Ex post evaluation – Tanzania

Sector: Health (CRS code 13030)
Project: Health Reform Programme II to IV, BMZ No. (II) 2003 65 072*, (III) 2003 65 890, (IV) 2006 65 281*
Programme Executing Agency: Ministry of Health and Social Welfare (MoHSW)

Ex post evaluation report: 2014

		Project A (Planned)	Project A (Actual)
Investment costs (total)	EUR million	---	1935.00
Counterpart contribution	EUR million	---	1189.00
Funding	EUR million	20.00	20.00
of which BMZ budget funds	EUR million	**20.00	**20.00

*) Random sample 2014
**) (II): EUR 10 m. (III): EUR 3 m., (IV): EUR 7 m.

Description: The three FC financing tranches are a co-financing operation of the Tanzanian Health Sector Strategic Reform (HSSP) in its second phase (2003-2008). The basket finance was provided by 17 different donors within the framework of a sector-wide approach (SWAp). The German contribution to the budget of the health sector spanned six years. The health reform was coordinated with the country's poverty reduction strategy and was part of a comprehensive reform programme. Decentralisation was of crucial significance in this respect.

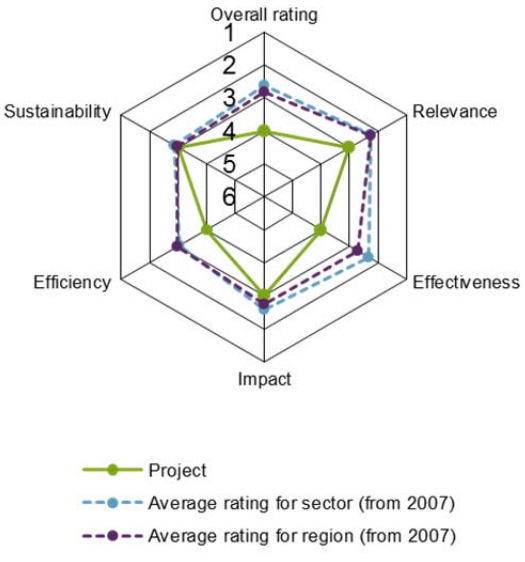
Objectives: The objectives of the FC tranches fully correspond to those of the health reform programme. The overall developmental objective of the health reform is to contribute to improving the health of the Tanzanian population by facilitating access to its health services and increase their use, quality and financing of those services. The programme's objective was to bring about a qualitative improvement in the health services.

Target group: The target group for the basket financing are the users of state-owned and non-profit health facilities with a public provision mandate, located on the Tanzanian mainland (excluding Zanzibar). This means that about 80% of Tanzanians are reached, in particular women and socially weak sections of the population.

Overall rating: 4 (Programme II - IV)

Rationale: Unsatisfactory effectiveness and efficiency with satisfactory relevance, developmental impact and sustainability lead to an overall evaluation as unsatisfactory.

Highlights: The health sector reform was based on a coherent strategy with an appropriate set of objectives. However, the parallel decentralisation reform as the main mode of implementation was not examined critically enough. Despite very weak Programme Executing Agency capacities both in the health sector and in the new decentralised management structure, it did prove possible to switch to new decentralised structures and processes in health care. But the primary health policy goals, such as improved use and quality of the health services, were not (sufficiently) achieved.



Rating according to DAC criteria

Overall rating: 4

Whether from a past or present perspective, the goals and indicators of the sector basket programme are relevant and adequate. However, insufficient consideration was given to the interdependency of a simultaneously implemented decentralisation reform on the one hand and purely sectoral reforms in the health sector on the other, i.e. the trade-off between what are actually dual objectives. Thus it has proven impossible to achieve the ambitious indicators of the basket financing, which are oriented exclusively towards sector-policy goals as well as the improved use and quality of health services. This is also reflected in the achievement of overall health objectives. These have been met where, parallel to the sectoral programme, there were financially well-resourced vertical disease control programmes (HIV, malaria, TB, vaccination) that build on and supplement the basic healthcare system. Wherever the basic healthcare services have been in demand (e.g. maternal health), the results failed to meet expectations to a significant degree. Almost no tangible progress has been made with the main healthcare systems such as medication logistics, the reference system (definition of the function of different agents and levels within the health system), staff training, recruitment and incentive systems or the improved integration of private healthcare service providers.

General conditions and classification of the projects

The three FC financing tranches are evaluated together for the following reasons:

1. In terms of their implementation arrangements, they are a coherent serial programme (basket approach in co-financing with other donors, SWAp).

They relate to the same phase of the health reform programme (2003-2008), and the agreed policy and reform measures are generally planned to take effect over the medium to long term. It is, therefore, impossible to separately evaluate the effectiveness, efficiency and overall developmental impact of the individual FC tranches, each of which has an implementation period of one to two years.

Relevance

The health SWAp was highly relevant to the extent that the Tanzanian health system had been in a lamentable state in the 90s, one which it began to recover from partially thanks to the extensive reforms contained in phase I of the reform programme (focus: general conditions of the healthcare sector), reforms whose continuation (HSSP II) was supported by the four FC tranches (focus: health improvement) that are evaluated here. The SWAp made it possible to pool donor funds and achieves a previously unheard-of level of coordinated sector financing. Even the World Health Organisation (WHO) goal of 15 % of the national budget being devoted to health spending was reached for a few years, but that figure has tended to decline again over the past two to three years. HSSP II was incorporated into a national reform package whose framework was the poverty reduction strategy. This package was shaped by the decentralisation reform of the state. The financial and administrative implementation of the decentralisation process in the health sector was the main feature of HSSP II. Thus it could be observed that, on the whole, lower priority was accorded to primary health topics such as high-quality service provision, the reference system, staff recruitment and incentive systems, the integration of church-based health institutions (PPP) and supervision/inspection etc.. This becomes particularly clear in the area of reproductive health which remains far less utilised than had been expected.

The reform package was based on the underlying assumption that, in the short to medium term, decentralisation leads to improved service quality in the health sector. Decentralisation appears to make sense in a country like Tanzania that covers so wide an area. Nonetheless, successful decentralisation also requires a strong and competent administration, which in a state with poor systems and capabilities cannot automatically be expected to result from the creation of new structures. Furthermore, when key responsibility for providing services is delegated to districts, a health reform can no longer be implemented directly, but is reliant upon interaction with the decentralisation authority and local administrations that have their own priorities, which in some cases differ from those of the Ministry of Health and Social Welfare (MoHSW).

The measures implemented in practice to enhance (provincial) structures and which were intended to take effect in the long term (20 to 30 years) meant a trade-off with regard to the short-to-medium term improvement in the population's health. It remains the case that there is an extremely unequal distribution and take-up of health services across the regions (primarily urban/rural). Despite the availability of free primary care, patients still have to make considerable additional payments (medication/consumables and out-of-pocket payments), meaning that the services have been chiefly utilised where they are offered at no cost whatsoever, specifically in the vertical disease prevention programmes (HIV/AIDS, TB, malaria, vaccinations) that were implemented outside the SWAp (and criticised for this). All treatment of pregnant women, older persons and children under the age of 5 is also now (technically) free. Moreover, the SWAp paid too little attention to the affordability of health services, which also includes issues related to logistics systems (availability of medication, patient transport).

Taking account of these ambivalences as well as trade-offs not considered at the planning stage, and in some cases an incorrect definition of priorities in implementation, we consider the relevance of the FC projects/programmes to be satisfactory.

Relevance rating: 3 (all 3 FC phases)

Effectiveness

The programme goal of HSSP II is to increase the use of medical services and improve their quality (solely sectoral objectives).

Outcome - Indicators[1]	Target 2010	2004	2010	2012	
Proportion of medically assisted deliveries	80 %	44 %	49 %		-
Prevalence rate for modern forms of contraception (15-49)	n/a	20 %	27.4 %		+
Proportion of children vaccinated against diphtheria (DPT-3)	n/a	80 %	88 %	92 %	+
Completed TB treatments	85 %	80 %	88%		+
Population is satisfied with health services	n/a	n/a	n/a	No	-
Outpatient use of health services (visits per capita)	n/a	n/a	8.5 % (2009)	6.9 %	-

A definite improvement can be confirmed for two indicators, namely TB prevention and children's health, and the clear increase in the contraceptive prevalence rate is also a move in the right direction. These are typically areas that were covered by vertical programmes and parallel projects (such as family planning via social marketing). The share of medically assisted deliveries remains far lower than expected as does awareness of HIV prevention methods, which even decreased slightly during the comparison period. While customer satisfaction with the health services grew from 1999 to 2007, a representative target group survey conducted in 2012 revealed a high level of patient dissatisfaction with health services in respect of the attitude of staff, high direct (out-of-pocket) payments and the poor availability of medication. The latter is also evidenced by a list, compiled by the WHO, of 14 generic tracer medications that were only readily available in 20 % of health facilities on the day checking took place. Stock-outs remain very frequent.

Conversely, there was a high degree of satisfaction with the free-of-charge, high-quality services provided within the disease control and vaccination programmes. It should also be noted that between 2009 and 2012, the number of outpatient clinic visits in Tanzania was comparatively low and is tending to decline.

[1] The indicators themselves are taken from HSSP II and thus from the programme appraisal reports, but their number was reduced for the purposes of the ex-post evaluation. Source for the target level: PRSP 2005, indicators without stated target programme appraisal report tranches II-III, figures 2004/10 from DHS, and for the 2012 figures the HRSP III "analytical mid-term review report".

This leads us to the conclusion that in the reform programme, which has been running for over 10 years, and despite the greatly increased sector budget, the MoHSW has not succeeded in raising the basic health services to a significantly higher standard. This still holds true if one lowers the high target criteria for institutional assistance with deliveries. The reason for this is the implementation design of the basket, which attached great importance to the administrative establishment of decentralised structures and processes but treated as secondary other core problems in the sector (e.g. demand being inhibited by e.g. out-of-pocket payments). In combination with the capacity-related planning deficits, this also resulted in absorption problems for the funds provided by donors. The positive outcomes of the vertical (off-budget) programmes would also not have been achieved in the basic services without the fundamentals (staff and equipment), but they were, at least in the short-to-medium term, more effective means of delivering services in the context of purely sectoral objectives.

Effectiveness rating: (all 3 FC phases)

Efficiency

In relation to the defined sectoral health goals, the health basket manifests a number of inefficiencies that can mainly be attributed to the underestimated or insufficiently considered trade-offs between sectoral and structural measures. When the goal of improved health provision is pursued over a 10-year period, it is not very efficient to devote time and resources to establishing decentralised structures and processes that can only become effective in the long term. Rather, the focus should be on the primary weaknesses in the healthcare system (quantity and quality of staff, medication logistics, etc.). However, in light of the country's poverty and Tanzania's dependence on donors, a question arises with respect to the perspective of the intervention: whether it is meaningful to focus on ensuring the health service provision for the population in a short/medium term or to opt for a long-term orientation on the allocation of the of scarce financial resources. In this case, a contradiction emerges. While the objectives tend to be short-term ones, the measures predominantly pursue medium to long-term goals.

It also came about, although it was not described in this way in the HSSP II sector concept or ruled out for good reasons, that over the past 10 years the healthcare infrastructure was expanded by about 50 % without nearly enough (qualified) staff or consumables being made available for this. In other words, many investments remain without impact. Even if one only considers access to health care, for a thinly populated country such as Tanzania there are probably more efficient solutions than those resulting from the construction of infrastructure, e.g. in the transport sector. Nonetheless, such considerations require a higher-level regional or even national plan/strategy. As their interests normally end with their area of responsibility, it cannot be left to provincial entities to take the relevant decisions. This means that the decentralisation of responsibility for infrastructure and staff generally harbours a (greater) risk of an even less efficient allocation of funds within the economy as a whole.

If one examines sector basket financing itself as an instrument and compares it to the financing of specific projects through the pooling of funds from donors, the former gives rise to considerable gains in efficiency in a programme as a result of the reduction in transaction costs for the MoHSW. This is the case at least in the long term because in both the short or medium term the establishment of and relationships with sectoral structures lead to process-related inefficiencies. This efficiency potential in Tanzania is, however, has not been exhausted neither by the donors nor the state. As compared to other financing instruments such as budget or sector budget financing, which link payments to implemented reform goals and achieved indicators, basket financing may be less efficient in the pursuit of specific outcome indicators, as it involves inputs agreed among donors and national entities as well as monitoring being mainly directed towards fund absorption.

Efficiency rating: 4 (all 3 FC phases)

Impact

The overall developmental goal of the health reform was to contribute to improving the health of the Tanzanian population by facilitating access to its health services and increase their use, quality and financing of those services.

Impact indicators[2]	Target 2010	2004	2010	
Reduced infant mortality per 1,000	50	68	51	+
Reduced child mortality (<5) per 1,000	79	112	81	+
Reduced maternal mortality per 100,000	265	529	454	-
Reduced HIV prevalence (15 - 24)*	n.a.	5.6%	2.0%	++
Fertility rate TFR (15-49)	n.a.	5.7	5.4	+

The achievement of the indicators defined during planning for the overall objective is predominantly positive. Fundamentally the target figures (of HSSP II, which were also established in the general budget support) appear to have been ambitious, primarily with regard to the risks and obstacles accompanying the decentralisation reform. The targets for children's health were just about reached. According to the prevailing sector analyses, this can essentially be attributed to the successes in combating malaria (largely via vertical programmes implemented by way of state structures). The same applies to the success in reducing the prevalence of HIV, which is partly attributable to changes in sexual behaviour mainly among young women as well as to the dispensing of antiretroviral medication[3]. Between 2004 and 2010, maternal mortality fell by about 16 % and is thus still well below target. A halving of the key figure had been planned. The lack of progress in the supervision of pregnancy and birth is reflected in this outcome. Maternal health was recognised to be a neglected aspect in HSSP II and was placed very high on the reform agenda for HSSP III, but this has produced no major successes to date. The fertility rate has decreased but remains high and has resulted in population growth of 2.9 % p.a. Family planning was not a priority area of the reform agenda.

All in all, it may be said that the overall developmental goals were in the main fulfilled. However, this is attributable to a broad range of varied programmes and projects and can only in part be regarded as the result of the health SWAp. In view of the groundwork on decentralised structures achieved with the basket finance, we nonetheless regard the result as satisfactory.

Impact rating: 3 (all 3 FC phases)

Sustainability

The sustainability of the programme must be assessed as ambivalent. As regards decentralisation, it is to be expected that in the long term it will prove possible to develop administrative structures that are able to plan and use funds transparently, which could improve the sustainability of the health services. On-site impressions gained from two other on-site ex post evaluations conducted in 2014 (Provision of Health Services in the Tanga region, BMZ No. 2003 65 031; Co-Financing of Social Marketing for Condoms and Contraceptives, BMZ No. 2005 65 796) seem to confirm this trend.

As far as the primary health outcomes are concerned, the result looks less positive. While health spending per capita rose sharply in recent years, this is chiefly due to greater dependence on donors in the sector (an increase from 27 % in 2003 to 41 % in 2011) and to a renewed increase in patient participation in costs (2006-09 an average of 40 % of total costs, 2012 about 60 %), which is not fair to the poor and, together with other factors, leads to comparatively low rates of use on average. It is true that the Tanzanian government's share of financing for health has also risen, but in light of an overall budget that has decreased slightly since 2010/11, no stable upswing is foreseeable. The persistently high population growth poses huge challenges to the financing of the social systems. In view of a shortfall in resources, no consistent strategy for improving the state of health of the population in the most effective and efficient man-

[2] Sources: for the target level: PRSP 2005, indicators without target: PV phases II-III, for the values 2004 to 2010: Tanzania demographic and health survey (TDHS)

* for HV the THMIS offers others figures: 2.4% *2007/08) and 2.0% *2011/12). The fall is primarily due to lower HIV rates among young women.

[3] Taking medication (ART) reduces HIV patients' contagiousness (medical prevention), while prolonging their lives, i.e. there are countervailing effects on HIV prevalence.

ner is in sight. Though the coherent strategy of HSSP II was and is correct, it is undermined by the government's parallel sectoral programmes (with donor financing). Initially, family planning did not have the political significance in the health system that it needed to have in the context of these issues. The situation is now different. All levels of the reference system also offer family planning (educational activities and a free contraceptive product range) alongside specific mother/child services in a separate section (reproductive health care, RHC) at least in urban and semi-urban regions.

Improvements in the quality of health services were partially achieved, but not to the aimed-for extent. Consequently, important subsystems in the area of health and the reference system, medication logistics and staff management continue to function inadequately. But here too isolated examples of progress, which reflect continuing reform endeavours, can be discerned (including a better structuring of the fee system, as an incentive to use the planned reference level, and an improvement in staff availability, although regional and disciplinary challenges still exist).

Sustainability rating: 3 (all 3 FC phases)

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).