Tanzania: Health Sector Reform /
Promotion of Reproductive Health Including the Prevention of HIV/AIDS

Ex post evaluation report

OECD sector	13030 / Health	
BMZ project ID	2000 65 813	
Project executing agency	Ministry of Health	
Consultant	not applicable	
Year of ex post evaluation report	2008	
	Programme appraisal (planned)	**Ex post evaluation (actual)**
Start of implementation	Q4 2001	Q4 2001
Period of implementation	24 months	24 months
Investment costs	EUR 705.6 million (FY 2000/01-2002/03)	EUR 776.8 million (FY 2001/02-2003/04)
Counterpart contribution	EUR 354.1 million (FY 2000/01-2002/03)	EUR 381.3 million (FY 2001/02-2003/04)
Financing, of which FC funds	EUR 5.1 million	EUR 5.1 million
Other institutions/donors involved	DANIDA, DFID, Irish Aid, the Netherlands, NORAD, SDC, World Bank, GTZ	DANIDA, DFID, Irish Aid, the Netherlands, NORAD, SDC, World Bank, GTZ
Performance rating	3	
• Relevance	2	
• Effectiveness	3	
• Efficiency	3	
• Overarching developmental impact	3	
• Sustainability	3	

Brief description, overall objective and programme objectives with indicators

The Tanzanian government has been pursuing a comprehensive reform programme since 1994/1995 with a view to improving health care services for the population (Health Sector Reform Programme). The reforms are intended to address the core problems of the sector and aim to decentralise responsibilities, prioritise basic health care services and preventive measures, and improve efficiency and coordination in allocating scarce resources. The German FC funding contributed to a basket fund which was set up jointly with DANIDA, DFID, Irish Aid, the Netherlands, NORAD, SDC, the World Bank and GTZ in 1999 to support Tanzania's health sector reforms as part of a common sector strategy (SWAp). The German FC contribution specifically focused on improving basic health care services and comprised measures to promote reproductive health and HIV prevention. The Tanzanian government agreed to incorporate non-budgeted measures worth EUR 5.1 million to promote reproductive health and

the prevention of HIV/AIDS into the basket fund, including contraceptive DMPA injections which had hitherto been financed under a FC sector programme (BMZ ID 1998 66 443).
The programme was a combination or mixture of an FC project (in the area of reproductive health and HIV/AIDS prevention) and a basket fund. Therefore, this ex post evaluation report sets out to evaluate the effectiveness of both approaches. The findings concerning the basket fund is essentially based on the conclusions of a joint evaluation of the Tanzanian health sector that was published in 2007 ("Joint External Evaluation – The Health Sector in Tanzania, 1999-2006"). In order to take account of the additional measures that were introduced by the German FC programme, internal KfW documents and data on the family planning and HIV/AIDS situation in Tanzania were analysed (Demographic and Health Survey, WHO and World Bank data). In addition, use was made of current data on the Tanzanian health care sector as published in the Health Sector Performance Report (HSPR, 2008).
The overall objective of the health sector reform and, therefore, of the German FC programme was to improve the health status of the Tanzanian population and of women, children and the poor (target groups) in particular. Since the FC programme was part of a nationwide health care reform, the following indicators were used in this ex post evaluation to measure to what extent the overall objective had been achieved: a reduction of infant, child and maternal mortality rates, an increase in the rate of skilled attendance at delivery, an increase in the immunisation rates for diphtheria, polio and tetanus among children aged 12 to 23 months and a reduction of HIV/AIDS prevalence and of the birth rate.
The health sector reform also aimed at using and allocating resources more efficiently and more effectively so as to improve both the provision and quality of health care services. Since the German FC contribution was part and parcel of a wider sector reform programme, its programme objective was likewise to improve the quality of health care services, particularly in the field of reproductive health and HIV/AIDS prevention. To achieve this objective, the programme proposed to ensure adequate supplies of laboratory materials, drugs and contraceptives, and to finance related infrastructure measures. The German FC contribution did not define any programme target indicators of its own. Rather, it used the corresponding indicators of the health sector reform programme. The latter refer to structural and institutional changes in the health care sector and are defined as follows:

a. Develop national standards for a basic health care package, train management teams at the district level to implement them and introduce a quality assurance system.
b. Make national institutions fully operational to monitor multi-sector HIV/AIDS initiatives and train their staff.
c. Integrate the health sector reform programme into the government's "Medium-Term Expenditure Framework" (MTEF) and ensure that a minimum of 50% of donor funds in the health care sector are accounted for by the MTEF.
d. Introduce and operate planning and management systems in 30% of the 114 districts and use block grants for funding purposes which are linked to project objectives, outcome and performance.
e. Set up and use a national multi-sector HIV/AIDS fund.

Project design / major deviations from the original programme planning and their main causes

The sector reform programme comprised a large number of individual measures which were listed in the health ministry's budget and were approved by the Basket Finance Committee. New planning and management systems were introduced at the central and local levels to improve the efficiency and quality of health care services. Financial resources from the basket fund were mainly used to cover running expenses and, to a lesser extent, to make reinvestments. At the given stage of development, no new investments were proposed, because they did not seem to make sense. Infrastructure reinvestments were used for basic health care facilities in order to improve, for instance, the infrastructure available to diagnose HIV/AIDS patients and treat related infectious diseases.
The German FC programme was set up in cooperation with GTZ. Technical Cooperation measures included consultancy work in the field of health care funding, district management, HIV/AIDS prevention and reproductive health. The combination of Financial and Technical Cooperation proved effective. The FC programme was implemented over a 24-month period as had been scheduled. At the time of programme appraisal, FC funds were earmarked only for the first stage of the health sector reform (in FY 2001/02 and 2002/03), but the last disbursement of

FC funds did not take place until the second stage was underway (in FY 2003/04), due to delays in the implementation at district level and in drawing up the district health plans in particular. However, there were no major deviations from the original concept of the programme.

Key results of the impact analysis and performance rating

The programme reached the defined targets for most indicators of the overall objective:

a. Even so, no progress was made in reducing maternal mortality since the programme was launched. The mortality ratio even rose from 529 (in 1996) to 578 maternal deaths per 100,000 live births (Tanzanian Demographic and Health Survey, DHS, 2004/05). However, this increase may be due to improvements in data quality.
b. The rate of skilled attendance at birth rose from 44% (Tanzanian Reproductive and Child Health Survey, TRCHS, 1999) to 51%, (HSPR, 2008), although approximately 40% of the health care centres do not have separate rooms to attend to mothers and children.
c. Infant mortality decreased from 99 (TRCHS, 1999) to 58 (HSPR 2008) per 1,000 live births.
d. Child mortality among children under the age of five sharply went down from 146 (TRCHS 1999) to 91 (HSPR 2008) per 1,000 live births.
e. The fight against diphtheria, polio and tetanus among children also made some progress, as the following figures show: immunisation rates among 12 to 23-month old children increased from 81% (TRCHS 1999) to 87% (HSPR 2008) in 2006, but in 2007, the rate dropped again to 83% (HSPR 2008).
f. The prevalence of HIV/AIDS among adults decreased to approximately 6.2% in 2007, according to World Bank statistics (down from 8.8% in 2003, according to WHO). This means that there is a fair chance to reach the Millennium Development Goal, which calls for a prevalence rate of 5.5% by 2015.
g. The birth rate dropped from 5.6 in 1998 (World Bank) to 4.9 in 2004 (WHO).

Even though these positive developments cannot solely be ascribed to the SWAp and the basket fund, it is fair to assume that they made a positive contribution to achieving the overall objective.
For the most part, the indicators of the programme objectives have been achieved as well:

a. National quality standards were introduced for basic health care packages, infrastructure facilities, equipment, quality assurance and staff. Management teams at the district level were trained to implement them. However, the qualification of the staff was not yet adequate to ensure effective quality assurance at the district level.
b. National institutions to monitor multi-sector HIV/AIDS initiatives were found to be fully operational and their staff had been trained.
c. The health sector reform programme was integrated into the government's MTEF, and 61% (vs. a target value of 50%) of the donor funds in the health care sector were accounted for by the MTEF in fiscal 2002/03.
d. Reformed planning and management systems and block grant funding were introduced in all 114 districts.
e. A national multi-sector HIV/AIDS fund was set up.

In addition to the trends in the indicators described, it was also essential for the achievement of the programme objective - enhancing the quality of health care services - to substantially improve the national systems for the distribution of drugs, medical supplies and equipment, the infrastructure and the health care information system. According to current estimates, 90% of all Tanzanians live within five kilometres of a health care facility. In that respect, both the district authorities and the hospitals (in the field of secondary and tertiary care) have an important role to play in improving health care services. However, the fact that hospitals had been given management responsibilities proved one of the essential weaknesses of the reform process. Problems are rooted in delays in the allocation of funds, poorly trained staff and severe shortcomings in ensuring drug supplies and maintaining infrastructures and equipment. Also, there were hardly any improvements in transport management, which had a negative impact on the accessibility and usability of health care facilities, putting poor population groups from remote rural areas at a severe disadvantage. The quality of health care services, particularly in the field of combating HIV/AIDS and malaria improved. The contraceptive prevalence rate

remained more or less stable, running at 25% in 1999 and 26% in 2004/05. Obviously, this is not satisfactory, given the high investment volume in this area.
The target group defined at the time of programme appraisal comprised the users of health care facilities that were open to the general public and run by government, private and church agencies. This definition was supposed to cover approximately 80% of the population, including women and socially disadvantaged groups that were severely affected by the HIV/AIDS epidemic and were specifically targeted by the FC programme. In general, we assume that the sector reform programme managed to reach out to this target group. As regards its support for women and disadvantaged population groups, it should be noted that, according to the final review, public health care facilities repeatedly reported significant shortages of certain contraceptives, which leads us to the conclusion that the needs of that target group were met only to a limited extent. In rural areas of the country, there was only very limited availability of health care services for HIV/AIDS prevention and treatment.
The sector reform programme made a direct contribution to poverty reduction (policy marker SUA). In Tanzania, the share of poor people in the overall population (target group) is 36% (World Bank 1999-2005). The programme improved the living conditions and the productive potential of the poor, who are particularly affected by diseases such as HIV/AIDS and by reduced life expectancy. At the district and local levels, the poor were involved in planning and managing health care services, even though their participation, especially at the municipal level during the first phase of the health sector reform, did not meet the expectations. In order to guarantee access to health care services for poor population groups, the poor, children and the elderly were exempted from the fee system introduced by the reform. Reproductive health care services were also provided free of charge.
The programme had a positive impact on gender equality. Women benefited particularly from measures to improve reproductive health care. For that reason, the programme is marked as G1. The programme was not intended to promote environmental protection and resource preservation. Nor did it have any significant adverse effect on the environment (policy marker UR 0). Participatory development and good governance were crucial for the implementation of the programme. The health sector reform has significantly stepped up the pace of decentralisation and has given the poor a more important role in the decision-making process (PD/GG 2).
We have arrived at the following conclusions regarding the programme's developmental effectiveness:
Relevance: The concept of the sector reform programme was appropriate to help address core issues in the health care sector such as funding gaps, shortcomings in the budget allocation process and in donor coordination, centralised structures, the inadequate skill level of staff and the insufficient quality of health care services. The poor health status of the population, particularly as caused by the spread of the HIV/AIDS epidemic, continues to be a major hindrance to the social and economic development of Tanzania and has been given top priority in the Tanzanian government's poverty reduction strategy PRSP II. It is fair to assume that any improvement of the health status would make a significant contribution to poverty reduction by producing both direct effects (e.g. by improving the performance of the workforce and promoting the built-up of human capital) and indirect effects (e.g. by avoiding illness which may lead to crop losses, income losses, a waste of skills etc.). Three out of eight Millennium Development Goals (MDG) are related to the improvement of the health care situation, which is also the overall objective of the programme: reduce child mortality (MDG 4), improve maternal health (MDG 5) and combat HIV/AIDS, malaria and other diseases (MDG 6). The German FC programme was integrated into Tanzania's health policies and into a sector-wide approach (SWAp). It was drawn up and implemented in close coordination with the donor community as part of a basket funding scheme. Moreover, the health care sector is one of the three focal points of development cooperation between Germany and Tanzania. Due to the large number of donors involved in the SWAp, there was a guarantee that the programme would be in line with the national health care policy objectives. In addition, large bilateral and multilateral programmes (GFATM, JICA, USAID) provided the Tanzanian health care sector with funds to step up HIV prevention and combat malaria and tuberculosis. However, this effort had not been integrated into the sector-wide approach, which in some instances led to distortions and shifts in the allocation of personnel and financial resources. Even so, the relevance of the programme is rated as high (sub-rating 2).

Effectiveness: The programme reached most of its objectives, as shown by the indicators discussed above. The indicators were defined as criteria that determine the framework of the health care sector, assuming that the quality of health care services cannot be improved unless these criteria are met. This approach is well warranted considering the character of the project which was drawn up as part of a programme-oriented basket fund for the early stages of the health sector reform, with priority given to structural reforms. However, weaknesses persist particularly in areas such as staff training, the participation of the population, reproductive health care services and hospital reform. According to DHS data, the contraceptive prevalence rate in Tanzania remained more or less stable between 1999 and 2005. During the implementation phase of the FC programme, it was not possible to ensure adequate supplies of all contraceptives (combined oral contraceptive pills, condoms, DMPA injections) at all public health care facilities, which reduced the effectiveness of the programme. Therefore, the effectiveness is rated as satisfactory (sub-rating 3).

Efficiency: The introduction of the SWAp and the basket fund led to efficiency gains, as different regulations and strategies of donor organisations were superseded by harmonised and/or coordinated procedures. Yet there is still further need to streamline the monitoring and coordination processes of the donors. The introduction of the basket fund to sponsor the health sector reform helped secure and increase funding for the health care system. At the local level, too, regional block grants, which are linked to programme objectives and performance goals, helped to provide a sound financial basis within the districts. The reform of planning and management systems increased the production efficiency in all districts. Major progress was made in the planning and budgetary processes and in the management and quality assurance of health care services at the local level. However, the reference system, which is crucial for the efficiency of the health care system, did not substantially improve, driving up treatment costs. Staff training, which also has a considerable influence on the efficient use of resources, made some headway, but still has a long way to go, particularly at the local level. There were hardly any efforts made to develop the transport system. As regards the efficient allocation of resources under the programme, there was a rise in the share of preventive health care spending and HIV/AIDS resources in the overall budget. Efficiency and equality criteria were used to allocate the budgetary funds to the districts, taking account of their population, poverty and morbidity profiles. All told, we consider the efficiency of the programme to be satisfactory (sub-rating 3).

Overarching developmental impact: As discussed above, the overall objective was achieved, except for an improvement of maternal health. Particularly, infant and child mortality showed positive developments. Immunisation campaigns, effective tuberculosis control, food supplement programmes, improved malaria diagnostics and treatment, improved drug availability and increased usage of mosquito nets all had a positive impact on health indicators. The sector reform programme brought about structural changes in many areas, which should pave the way for improving the quality and efficiency of health care services. Moreover, both the prevalence of HIV and the birth rate decreased during the implementation of the sector reform. In summary, the overarching developmental impact is rated as good (sub-rating 2).

Sustainability: The programme has led to structural reforms that will have long-term effects on the health care sector. The sector-wide programme (SWAp) and the basket fund both take a long-term approach, even though some donors will provide budget financing in the future. The number of donors involved in the basket fund has increased to 11, which may be seen as evidence of the growing trust in this financing tool. Both per-capita spending on health care (rising from USD 4.20 in 2000 to USD 14.00 in 2007/2008) and the share of health care spending in the overall budget (rising from 8% in 2000/01 to 10.8% in 2007/08) have progressed. In line with the regional context, donor funds do make a large contribution to funding the health care system. But the fee system, the health care fund of the municipalities and the health insurance system for state employees also provide finance, albeit only on a small scale so far. This diversification in the funding of health care services has improved the health care system's resilience to crises. The relevant institutions, particularly the ministry of health and the local health authorities, have assumed new roles, boosting the implementation of the reform. However, shortcomings in the skill level, mindset and placement of health care staff (particularly in rural areas where staff turnover is high and understaffing is a severe problem) continue to have adverse effects on the sustainability of both health care programmes and services. Overall, the sustainability is rated as satisfactory (sub-rating 3).

Overall rating: All told, the overall performance of the programme is rated as satisfactory (rating 3).

General conclusions and recommendations

- The approach of incorporating the FC programme into the larger sector programme (SWAp) has proven successful in promoting health care sector reforms. However, coordination among donors needs to be improved.
- The basket fund is an innovative financing tool that helps reduce coordination efforts for the government and raise additional funds for the sector. The basket fund did not lead to a 'crowding out' of the government's own contributions. It is important to consistently introduce transparent finance systems at government and project executing agencies from the outset to hold them accountable for the use of the funds provided and minimise the risk of misallocations.
- At the next stage of the reform programme, there should be more participation of the population in order to expand access to health care services for the poor and improve the operation and maintenance of health care facilities. Decentralisation should be stepped up by clearly defining the competencies of newly-founded and/or reformed institutions, i.e. by assigning clear rights and responsibilities at all regional levels.
- As approximately 40% of all health care services in Tanzania are provided by non-governmental facilities (NGOs, private sector), there is a crucial need for coordination among the public, private and ONG sector (e.g. involvement of non-governmental service providers in the planning and management of health care services at the district level, conclusion of financing and service level agreements etc.).

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

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

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

A rating of 1 to 3 is a positive assessment and indicates a successful project while a rating of 4 to 6 is a negative assessment and indicates a project which has no sufficiently positive results.

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 an improvement is very unlikely. 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. A rating of 1 to 3 indicates a “successful” project while a rating of 4 to 6 indicates an “unsuccessful” project. In using (with a project-specific weighting) the five key factors to form a overall rating, it should be noted that a project can generally only be considered developmentally “successful” if the achievement of the project objective (“effectiveness”), the impact on the overall objective (“overarching developmental impact”) and the sustainability are considered at least “satisfactory” (rating 3).