

# Ex post evaluation – Tanzania

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**Sector:** 12220 Basic healthcare  
**Project:** District healthcare Tanga, CP, BMZ No. 2003 65 031\*  
**Programme executing agency:** Tanga Regional Administration, represented by the Regional Administrative Secretary (RAS)



## Ex post evaluation report: 2014

		Project (Planned)	Project (Actual)
Investment costs (total)	EUR million	16.50	39.20
Own contribution**	EUR million	11.50	34.20
Funding	EUR million	5.00	5.00
of which BMZ budget funds	EUR million	5.00	5.00

\*) Projects in 2014 random sample

\*\*) State contributions of executing agency for health sector in Tanga that were not only available to the project (including basket financing funds)

**Description:** The project is a cooperation project between FC and TC (the former DC organisations of GTZ and DED, now GLZ) to improve the health services in the region of Tanga. Based on medium-term hospital development plans (supported by TC), rehabilitation work was financed in hospitals and health centres in six districts of the Tanga region to equip the hospitals with medical devices and build new housing for staff. The financing of these measures was designed to improve patient care in the region.

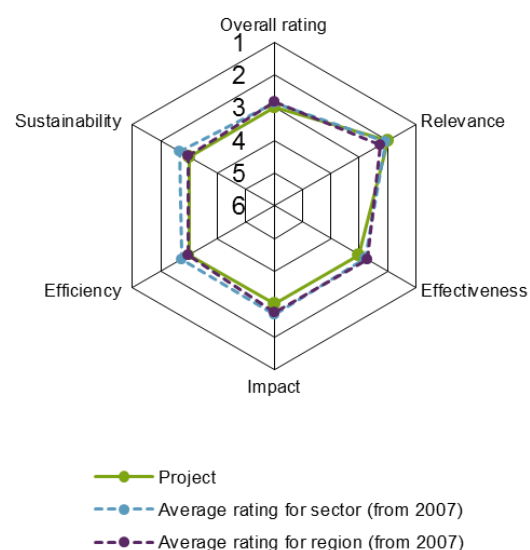
**Objectives:** Enhancing the infrastructure prerequisites to provide healthcare services was aimed at improving the use of healthcare services in the region of Tanga (project objective). This was designed to contribute towards the development policy goal of the FC measure, i.e. improving the health of the population in Tanga.

**Target group:** The target group included the population in the catchment area of the funded health institutions in the region of Tanga, which exhibits a high ratio of women – many of whom are pregnant – and children of poor sections of the population. Those who are better off mostly visit private clinics.

## Overall rating: 3

**Rationale:** The project succeeded in overcoming bottlenecks in healthcare services and making out-patient care processes more efficient. The project contributed to the marked improvements achieved at an overall development policy level. Maintenance activity is still insufficient, as is the management of waste disposal.

**Highlights:** The public healthcare system is generally available to any and all patients. However, access is limited for the very poor parts of the population – especially those in remote areas – because of the high transport costs (insufficient number of ambulances) combined with the user charges or extra payments required for medication.



## Rating according to DAC criteria

### Overall rating: 3

#### Relevance

At the planning stage of the project, core problems in the healthcare sector of Tanga arose above all from the poor quality of health care, which was evident among other things from long waiting times in hospitals, the limited availability of drugs, poor hygienic conditions and a lack of appropriate facilities for patient admissions. In addition, there was a severe lack of (qualified) personnel, and the range of services in the healthcare sector was insufficient, both in terms of quantity and quality. The project addressed these problems, but focused more on health infrastructure as well as the provision of medical equipment to improve healthcare facilities and therefore the quality of service in the region of Tanga. It was designed as an open project in order to respond flexibly to various needs and allow for adjustments during project implementation. However, it also made sense to prepare hospital development plans (supported by GIZ) required in the course of the project to ensure that FC measures are integrated into a long-term regional infrastructure development concept.

The healthcare sector was one of the priority areas of development cooperation with Tanzania at the beginning of the project, and also belonged to the priority sectors as part of the Tanzanian poverty reduction strategy. The healthcare sector is still a priority of bilateral cooperation between Germany and Tanzania. However, the focus within the sector has changed. New projects focus more on the demand side, through the establishment of the health insurance scheme for example.

The results chains underlying this concept are broadly plausible. More specifically, the implemented measures (construction and equipping) should contribute to an improved quality of healthcare services in hospitals, and thereby improve the health situation especially of those from poorer sections of society. In terms of use by the particularly poor population, the access barriers resulting from transport costs (cf. section on Efficiency) were not properly taken into consideration.

Out of a total of four healthcare service levels, the project focused predominantly on the third and fourth level of the reference system (on district hospitals as well as the regional hospital of Tanga). Primary and secondary levels were supported only in some cases. Given the support of lower levels secured by parallel projects (including basket funding) and the considerable deficits at the third and fourth levels at the time of the project appraisal, the focus is correct from today's perspective too.

#### Relevance rating: 2 (good)

#### Effectiveness

Four indicators are used to measure progress in reaching the project aim defined as “enhancing infrastructure prerequisites to provide services and improve their use”. Indicators are evaluated on the basis of data relating to FC-funded hospitals and data provided by of the Tanzanian statistical office, in addition to observations during field visits:

Indicator	Ex post evaluation
<p>(1) Increase in number of out-patients in the supported institutions (per year)</p>	<p>Overall, the number of out-patients has increased significantly since the project appraisal. This is confirmed by hospital data and other sources**. The number grew by roughly 60 % in the regional hospital of Bombo and by around 65 % in the district hospital in Korogwe (as of 2013). In the Pangani district hospital the number of patients has risen over the years, but dropped from 2012. In 2013 it fell by roughly 25 %. The reason for this decrease is the referral letter introduced in 2012. Without an appropriate referral, patients must pay a much higher charge for admission to hospital (from EUR 1 up to EUR 5).</p> <p><b>→ The indicator is fulfilled</b></p>
<p>(2) Occupancy rate of beds (quality of services through assessing use of supported facilities)</p>	<p>→ On average (with considerable variances) the utilisation of facilities is around 85 % in all supported facilities. In four of the six facilities visited the occupancy rate of beds was very high, ranging from 90 % to 110 %. By contrast, the utilisation of the remaining two hospitals visited (Pangani and Bombo) seemed to be far below capacity (with an estimated bed occupancy rate between 60 % and 70 %).</p> <p><b>→ The indicator is just about fulfilled</b></p>
<p>(3) Overall condition of equipment</p>	<p>During field visits, the general working conditions of the funded equipment and in particular the delivered autoclaves*, washing machines and generators were examined. Some of the equipment had not been in operation for some time. For instance, the autoclave was fully operational in only two out of four cases. There was barely any budget allocated for maintenance and repair. There is no preventive maintenance, while the repair process and procurement of spare parts are insufficient.</p> <p><b>→ The indicator is not fulfilled</b></p>
<p>(4) Greater staff availability in the supported hospitals (i.e. number of physicians, midwives and other medical personnel)</p>	<p>The general impression in all of the visited healthcare institutions was that there is sufficient staff availability. This is also confirmed by hospital data. There is barely any lack of specialised personnel at more attractive locations such as in urban centres. Moreover, other sources** confirm significantly better staff availability in Tanga compared to other regions in Tanzania.</p> <p><b>→ The indicator is fulfilled</b></p>

\*) Autoclave: a piece of apparatus used for sterilising medical equipment – financed through the project.

\*\*) Midterm Analytical Review of Performance of the Health Sector Strategic Plan III 2009-2015 (HSSP)

Overall the project was able to achieve its target indicators, except for the maintenance condition of the equipment. However, the growing availability of personnel in the region presents significant discrepancies between urban and rural areas. It became apparent that staff housing availability in rural areas provides an incentive for recruiting and retaining qualified personnel in the region. This was partly financed by project funds, predominantly in basic health stations and medical centres.

**Effectiveness rating: 3 (satisfactory)**

## Efficiency

The project measures were mostly carried out according to plan. The implementation of the project was extended from an original period of 36 months to 46 months. The main reasons were delays caused by construction companies failing to provide their services in a timely manner as well as bottlenecks in the supply of construction materials. The costs of the infrastructure measures are EUR 280-290 per m<sup>2</sup>. By regional standards these costs seem to be quite favourable. Yet they cannot be compared directly to other projects in sub-Saharan Africa given the highly individual composition of project measures.

By focusing on the third/fourth level in the reference system, existing supply deficits were reduced and so the requirements for the efficient functioning of the reference system were achieved. The funded infrastructure measures concentrated on the out-patient department (OPD), the rehabilitation of buildings, the construction and equipping of the Central Sterile Supply Department and on surgical departments. By focusing on out-patient departments, attempts were made to boost efficiency in management, because the out-patient department plays a key role in the hospital and is the first point of contact for the majority of patients. The construction and equipping of the CSSD facilitated better hygiene throughout the hospital. The measures did not result in broader capacities in any of the cases.

The system is still struggling with a certain overload at the third level since the hospitals do not necessarily demand referrals or make a suitable distinction between the standard entry fees – especially between the second (health centre) and third (district hospital) levels (roughly EUR 0.50 for the second level and around EUR 1.50 for the third level) to create a suitable incentive for making adequate use of the reference system.

The target group of the project is the population living in the catchment area of the funded health care institutions, most of whom come from poorer parts of society. Those who are better off mostly visit private clinics and doctor's practices. Theoretically, all four of the reference levels in the public health system are open to all parts of the population. Access, however, is limited de facto because of the problems particularly poor patients have of paying their medical bills, especially at the higher levels located in urban centres. Although Tanzanian healthcare exempts pregnant women, mothers, children under 5 and very poor people from paying medical costs, this rule is not strictly applied. It is often thwarted by users of healthcare institutions having to pay for missing medicines or for special services themselves. User fees are not the only access barrier, but also transport costs, which – depending on the case – can even be higher than the treatment costs and overall become a financial obstacle. This applies particularly for people who live in remote rural locations.

To sum up, the project's efficiency is rated satisfactory given the good production efficiency (costs/output), but also taking into account the prevailing inefficiencies in using the higher levels of the reference system and the fact that use of the system is not fully guaranteed for particularly poor people.

**Efficiency rating: 3 (satisfactory)**

## Impact

At the time of the project appraisal the ultimate objective was specified as improving the health of the population in the region of Tanga, but no indicators were set. As part of the ex post evaluation, maternal and child mortality in the region of Tanga were used as indicators:

Indicator	Status PA	Ex post evaluation
(1) Maternal mortality rate (per 100,000 live births)	Tanzania: 2004: 529/100,000 (DHS)*  Tanga: 310/100,000**	Tanzania: 2012: 410/100,000 (WHO)  Tanga: 225/100,000**
(2) Infant mortality rate (per 1,000 live births)	Tanzania: 2004: 112/1,000 (DHS)  Tanga: no info Northern Zone*** 105/1,000 (DHS Key Findings)	Tanzania: 2011: 81/1,000 (DHS)  Tanga: no info Northern Zone*** 58/1,000 (DHS Key Findings)

Sources: \*) Demographic and Health Survey (2010); \*\*) Regional Administrative Secretary Tanga; \*\*\*) Includes 3 other regions in addition to Tanga.

Both indicators confirm a marked improvement in the average health of mothers and children in the country over the last ten years. At district level, however, the indicators were not fully reliable (data sometimes contradictory) or not available. The observations and discussions on site, however, allow us to conclude that the very positive national trend also applies for the regional average.

The positive development of the indicators can be attributed amongst other things to the wide-ranging donor support, which frequently focused on aspects relevant for mothers and children and was implemented via different instruments: particularly with basket financing (partly financed from Germany) that supported the decentralised funding of basic district health systems, and with projects to support expectant mothers (free health insurance for a certain period). The contribution made by the project evaluated here concerned the rehabilitation and equipping of 6 out of the 9 public healthcare facilities at reference levels 3 and 4 in the region of Tanga. They represent a key pillar for the treatment of illnesses suffered by the roughly 2.4 million inhabitants of the region, over and above basic health issues. Accordingly, it is assumed that the project has helped the positive trend.

**Impact rating: 3 (satisfactory)**

### Sustainability

Use in the future of the funded healthcare institutions is essentially determined by the annual growth in the population (roughly 3% p.a.) and the increase in the share of insured people – even though the current incentive system tries to promote the use of the primary and secondary levels via slightly differentiated user fees and the referral letters for higher levels (a system not stringently adhered to). This is all designed to relieve the pressure on the higher reference levels and ensure more efficient use. The insurance systems now introduced exert a positive impact on the suitable use of the facilities because they are increasingly called upon through the insurance. Local discussions also revealed that the number of insured patients (via the National Health Insurance Fund (NHIF) or Community Health Funds (CHF) for example) is rising at a disproportionately high rate as patient numbers increase. Consequently, the overall relevance of these insurance systems for the use of the healthcare services on offer (both public and private) has risen, and will be increasingly important in the future too. This could also be a factor that improves access to medical care at the third and fourth reference levels for the particularly poor rural population.

Healthcare in the medium term will be dependent on significant external financial contributions amounting to roughly 30% of the total costs. The proceeds from user fees and insurance systems are not nearly enough to cover the running costs of basic health services. And demand for health services is set to rise further in the coming years due to demographic growth. At the same time, the volume of external funding

in healthcare has fallen slightly in recent years. A renewed increase is currently not anticipated. It remains to be seen whether the favourable economic growth in Tanzania at present (4% per capita per year) can be used to reduce this donor dependency in the coming years.

There are no apparent constraints either regarding the recruitment of medical personnel for the higher reference levels, which are always located in urban centres. By contrast, finding qualified personnel for remote rural areas is still difficult. The regional administration endeavours to resolve this by means of financial incentives (swift payment of salaries, staff accommodation or furniture).

The project attempted to promote a culture of maintenance. However, the field inspection made it clear that maintenance is a problem at all of the facilities visited. In the district hospitals there is hardly any budget available for maintenance (if there is one, it is <1 % of the hospital budget), which is why little maintenance of equipment takes place. Furthermore, only one person is responsible for all the maintenance of complex equipment in the region, which means for roughly 35 healthcare facilities at the second or higher level. The realisation that a maintenance system is required both for buildings and equipment does not seem to have risen much over the years.

In summary, the good and rising usage intensity expected of the funded health facilities and the improved availability of medical personnel in combination with the ongoing failings in maintenance result in satisfactory sustainability.

**Sustainability rating: 3 (satisfactory)**

### 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:

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

Ratings level 1-3 denote a positive assessment or successful project while ratings level 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. Ratings 1-3 of the overall rating denote a "successful" project while ratings 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" (rating 3).