Ex post evaluation – Tanzania

Sector: Promotion of reproductive health (CRS code 13020)
Project: FC module as part of a DC programme: Social security for poor people to improve maternal health and HIV prevention (2007 65 545*) and NHIF complementary measure (CM) (2009 70 152), Phase I
Implementing agency: National Health Insurance Fund (NHIF)

Ex post evaluation report: 2018

		Project (Planned)	Project (Actual)	CM (Planned)	CM (Actual)
Investment costs (total)	EUR million	18.17	18.17	1.50	1.48
Counterpart contribution	EUR million	6.67	6.67	0.00	0.00
Funding	EUR million	11.50	11.50	1.50	1.48
of which BMZ budget funds	EUR million	11.50	11.50	1.50	1.48**

*) Random sample 2017;

**) Residual funds were transferred to BMZ No. 2015 67 379 (Phase II of the project).

Summary: The project funded one-year memberships of the National Health Insurance Fund (NHIF) for poor, pregnant women in Mbeya and Tanga, which included prenatal care, obstetrics, postnatal care and neonatal care, as well as a broad range of health services. FC subsidised 50% of the registration fee for a Community Health Fund (CHF) for the women's families, offering a basic care package. FC also financed basic medical, information and communication equipment for the NHIF, measures to raise awareness among the target group and the health facilities, as well as monitoring and evaluation activities. The complementary measure comprised technical advisory services as well as training measures for the NHIF staff, in order to support the fund in extending its insurance services to a wider section of the population. The project and complementary measure constitute an FC module within the framework of a DC programme.

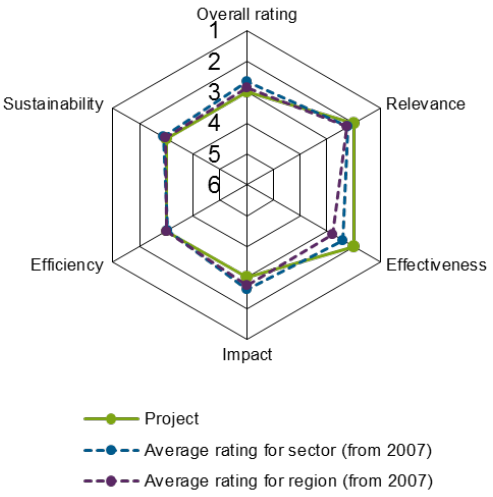
Objectives: The overarching developmental objective (impact) of the project was to improve the general health of all Tanzanians, taking into account particularly vulnerable and disadvantaged population groups in Mbeya and Tanga. The programme objective (outcome) was to improve equal access to high-quality reproductive health services and their use by poor, pregnant women and their newborns in the target regions of Mbeya and Tanga. A secondary objective was to contribute to the further development of the national health insurance system by extending the NHIF insurance system to poor and disadvantaged population groups.

Target group: The target group of the project was poor, pregnant women and their newborns in the regions of Mbeya and Tanga, along with their families (the latter added ex post).

Overall rating: 3

Rationale: The project contributed to a tangible improvement in poor, pregnant women's access to reproductive health services, and had a positive impact on maternal and neonatal health in Tanga and Mbeya. The NHIF was strengthened by the project and was able to gather some important experience for its future role as a universal health insurance provider. The main weaknesses evident in the project are the efficiency with which the funds are used and the lack of a solution so far for the future financing of subsidised insurance contributions.

Highlights: As a pilot project, its implementation entailed a variety of challenges. These were handled very well and practical solutions were developed, such as registering by text message or e-claiming.



Rating according to DAC criteria

Overall rating: 3

Ratings:

Relevance	2
Effectiveness	2
Efficiency	3
Impact	3
Sustainability	3

Relevance

With per capita income of around USD 2,946 in 2017,[1] Tanzania remains one of the poorest countries in the world today. Although the country's economy has seen comparatively strong growth over the past ten years and the poverty rate fell to 26.9% (national poverty line) in 2016, the absolute number of poor people has not declined given the strong population growth.[2]

At the time of the project appraisal, the state of health of the population pointed to deficiencies in basic health care, particularly in the area of mother and child health. According to the Tanzania Demographic and Health Survey (TDHS 2004/2005), the maternal mortality rate in 2004/2005 was 578 cases per 100,000 live births and the neonatal mortality rate was 32 cases per 100,000 live births. Although the health status of the population has improved slightly in recent years, it remains inadequate. In 2016, the average life expectancy was 66 years.[3] The maternal mortality rate in 2015/2016 remained high at 556 per 100,000 live births, as did the neonatal mortality rate at 25 deaths per 1,000 live births.[4]

Important factors contributing to the poor state of health still include great inequality in health care and difficult access to health services of sufficient quality, especially among the poor population. Although health services for pregnant women and children up to the age of five have been free since the mid-1990s, out-of-pocket payments were widespread at the time of the project design. Pregnant women usually had to bring a clean delivery pack[5] with them to give birth in a health care facility, and the women or their relatives were required to procure the necessary medicines at their own expense. This prevented poor women in particular from taking advantage of preventive medical examinations and giving birth in health care facilities. At the same time, the health care facilities lacked the financial means to procure medicines and consumables or to make smaller investments in medical equipment. In addition, a significant lack of skilled or qualified personnel meant that the overall quality of reproductive health services was inadequate. The difficult access to medical care for poor pregnant women and their newborns and the poor quality of reproductive health services resulted in an unacceptably high maternal and neonatal mortality rate, and represented a core problem in the Tanzanian health sector at the time of the project appraisal.

The results chains underlying this project broadly rest on sound logic. Subsidising the costs of temporary insurance for poor pregnant women and their newborns, for example, was intended to facilitate access to health services and reduce the financial burden on families. This, in turn, was intended to reduce health risks. Diseases were to be detected and treated more quickly, and secondary illnesses avoided. Overall, the health status of mothers and newborns was to be improved. The NHIF was to reimburse benefits directly to health care facilities in a timely manner. The improved financial situation of health care facilities and increased competition between public, private and church-run institutions – which women are free to

[1] Measured as per capita GDP at purchasing power parity.

[2] Source: World Bank.

[3] Source: World Bank.

[4] Source: Tanzania Demographic and Health Survey 2015/2016.

[5] A clean delivery pack usually contains soap, a plastic pad, a sterile razor blade, sterile gloves and sterile material for tying the umbilical cord.

choose between – was to improve the quality of health services. The project-executing agency NHIF was to be strengthened institutionally, and opened up to new population groups.

However, in order for financing the demand for health services to be effective, one important prerequisite is that the supply of health services is able to keep up. At the project appraisal, the risk that personnel in health care facilities would be lacking or insufficiently qualified was rated as high. Indeed, the personnel situation at health care facilities has worsened since the government imposed a hiring ban in 2016 and dismissed employees without valid certificates. One further aspect which was not taken into proper account during the project design is transport costs. Women continue to bear the costs of transport to health care facilities themselves, which is a major obstacle, especially for pregnant women in remote areas.

The involvement of the Community Health Fund (CHF) also seems contradictory. Initially, the project concept only provided for subsidies for poor pregnant women through the NHIF. As the largest national health insurer, the NHIF was most likely to command the necessary capacities required to implement the project. After the NHIF was given control of the CHF in 2009, the project was extended – ostensibly at the request of the Tanzanian government and German TC – to include the component of temporary health insurance for the women's families via the CHF. From an efficiency perspective, the parallel promotion of two health insurance systems makes little sense. The inclusion of the CHF can, however, be justified as a step on the way to institutional reorganisation. In the medium term, the CHF and NHIF are to be merged to form the Single Mandatory National Health Insurance scheme (SNHI).

In addition to introducing general health insurance for all Tanzanians, the improvement of access to health services for particularly disadvantaged population groups remains an important goal for the Tanzanian government. The project continues to be in line with the national sector strategy set out in the Health Sector Strategic Plan 2015-2020 (HSSP), which is derived from the Sustainable Development Goals (SDG), the National Vision 2025 and the Growth and Poverty Reduction Strategy (MKUKUTA). The project formed part of the Tanzanian-German Programme to Support Health (TGPSH) complemented other German DC projects. It was integrated into the development cooperation between major donors and the Tanzanian Ministry of Health as part of a sector-wide approach.

Relevance rating: 2

Effectiveness

The programme objective was to improve equal access to high-quality reproductive health services and their use by poor pregnant women in the Mbeya and Tanga regions. The secondary objective was to contribute to the further development of the national health insurance system by extending the NHIF insurance system to poor and disadvantaged population groups. These objectives also appear appropriate from today's perspective.

The objective indicators were adjusted several times during the programme implementation period. Some of the indicators defined at the PA were replaced with indicators from the District Health Information System (DHIS), which holds important data on mother-child health. At the time of the EPE, the following indicators were used to measure the project's success, although their significance is limited to some extent due to a lack of data availability and quality:

Indicator	Status PA, Target value	Ex post evaluation
(1) Aggregate number of poor pregnant women in Tanga and Mbeya who are registered in the NHIF	Project appraisal: - Target value: 130,000	Financed using funds from Phase I: 262,000 Source: NHIF

(2) Aggregate number of families of poor pregnant women in Tanga and Mbeya whose registration fee for a CHF was subsidised	Project appraisal: - Target value: 130,000	Financed using funds from Phase I: 294,420[6] Source: NHIF
(3) Proportion of births supervised by skilled health personnel (in %)	Project appraisal: Tanga: 67.9 Mbeya: 82.9 Songwe: 76.3 Source: DHIS (Data as of 2014, no comparable data available for the years prior to 2014) Target value: 80	End of Phase I (2016): Tanga: 83 Mbeya: 90.6 Songwe: 85.3[7] Source: DHIS
(4) Proportion of births taking place in health care facilities (%)	Project appraisal: Tanga: 41.3 Mbeya: 43.1 Source: TDHS 2010 Target value: 80	End of Phase I (2015/2016): Tanga: 66.8 Mbeya: 64.9 Source: TDHS 2015/2016
(5) Proportion of pregnant women attending four or more prenatal examinations (%)	Project appraisal: National: 42.8 Source: TDHS 2010 Target value: 80	End of Phase I (2016): National: 50.7 Source: TDHS 2015/2016
(6) Proportion of correct bills (in %)	Project appraisal: - Target value: 95	95 (proportion of bills reimbursed by the NHIF) Source: NHIF
(7) Average period between claim by health care facility and reimbursement (in days)	Project appraisal: - Target value: 60	End of Phase I: 54 Source: NHIF
(8) Proportion of health care facilities performing normal births that have at least one delivery kit[8] in stock	Project appraisal: No comparable data available.	End of Phase I (2014/2015): National: 87% Tanga: 88% Mbeya: 92% Source: Tanzania Service Provision Assessment Survey 2014/15

[6] The aggregate number of poor pregnant women registered in the NHIF differs from the aggregate number of subsidised families, as the women and their families were financed from different Phase I budget lines. The registration of women and their families continued after the Phase I funds were exhausted. NHIF, the project-executing agency, pre-financed the related expenditure until Phase II was officially launched in August 2016 and corresponding funds were released.

[7] The Songwe region separated from the Mbeya region in 2016.

[8] A delivery kit includes basic sterile equipment for obstetrics (umbilical clamp, umbilical scissors, episiotomy scissors, suture material, needle and needle holder).

(9) Proportion of health care facilities performing normal births where at least one employee has undergone training in obstetrics and neonatal care in the past two years.	Project appraisal: No comparable data available.	End of Phase I (2014/2015): National: 23% Tanga: 41% Mbeya: 20% Source: Tanzania Service Provision Assessment Survey 2014/15
(10) Proportion of HIV-infected pregnant women receiving anti-retroviral therapy (ART) for the prevention of mother-to-child transmission (PMTCT) (in %)	Project appraisal: National: 63 Source: UNAIDS	End of Phase I (2016): National: 76 Source: UNAIDS

From February 2013 onwards, the programme covered all the districts of Tanga and Mbeya. The number of registrations of poor pregnant women in the NHIF increased steadily, as did the number of service bill claims submitted by the health care facilities. By the end of 2015, the budget earmarked for Phase I was largely exhausted. Further registrations were pre-financed by the NHIF until the start of Phase II of the project in August 2016. The project objective of 130,000 registrations of pregnant women in the NHIF and of their families in the CHF during Phase I was far exceeded.

The billing of services has also improved continuously. At the end of Phase I, there was an average of 54 days between the NHIF receiving the benefit claim and the reimbursement being made to the health care facility. At the ex post evaluation in September 2018, the majority of the visited health care facilities reported that their services were generally reimbursed within 20 to 30 days. Approximately 95% of the claims received by the NHIF during Phase I were reimbursed. In the event of incorrect or unjustified billing, the NHIF provided feedback to those responsible at the health care facilities.

The registration process was a challenge during the implementation period. For example, the relevant forms were often not available at the health care facilities, or completed applications were not forwarded to the NHIF in a timely manner. Following the introduction of technology in September 2015 which allows health care facilities to register women by text message, this problem has been significantly reduced. The idea of an insurance card for pregnant women proved to be unworkable owing to logistical difficulties. For this reason, health care facilities have started to write women's registration numbers on their 'mother's ID' (Reproductive and Child Health Card; RCHC), which must be brought with them to every check-up as well as to the birth.

At the ex post evaluation, all the visited health care facilities reported that the project was widely known in their region and very well received by the pregnant women. The consultant accompanying the project estimated that the programme covered around 56% of all births in Tanga and around 63% of all births in Mbeya in 2015.[9] The increased use of reproductive health services is also reflected in the fact that the proportion of births accompanied by skilled personnel increased significantly in all project regions during the project.

At the same time, the financial situation of the health care facilities has improved considerably. The project meant that health services, which previously had to be provided free of charge, could be billed via the NHIF. The reimbursements went directly into the accounts of the health care facilities. Many smaller health care facilities opened their own accounts for the first time as a result of the project and were able to use their own funds to buy medicines, make smaller investments in medical equipment or infrastructure, or pay employees a bonus for their overtime. This has strengthened the independence of the health care facilities and had a positive impact on the quality of the health services that they provide.

A study into patient satisfaction carried out in August 2015 and discussions with patients as part of the ex post evaluation underline this result. The fact they were able to access health services free of charge at

[9] Source: GFA (2016): Improved Access for the Poor Pregnant Women to Improve Maternal Health and HIV-Related Services in Tanzania - Final Report

any time and no longer had to worry about medication and consumables brought enormous financial and emotional relief for pregnant women. Equally positive for the women was that they were free to choose their health care facility. For some women, arranging transport to a health care facility and obtaining food during longer stays were difficult.

The lack of qualified personnel and suitable premises stood in the way of a further improvement in service quality. Some facilities benefited here from the option to obtain a loan from the NHIF based on their average reimbursement figures, which could then be used finance infrastructure investments. Larger facilities in particular, such as the META Referral Hospital in Mbeya, saw the programme as a business model and worked to attract pregnant women as patients. Other facilities, on the other hand, failed to charge in full for their services and the opportunities offered by the programme remained largely unexploited as a result. In these cases, better hospital management could also help to improve the quality of service.

HIV prevention was also an objective of the project design. The prevention of mother-to-child transmission (PMTCT) of the virus was to be ensured by anti-retroviral therapy. However, this objective was not pursued and HIV-related health services were not reimbursed by the NHIF as they were covered by other HIV prevention programmes, such as PEPFAR. Progress in this respect therefore cannot be attributed to the project under evaluation.

The secondary objective of further developing the national health insurance system can be regarded as fulfilled. Through the programme the NHIF was able to gain valuable experience in insuring poorer population groups. Registration and settlement processes saw continuous improvement, which was also to the benefit of regular members of the NHIF. Further steps will be necessary to enable the NHIF to handle the planned Single Mandatory National Health Insurance (SNHI). Nevertheless, the NHIF has already made important progress.

Overall, the programme objectives at outcome level can thus be regarded not only as realistic but also as largely fulfilled (partially fulfilled for certain aspects).

Effectiveness rating: 2

Efficiency

When considered in comparison to traditional input financing, the approach pursued here of demand financing for health services offers potential for a more efficient allocation of resources. This efficient allocation is also helped by promoting competition between health care facilities, which is achieved by allowing pregnant women to choose freely between state, private and church-run institutions. At the same time, the NHIF has put systematic quality controls in place to ensure that the health care facilities make proper use of the funds they receive. For example, the NHIF regularly monitors not only the financial situation of the health care facilities in Tanga and Mbeya, but also the quality of the services provided. To this end the NHIF conducts surveys of insured people and visits health care facilities, as part of which assessors work through a list of quality criteria. If these criteria are not met, the NHIF may not reimburse for services in cases of doubt.

The implementation of the project was subject to considerable delays. The contracts with the Tanzanian government were signed at the end of 2009, but the programme was not rolled out in the four pilot districts in Tanga and Mbeya until 2012. This delay was due to protracted contract negotiations with the consultant, and to the need to adapt the project concept after the Tanzanians expressed their desire to include the CHF.

In Phase I of the project, around 63% of the project funds totalling EUR 13 million was used to reimburse health services for pregnant women and their newborns via the NHIF. Approximately 9% was spent on subsidising the fees for registering families in the CHF. The remaining funds were divided between expenditure on marketing campaigns (4%), IT hardware and software (1%), medical equipment for health care facilities (4%) and consultancy services provided by the consultant (18%).[10]

[10] Source: GFA (2016): Improved Access for the Poor Pregnant Women to Improve Maternal Health and HIV-Related Services in Tanzania - Final Report

From the point of view of efficiency, it is positive that reimbursements for health services provided to pregnant women and newborns were paid directly to the facilities and managed by them on a decentralised basis. The registration fees for the CHF were initially passed on to the health care facilities via the District Health Offices. Some District Health Offices withheld funds, however, and as a result, in 2014 the NHIF started to transfer the registration fees for the CHF directly to the health care facilities that had enrolled.

The registration fee for the CHF covered all health services provided by the health care facilities to insured family members on a flat-rate basis. Unlike pregnant women and newborns insured under the NHIF, the health care facilities were unable to bill individual services for family members insured in the CHF. In many cases, this resulted in the health care facilities enrolling the family members but not informing them of their insurance claims, or providing them with low quality health services only. Thus integrating the CHF has done relatively little to embed the concept of health insurance among the population. The approximately EUR 1.2 million provided for insuring the families could have been used more efficiently by creating appropriate performance incentives for the health care facilities.

The project's targeting approach is also not very convincing from the point of view of efficiency. The target group was poor pregnant women in Tanga and Mbeya. However, since it proved difficult to identify the poor among the pregnant women, all women in Tanga and Mbeya were ultimately given access to the programme.[11] This is understandable, and may even have increased acceptance of the programme among the general population and therefore also within political circles. However, Tanga and Mbeya by no means number among the poorest regions of Tanzania. If the funds had been channelled to other Tanzanian regions using a geographical targeting approach, the positive impact on the health of all Tanzanians might have been greater.[12] In addition, women in rural and remote areas were less aware of the programme and faced significant challenges in arranging transport to a health care facility. Poverty is particularly pronounced in these areas, however. It would also have been desirable at this point for the funds to be used more efficiently in targeting particularly poor women especially. The introduction of a new technology that made it possible to register by text message is seen as a positive development. Internet access was not necessary to register, which really simplified and accelerated the registration process in rural areas.

No "gatekeeping mechanism" was implemented, meaning no reference system was put in place for women insured under the NHIF. This meant that women could go to regional hospitals at any time, even if their pregnancy was normal and no complications were to be expected. These hospitals were able to charge more for their services than smaller health care facilities, which increased insurance costs unnecessarily and prevented the efficient allocation of funds.

Overall, the efficiency of the project can still be assessed as satisfactory.

Efficiency rating: 3

Impact

The overarching developmental objective of the project as defined at the PA was to improve the general health of all Tanzanians, taking into account particularly vulnerable and disadvantaged population groups. However, given that Phase I of the project covered only the regions of Tanga and Mbeya, which together account for less than 9% of Tanzania's population, giving further detail seems appropriate. For the EPE, the objective is thus to improve the general health of all Tanzanians in Tanga and Mbeya, taking into account particularly vulnerable and disadvantaged population groups. Maternal and neonatal mortality rates were to be used as indicators for the achievement of this objective, resulting in the following picture at the EPE:

[11] One method for determining need – which is currently under examination, but did not exist during Phase I of the project – is to use the income data collected within the context of the World Bank's Tanzania Social Action Fund (TASAF).

[12] The project was extended in Phase II to include the regions of Mtwara and Lindi, which have an above-average proportion of poor people relative to the rest of Tanzania.

Indicator	Status PA, target PA	Ex post evaluation
(1) Maternal mortality rate (number of deaths per 100,000 live births)	Project appraisal: National: 454 Source: TDHS 2010 Tanga: 194 Mbeya: 127 Source: DHIS 2012/GFA Impact Study Target value (national): 265	End of Phase I: National: 556 Source: TDHS 2015/16 Tanga: 99 Mbeya: 129 Source: DHIS 2016/GFA Impact Study
(2) Neonatal mortality rate (number of deaths per 1000 live births)	Project appraisal: National: 26 Source: TDHS 2010 Tanga: 5 Mbeya: 8 Source: DHIS 2012/GFA Impact Study	End of Phase I National: 25 Source: TDHS 2015 Tanga: 4 Mbeya: 10 Source: DHIS 2016/GFA Impact Study

At the national level, maternal and neonatal mortality rates can be derived from representative population surveys such as the Tanzania Demographic and Health Survey (TDHS). However, since the values obtained are based on estimates that are subject to a high degree of statistical uncertainty, they do not allow clear conclusions to be drawn about the development of maternal and neonatal mortality.[13] Statistical uncertainty is even greater at the regional level, and as such no reliable conclusions can be drawn here.

In an alternative approach, the deaths officially reported by the health care facilities via the District Health Information System (DHIS) can be aggregated, resulting in significantly lower maternal and neonatal mortality rates. The reliability of these values is likely to be comparatively low, however. In discussions with hospital staff for example, it became clear that the documentation of patient arrivals and their whereabouts is not always completed due to the high workload. It was not uncommon for there to be a lack of understanding about why such documentation is useful. At the regional level, distortions are also likely to arise from the fact that certain hospitals – for example, the META Zonal Referral Hospital in Mbeya – treat an above-average number of high-risk patients from a large catchment area and thus register a correspondingly high number of deaths.

In addition to data quality, causal attribution is also a problem. It is virtually impossible to provide statistical proof that the project had a causal effect on maternal and neonatal mortality. Nevertheless, it appears plausible that the number of deaths among mothers and newborns in the target regions has decreased as a result of the project implementation. This was also confirmed by the doctors and nurses at the health care facilities who were surveyed during the ex post evaluation as well as by the regional/district medical officers who were interviewed (RMO/DMO). Based solely on the improved supply of medicines and equipment, these health workers felt that the programme had a positive effect on the number of deaths in their facilities.

We can therefore assume that the programme has had a positive overarching developmental impact overall, although the available data and the problem of causal attribution do not allow a clear conclusion to be drawn.

Impact rating: 3

[13] For example, the estimated maternal mortality rate for 2010 of 454 is within the 95% confidence interval [353; 556], and the estimated rate for 2015/16 of 556 is within the 95% confidence interval [446; 666]. The confidence intervals overlap, and as such the estimated values for 2010 and 2015/2016 do not differ from one another to a statistically significant extent. See also the Tanzania Demographic and Health Survey 2015/2016.

Sustainability

The financing of the Tanzanian health sector is still heavily dependent on external donors. In the 2014/2015 financial year, external donors accounted for around 37% of total health expenditure. Private households accounted for roughly the same share. Only around 28% of health expenditure was financed from public funds.[14] Even the introduction of compulsory health insurance (SNHI, Single National Health Insurance) will only go a small way towards resolving the problem of underfunding in the health sector.[15] Health expenditure for the poor population will continue to require heavy subsidisation, which will be virtually impossible without funds from external donors. The need for sustainable financing of the health sector for Tanzania as well as for many other developing countries must therefore be put into perspective.

Nevertheless, the financial sustainability of the project under evaluation must be assessed in a critical light. If the project is not extended beyond Phase II, it will no longer be possible to register women in the NHIF after a certain time, and the health care facilities would – by their own estimation – quickly revert to a situation that one medical officer described as "helping with nothing". Doctors, midwives and administrative staff at all of the visited facilities emphasised that the programme had enormous benefits for poor pregnant women and that a phasing out would have serious consequences, especially if an SNHI had not been implemented before. Many health care facilities generate a substantial part of their income from this programme and would no longer be able to cover the costs of medicines and consumables if it were phased out. It would also no longer be possible to adequately maintain and service the equipment and infrastructure financed by the programme.

Stronger establishment of the insurance concept among the general population is encouraging, although this effect could have been much greater if, for example, the integration of the CHF had been designed differently, and insured people had actually been provided with an insurance card or more specific information on how health insurance works. There are no reliable figures on the proportion of insured people in Phase I who enrolled in the CHF at their own expense following the expiry of their membership. There has, however, been a slight overall increase in the proportion of the population with health insurance for Tanga and Mbeya.[16] In addition, the project has helped to strengthen the independence of small health care facilities in particular on a sustainable basis.

The effects of the project on the NHIF are also considered to be sustainable from a structural perspective. As part of the project, the project-executing agency was able to gather important experience in insuring poorer sections of the population, as well as continuously improving its registration and billing processes. These are important steps that have prepared the NHIF for its role as a universal health insurance provider.

In keeping with its character as a pilot endeavour, the project under evaluation can be credited with important learning effects relating to the roll-out of health insurance for poor and vulnerable population groups. For example, implementing the concept resulted in the development of various innovative and practical solutions, such as registering by text message or use of the 'mother's ID' as a health insurance card.

Overall, the sustainability of the project can therefore be rated as satisfactory.

Sustainability rating: 3

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[14] See Wang, H. and N. Rosemberg (2018): Universal Health Coverage in Low-Income Countries: Tanzania's Efforts to Overcome Barriers to Equitable Health Service Access, Universal Health Coverage Study Series No. 39, World Bank Group, Washington DC.

[15] See Prabhakaran, S. and A. Dutta (2017): Actuarial Study of the Proposed Single National Health Insurance Scheme in Tanzania, HP+ Policy Brief.

[16] See Tanzania Demographic and Health Survey 2010 and 2015/2016.

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).