the calculated costs are far in excess of the normal regional levels

Highlights: The rehabilitation failed to accomplish the planned increase in the use of the promoted health-care infrastructure. On the contrary: the number of patients is falling. The reasons for the low use of the institutions could not be analysed in depth during the evaluation. There is no doubt that the relatively high official and unofficial patient fees prevent the poorer parts of the population from using the institutions, while those who are better off prefer to go private. The lack of functionality in important equipment as well as the poorly motivated or absent personnel play a role too.



Rating according to DAC criteria

Overall rating: 5

Relevance

At the programme appraisal, it was rightly pointed out that, despite having better economic opportunities than many neighbouring countries, Cameroon's health indicators were unsatisfactory and similar to those of much poorer neighbouring countries. Improving the health situation of the Cameroonian population was therefore of the utmost importance in terms of development policy. The Millennium Development Goals have given high priority to improving health and determined two objectives in areas where Cameroon had – and unfortunately continues to have – very unsatisfactory results, namely infant and maternal mortality rates. Accordingly, Cameroon's Health Strategy (updated in 2009) also stipulates that the maternal mortality rate should be reduced by 40 % and the infant mortality rate should be reduced by two-thirds by the year 2015. The project is in line with international objectives and with the main aims of German DC in terms of its focus on improving the health situation. Cameroon is a priority country for German DC, and its health sector was one of three DC priority sectors both during programme planning and in the implementation. Therefore, a programme which aims to improve the health situation of the population should still be evaluated as very relevant.

The selection of the supported regions was the result of the regional focuses of German DC in the health sector in Cameroon (south-west of the country). The supported institutions were selected on the basis of verifiable criteria, such as existing refurbishment needs not covered by other donors, preliminary work of health care facilities in the form of preliminary studies, size of the target group, etc.

From today's perspective, however, it should be critically examined whether the underlying results chain between the measures (rehabilitation of health infrastructure and procurement of new equipment) and the programme objective (use of improved range of services) had significant gaps and gave too little importance to numerous factors which were indispensable for the achievement of the objectives. These include, inter alia, a sufficiently large supply of qualified and motivated staff; sufficient financial resources for the ongoing procurement of drugs, consumables and spare parts; regular maintenance of buildings and equipment; a welcoming environment for patients as customers; and fees which are affordable for poorer sections of the population. In terms of the concept, the unsatisfactory starting conditions with respect to the supply of water and electricity were not sufficiently taken into account. No voltage compensation devices were provided, for example, despite known voltage fluctuations. Health centres were refurbished although the water supply was not ensured in advance. Similarly, a critical view should be taken of the lack of waste disposal, which was introduced by the partner at the hospital in Edéa only after completion of the programme.

Furthermore, it was not possible to realise the original concept, which was to complement the comprehensive range of TC advisory services available at the time of the programme appraisal by rehabilitating infrastructure as part of a cooperation programme. The cooperation was then limited to the servicing and maintenance component of the TC as a key element of sustainability. As further donors withdrew from supporting the measures to rehabilitate the health infrastructure shortly after the beginning of the programme, the programme was incorporated into higher-level programmes to a lesser extent than had been expected at the appraisal.

Relevance rating: 3

Effectiveness

The programme objective was to improve the quality and quantity of health care in the beneficiary districts by creating a range of services of sufficient quality at the rehabilitated health institutions. The achievement of this programme objective was to be reviewed on the basis of a total of four indicators. But the collection of data for these indicators was limited to the four supported hospitals (two of which are under private denominational ownership), while no indicators were defined for monitoring the impact of the programme in the six rehabilitated health centres and no data was collected in this regard during the programme imple-

mentation period. The following table therefore summarises only the results of the statistics collected by the implementation consultant in the four supported hospitals, and is based on the results of the consultant's final report. The data summarised here draws a comparison between the year 2007 (before the start of rehabilitation measures) and the results from the years 2009 and 2010, when all infrastructure activities were completed, with the exception of the rehabilitation of the hospital in Edéa. The current data was gathered during the visits to the health facilities in 2015. However, this was unable to show any positive changes overall with respect to the situation in 2009/10 and the consultant's report in 2014. Unfortunately, the Ministry of Health was unable to provide more up-to-date information in relation to the patient statistics of the supported health facilities. The extent to which the handwritten patient statistics from the two hospitals visited are reliable could not be verified.

| Indicator | Starting value 2007 | Target value 2009** | Value 2010*** | Edéa Hospital, 2015**** |
|--|---|---------------------|---------------|--|
| (1) Increase in the degree of utilisation of the four rehabilitated hospitals by a total of 10 %, measured on the basis of the number of new consultations per year. | 24,814 | 27,295 | 20,274 | -18 % in comparison to the starting value from 2007. |
| (2) Increase in admissions to the rehabilitated hospitals by a total of 10 %, measured by the number of inpatient admissions per year. | 8,581 | 9,439 | 7,287 | These statistics are no longer collected in the visited hospitals. |
| (3) Increase in operations in the rehabilitated hospitals by a total of 20 %. | 2,610 | 3,132 | 1,021 | - 39 % |
| (4) 80 % of the equipment supplied is still in working order three years after being supplied. | At the PCR (three years after delivery), less than 80 % of the equipment supplied was still in working order. The selective on-site visit at the ex-post evaluation confirmed this observation. | | | Significantly less than 80 %. |

* Values of utilization are added up for each of the four supported hospitals. The chosen indicators for outpatient treatments (new consultations) are the statistics typically collected in hospitals, while there are no figures for repeated consultations, or these are very low.

** Two years after completion of the measure;

*** Figures from the consulting firm's final report, 2011 and aide memoire of the Programme Completion mission;

**** Figures are based on the patient statistics from one of the hospitals visited locally (Edéa). The statistics from the second hospital visited did not appear to be very reliable (Wum).

The results show that the use of infrastructure has not increased as planned, but is instead still declining consistently. The on-site visits in two of the four hospitals as well as in two of the six supported health centres confirmed this picture.

The reasons behind this very limited demand cannot be analysed in depth on the basis of such a limited survey. The reason for the decline in demand cited in the reporting as well as during the visit to the hospital in Edéa is that competition from private and church health services has increased. According to a study by the World Bank (2013), however, the unsatisfactory health figures in Cameroon are essentially attributable to the fact that the patient fees are the main source of income for health facilities and the fees, which are still very high in comparison to many other countries, hold many patients back from visiting health facilities. No reliable information is available in relation to the amount of the official and unofficial user fees charged by public, church and private health facilities. We can add to this the low quality of services in many public institutions. According to UNICEF (2014), 97 % of births are assisted by qualified health professionals in the richest 20 % of the population, but this figure drops to 19 % for the poorest 20 %, which

is very low even by global standards. This indicates that the richer Cameroonians probably use (better) private services, while the poorer population cannot afford them due to the amount of the fees charged by public health institutions. The state contribution amounts to approximately one third of the health expenses incurred (WHO 2012). The proportion which is privately financed amounts to two thirds of total expenditure, and this is made up almost exclusively of out-of-pocket payments from patients.

Effectiveness rating: 5

Efficiency

A programme for the rehabilitation of health infrastructure can be evaluated only to a limited extent with regard to its production efficiency. The reason for this is the individuality of the rehabilitation components which determine whether the rehabilitation is within the usual price range, but for which there are no standard costs. If we consider the rehabilitation costs of the hospital in Edéa, at approximately EUR 2.74 million these make up around 55 % of the rehabilitation costs of the hospitals and around 35 % of the total costs (excluding personnel support) of the project. Based on an area of 5,350 m² this results in total costs of more than EUR 500/m² (around EUR 330/m² of which is for building rehabilitation), both of which are far above the usual budget for the region. Building rehabilitation alone at Wum hospital amounted to EUR 206/m².

Furthermore, the previously estimated total costs had to be revised. Originally, up to six district hospitals and 15 health centres were to be rehabilitated using the earmarked funds. In the course of the programme, the number of facilities was limited to four district hospitals and six health centres. This was due to the greatly increased demand for necessary rehabilitation. What's more, the planned implementation period was considerably exceeded. While it was planned that the programme would be implemented over 48 months, 84 months were required, despite the reduced number of locations in relation to the original planning. This was mainly due to difficulties involving state bureaucracy and the often lacking expertise of the subcontractors.

The allocation efficiency of the programme, that is, the effect achieved per euro, can also only be assessed to a limited extent in quantitative terms because the benefits which resulted from the programme cannot be monetised. As a result, the assessment drew primarily on information such as utilisation of the infrastructure and maintenance practices. The on-site observations revealed that many procurements and construction measures had never been used or were no longer in use (six years after being put into operation). The flushing toilets provided in all health facilities, but which it had never been possible to use because there was no water supply in the health centres at the time – nor has one been installed since – should be mentioned here in particular¹. Furthermore, numerous devices procured as standard, such as dental devices, could not be used because the corresponding dentists were not yet on site at the time of the appraisal – and still are not. In particular, however, the fact that many of the devices had fallen into disrepair after a short time, in some cases never having been in working order, and that at the ex-post evaluation some of the rehabilitated facilities were already in need of further comprehensive rehabilitation, does not suggest a high impact efficiency of the funds used.

Efficiency rating: 4

Impact

The ultimate objective of the programme was to improve the population's health in the supported districts. Ultimate objective indicators were not determined at the appraisal. Due to numerous factors over which the programme had no influence, it would probably be difficult of course to establish a causal link between the programme measures and the improvement of the target group population's health situation. At the ex-post evaluation, however, the reduction of maternal mortality and of child mortality in the three programme regions, as two of the Millennium Development Goals, were used as proxy indicators for the achievement of the ultimate objective. At the national level, a comparison of the figures between the 2004

¹ The reason listed on the final inspection report for the lack of water supply was that test drilling would have produced negative results (poor water quality). Whether this test drilling yielded the same negative results in all health centres and whether a water supply, albeit of unsatisfactory quality, would not have been better than no water supply at all, could not be determined from the documents.

and 2011 EDS (EDS - Enquête Démographique et de Santé) in relation to child mortality shows an improvement from 144 per 1,000 live births to a still unsatisfactory rate of 122 per 1,000, while the rate of maternal mortality deteriorated significantly between 2004 and 2011, from 669 per 100,000² (1998-2004) to 782 per 100,000 (2004-2010). What is noticeable in this regard is the differentiation between the socio-economic quintiles of the population. For example, child mortality has improved, particularly in the 60 % of the population that are better-off (reduction of 18-22 %), while the poorest 20 % of the population have been able to achieve only a marginal improvement of just under 3 % (period 2004-11). In 2011, their infant mortality rate was still 189 per 1,000 live births.

The fact that, with the exception of Edéa, the programme failed to establish adequate disposal facilities for medical waste as part of its rehabilitation efforts should be regarded very critically. In Wum, as well as in the two visited health centres, highly contaminated syringes were simply left lying around. Even in Edéa, the proposed disposal concept was implemented by the government long after rehabilitation. The corresponding electrical incinerator had been installed recently and did not look used. The programme should therefore be evaluated critically from the point of view of health and the environment, and assessed as clearly insufficient overall.

Impact rating: 5

Sustainability

With regard to the sustainability of the project, a distinction should be made between two different forms of sustainability: financial and institutional. In the case of financial sustainability, the question arises as to whether the partner is able to ensure ongoing operation, as well as the replacement of the investment. It is clear from the results of the visits to the health-care facilities, as well as from the lack of budget allocations and the very limited internal resources of the health-care facilities, that financial sustainability has not been achieved. None of the health facilities visited received any state contributions to their operating or investment costs, with the exception of the allocation of funds to partly cover the staff and the costs for these employees. Instead, the state expects the health-care facilities to finance their operating costs as well as replacement investments from the patient fees alone. These patient fees are far from sufficient to provide an offering that is satisfactory in qualitative terms, but are at the same time too high for the poor population, which explains the low demand.

With regard to the institutional sustainability of the rehabilitated facilities or, in other words, the question of whether the management and employees of health care facilities have the skills to manage the facilities economically and at the same time provide services of satisfactory quality, the field visits have in all cases shown the limitations of the skills and motivation of the health-care facilities' employees. The many malfunctioning devices, poor condition of the facilities, high staff absences and low level of patient demand were seen as an expression of the lacklustre service offered by staff. It must be acknowledged that through the maintenance fund, the staff and technical support of maintenance and the training measures which unfortunately stopped in 2007, the programme has made important contributions towards improving the competence of management within health-care institutions, doctors, nursing and maintenance staff (e.g. maintenance contracts as part of the project) and thus differentiates itself in a positive way from many other infrastructure programmes. Unfortunately, the fruits of this support have largely been lost due to extensive personnel changes (only the maintenance technicians were still active on site) and, above all, because of the lack of maintenance funds provided by the Ministry of Health.

Sustainability rating: 4

² Differing information is available concerning this: WHO 2012: 590/100,000; World Bank (2013) 690/100,000. There is agreement, however, in relation to the negative nationwide trend.

Notes on the methods used to evaluate project success (project rating)

Projects (and programmes) are evaluated on a six-point scale, the criteria being **relevance, effectiveness, efficiency** and **overarching developmental impact**. The ratings are also used to arrive at a **final assessment** of a project's overall developmental efficacy. The scale is as follows:

| | |
|----------------|---|
| Level 1 | Very good result that clearly exceeds expectations |
| Level 2 | Good result, fully in line with expectations and without any significant shortcomings |
| Level 3 | Satisfactory result – project falls short of expectations but the positive results dominate |
| Level 4 | Unsatisfactory result – significantly below expectations, with negative results dominating despite discernible positive results |
| Level 5 | Clearly inadequate result – despite some positive partial results, the negative results clearly dominate |
| Level 6 | The project has no impact or the situation has actually deteriorated |

Rating levels 1-3 denote a positive assessment or successful project while rating levels 4-6 denote a negative assessment.

Sustainability is evaluated according to the following four-point scale:

Sustainability level 1 (very good sustainability): The developmental efficacy of the project (positive to date) is very likely to continue undiminished or even increase.

Sustainability level 2 (good sustainability): The developmental efficacy of the project (positive to date) is very likely to decline only minimally but remain positive overall. (This is what can normally be expected).

Sustainability level 3 (satisfactory sustainability): The developmental efficacy of the project (positive to date) is very likely to decline significantly but remain positive overall. This rating is also assigned if the sustainability of a project is considered inadequate up to the time of the ex post evaluation but is very likely to evolve positively so that the project will ultimately achieve positive developmental efficacy.

Sustainability level 4 (inadequate sustainability): The developmental efficacy of the project is inadequate up to the time of the ex post evaluation and is very unlikely to improve. This rating is also assigned if the sustainability that has been positively evaluated to date is very likely to deteriorate severely and no longer meet the level 3 criteria.

The **overall rating** on the six-point scale is compiled from a weighting of all five individual criteria as appropriate to the project in question. Rating levels 1-3 of the overall rating denote a "successful" project while rating levels 4-6 denote an "unsuccessful" project. It should be noted that a project can generally be considered developmentally "successful" only if the achievement of the project objective ("effectiveness"), the impact on the overall objective ("overarching developmental impact") and the sustainability are rated at least "satisfactory" (level 3).