Tanzania: Joint Social Services Programme – Health, Phase II

Ex-post evaluation report

OECD sector	12230/Basic health infrastructure	
BMZ project ID	1997 65 355	
Project executing agency	Christian Social Services Commission (CSSC)	
Consultant	--	
Year of ex-post evaluation report	**2009**	
	Project appraisal (planned)	**Ex-post evaluation (actual)**
Start of implementation	Q 1 1998	Q 3 1998
Period of implementation	40 months	69 months
Investment costs	EUR 3.4 million	EUR 3.4 million
Counterpart contribution	---	---
Finance, of which FC funds	EUR 3.4 million	EUR 3.4 million
Other institutions/donors involved	GTZ, EZE, KZE	GTZ, EZE, KZE
Performance rating	3	
• Relevance	2	
• Effectiveness	3	
• Efficiency	3	
• Overarching developmental impacts	3	
• Sustainability	3	

Brief Description, Overall Objective and Programme Objectives with Indicators

Phase II of the Joint Social Services Programme – Health (BMZ ID: 1997 65 355) was part of a multilateral cooperation by the German churches (EZE, KZE/Misereor), KfW and GTZ with the Tanzanian churches, represented by the programme executing agency, the Christian Social Services Commission (CSSC). In Phase II, the measures from Phase I (BMZ ID: 1993 65 743) were largely continued with FC funds. Phase I had comprised support for four Tanzanian districts (Bunda, Dodoma, Sengerema and Tunduru) in equipping, constructing and rehabilitating church health care facilities. Additional Measures were added in Phase II: the initial endowment of a revolving drug fund, the construction of personnel housing at health care facilities and setting up zonal maintenance services. Support was given to both church and government facilities. In a complementary TC measure, health personnel were qualified in technical and organisational matters as well as in management methods. The authorities of the German churches bore most of the finance for the executing agency, CSSC.

The programme objective was the nationwide improvement in the quality of services by the church health care facilities, particularly in the four programme districts already promoted in Phase I. This was to make a contribution to improving the health status of the rural population of Tanzania (overall objective). Programme objective indicators were: increased use of the rehabilitated health care facilities, use of the delivered technical medical equipment and its functionality as well as the permanent availability

of 80% of the drugs supplied in three-quarters of the hospitals with drug funds 24 months after introduction. The programme appraisal set no initial indicators for the overall objective achievement. At ex-post evaluation, the indicators applied were the decline in maternal mortality and the reduction in the mortality rate of children under five years of age.

Programme Design/Major Deviations from Original Programme Planning and Main Causes

Phase II of the sectoral programme was conceived and implemented in an open format. At appraisal, the plan was to rehabilitate up to 6 church hospitals, build or rehabilitate about 40 basic health stations and hospitals as well as construct and partly renovate 26 personnel housing units. Altogether 6 hospitals and 20 basic facilities were actually rehabilitated in the 4 programme districts and 33 standard personnel housing units financed nationwide at 13 church hospitals. The deviations in the number of rehabilitations were due to the larger rehabilitation needs ascertained at the health care facilities during programme implementation and the substantial rise in building costs. The increase in the number of rehabilitated or furnished and fitted personnel housing units from 26 to 33 is generally attributable to efficient planning. Three of the four planned maintenance services were set up in Phase II. Residual funds from Phase II were used in Phase III to build and to fit out the fourth maintenance workshop.

Owing to the high supervisory input largely due to the many locations and their nationwide distribution, the period of implementation was extended from 48 planned months to 69.

Key Results of Impact Analysis and Performance Rating

The target group of the programme was the poor population of Tanzania, primarily in the four rural programme districts in Tanzania. The majority of the inhabitants in these districts is poor. 38% of the rural population earn less than the equivalent of about EUR 8 per capita and month (national poverty line). The monthly average income in 2007 in the programme's Tunduru District amounted to EUR 24 per person, as compared with about EUR 50 in Dar es Salaam. Recurrent bad harvests exacerbate the precarious situation for rural households. After meeting basic needs, only an average 1.8% of household budgets can be spent on health in rural areas. According to our assessment, the target group can therefore be considered as reached.

We assess overall developmental efficacy as follows:

A goal of the current national health development plan is the quantitative and qualitative improvement of health care facilities. The overall objective of contributing to improving the health status of the rural population in Tanzania implicitly supports the attainment of MDGs 4 and 5 (reduce child mortality; improve maternal health) and hence conforms with key goals of German development cooperation. The health sector has been a priority sector of development cooperation with Tanzania since the end of the nineties. The measures in Phase II were aligned with national sectoral strategies, which provided a frame of reference for international programmes/projects and guaranteed a concerted donor approach. Thanks to the integrational cooperation approach in German development cooperation, as also included in the design of the two programme phases, cooperation could be stepped up with other donors and major influence exerted on the direction of sectoral development. We therefore classify the programme's relevance as good (Subrating 2).

The programme objective - the nationwide improvement of service quality in church health care facilities measured by higher user rates, the use and functionality of the equipment supplied and the availability of drugs - was met in part. Despite financial difficulties and a shortage of skilled personnel, patient use has largely stabilised and even partly increased according to information from interviews. The buildings and equipment provided and rehabilitated have enabled the implementation of national

health programmes and the delivery of basic health care. The maintenance centres make a contribution to servicing the infrastructure and have initiated a change in attitudes towards preventive maintenance. The established revolving drug funds have not proved to be sustainable. This measure did, however, at least draw attention to the issue of charging fees in the facilities involved. Cooperation of the programme executing agency CSSC with the promoted public health care facilities has stepped up communication between the government and church operators and among all those responsible at all levels, resulting in improved services. Altogether, we assess the effectiveness of the programme as satisfactory (Subrating 3).

The actual rehabilitation needs of the individual health care facilities proved to be considerably larger than assumed at project appraisal after the selection of the buildings (open programme). Since the building costs also rose substantially during implementation and the broad distribution of the facilities incurred additional costs and delays, fewer health care facilities were rehabilitated than planned, but additional personnel housing was built at individual locations. The ex-post evaluation found that the building quality was high by national standards (e.g. no moisture in the rooms thanks to good ventilation, hygienic waste water collection). We consider the total costs of the programme to be adequate. Improved health care can be expected to have made a contribution to higher labour productivity, fewer losses of working hours due to illness and hence to higher rural standards of living. Altogether, programme efficiency is gauged as satisfactory (3).

The infrastructure provided by FC has made a contribution to basic care and the implementation of national health programmes in the rural areas of Tanzania where outreach was previously limited. In all probability, the implementation of the national mother-child health programme in the buildings provided contributed to improving health in the programme regions. This is also indicated by the sectoral figures on maternal and child health. The maternal mortality rate in 1998 amounted to 392 deaths per 100,000 live-births in the programme district Tunduru, for example. This figure had improved to 251 by 2007. Comparative figures for the other programme districts are not available. Since project appraisal, the infant mortality indicator has also improved continuously. The indicator in 1996 still amounted to 160 deaths per 1,000 live-births nationwide, while an average of 105 children under five years died between 2002 and 2004. For 2008, infant mortality came to 91 per 1,000 live-births. This development is also discernible in the promoted programme districts. The indicator in Tunduru District declined from 222 deaths in 1994 to 183 in 2007. Altogether, we judge the overarching developmental impact to be satisfactory (Subrating 3).

Due to the good building quality and in view of the ongoing reforms in financing the Tanzanian health care system (basket finance, national insurance systems, patient fees), we expect the promoted infrastructure to be sustainable in the medium term. The current national health development plan provides for intensive measures to meet the large need for specialist staff. This, however, calls for time-consuming improvements in secondary and tertiary education and an adequate system of incentives, particularly for skilled personnel in rural areas. Due to the financing arrangements for health care facilities till now, virtually no maintenance planning has been conducted. This is changing, however, primarily due to the decentralisation of operational responsibility and direct funding, which will enable the maintenance facilities to consolidate and develop their services. The sustainability of the developmental impacts of the programme phase depends decisively on future progress in sectoral reform. Close dialogue between the donors and the Tanzanian Government in strategy development and implementing sectoral reform, in which German development cooperation is also intensively involved, afford promising intervention points for co-shaping future sectoral development. Sustainability is judged to be satisfactory (3).

In all, we assess the developmental efficacy of the programme as satisfactory (Rating 3).

General conclusions

Where programme executing agencies are specially founded to carry out programmes, they should receive support in institutional development, not just financial assistance. Special attention should be paid to the multiplier role for information transfer between the government level and non-governmental operator units.

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 ("effec-

tiveness”), the impact on the overall objective (“overarching developmental impact”) and the sustainability are considered at least “satisfactory” (rating 3).