Togo: Rehabilitation of basic health care centres in the central region

Ex post evaluation

OECD sector	12230 – Basic health care infrastructure	
BMZ project ID	1995 66 803	
Project-executing agency	Ministère de la Santé Publique (MSP) and its regional directorate in the central region	
Consultant	GTZ (international services for construction measures and procurement)	
Year of ex post evaluation	**2006**	
	Programme appraisal (planned)	**Ex post evaluation (actual)**
Start of implementation	Q2 1996	Q4 1996
Period of implementation	33 months	47 months
Investment costs	EUR 2.9 million	EUR 3.0 million
Counterpart contribution	EUR 0.1 million	EUR 0.2 million
Financing, of which Financial Cooperation (FC) funds	EUR 2.8 million	EUR 2.8 million
Other institutions/donors involved	GTZ	GTZ
Performance rating	4	
• Significance / relevance	4	
• Effectiveness	4	
• Efficiency	5	

Brief description, overall objectives and project objectives with indicators

The objective of the cooperative project involving GTZ (TC) and KfW (FC) was to improve the efficiency of health care facilities in the central part of Togo at all levels. From the FC perspective, this objective was to be achieved by improving the health care infrastructure in this region (essentially, rehabilitating existing basic health care facilities and building new ones, extending the district hospitals and a polyclinic in Sokodé, improving the regional hospital, appropriately equipping the health care facilities and important central services. The main objective was to improve the health of the people in the central region; the programme objective was to improve the efficiency of the existing health care facilities. The indicators in the ex post evaluation were a user rate (first consultations per number of residents in one year) of at least 40% and bed occupancy rates in the hospitals of 30-40%. (The target levels were therefore lowered by comparison with the programme appraisal, which set the indicator values for the user rate at at least 60% and for the bed occupancy rate at at least 50%.

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

The project was carried out as an open programme in cooperation with GTZ and was largely in line with what had been planned. The TC measures targeted an improvement in the supply of medicines, basic and advanced staff training and the maintenance of the health care facilities.

The specific FC measures were established during the detailed planning stage. They included constructing nine new rural health stations and refurbishing 25 rural health stations, extending two provincial hospitals and an urban polyclinic as well as supplying these establishments with medical equipment including a cold chain for vaccination programmes. Together with the regional hospital in Sokodé, to which a blood transfusion centre and a maintenance centre has been added, this led to a fundamentally autonomous supply system that is operative apart from specialist staff and the delivery of medicines. The distribution of generic medicines, for which a charge is made, by integrated local chemists shops, which obtain their supplies from a central state chemists, is intended to form the financial basis for the operation in advance of the provision of medical services.

To ensure that the facilities run as reliably as possible, in accordance with the Bamako Initiative, the various establishments (still without specialist state staff) have been made independent under an operating committee (civil society, administration, specialist staff) and with the work being spread in a three-tier system comprising health stations for basic health care and provincial hospitals and a regional hospital as reference levels.

Key results of the impact analysis and performance rating

In 2004 Togo put the bed occupancy rate at the hospitals in the central region at 36% and 50% respectively, with a uniform user rate of 38%. The two figures are well above the average in Togo of 30% for bed occupancy and 24% for the user rate and roughly correspond to the targets revised during the ex post evaluation. Current health care provision for the people in the central region, where provision was previously inadequate, has thus been improved to well above the national level.

However, the project cannot be unreservedly be considered a success because the supply system that was basically designed specifically for the purpose and largely operated with commitment is not sustainable in the underlying unfavourable socio-economic conditions that are referred to in Togo as the “crise socio-politico-économique”.

This is primarily due to the fact that the totalitarian regime that is opposed to reform is to an extent internationally isolated and has high levels of expenditure in order to keep going coupled with low DC contributions. For the health care sector, this means that the State is fulfilling its ongoing obligation to finance specialist staff less and less and has stopped financing reinvestment in health care facilities. At the same time, the top prices for medical services and medicines have been frozen at an insufficient level; in view of the fact that income has been declining for years, the people could not afford to pay any more.

In the central region in 2003, with average costs of EUR 4.38 per patient (73% above the national average) and revenues of EUR 3.77 (41% above the national average), this led to a loss of EUR 110,000 or 13.8% of turnover. The deficit can be attributed to the fact that state staff who are not replaced are increasingly financed through funds from the regional health care system. All the funds planned for maintaining salaries are being initially used for that purpose and, in the next stage, parts of the budget for medicines will be used. In that connection use is also being made of less expensive staff, who are increasingly poorly qualified, and the costly supervision and further training of staff, which is therefore becoming increasingly important, is being neglected. This is triggering a downward spiral at more and more health care facilities, which is particularly critical in the case of major damage (such as to the water supply or laboratory equipment).

The project made the health care system in the project region more attractive. The local people also make use of this improvement, particularly at the two reference levels of the prefecture hospitals and the regional hospital. However, these improvements do not currently appear to be sustainable because, as indicated, they assume a staffing and financing basis that, given Togo’s negative macroeconomic development, does not exist at present and is hardly likely to be achieved in the foreseeable future.

The programme is of direct benefit to the local people in the central region, most of whom are poor. In keeping with the project design, women and their children are the main people to take advantage of the improved health care services, including the free vaccination programmes.

With the introduction of the operator committee, which is generally functioning satisfactorily, and a partial decentralisation of the system at the regional level, the project made an important conceptual contribution to strengthening the ability of the people in Togo to help themselves. The project served as a model for the reorganisation of the health care system in other regions. It also laid the foundation for the intensification and broad application of self-help elements in health care administration.

However, the people concerned cannot take full advantage of the self-administration opportunities provided by the concept because the Togolese government is still not permitting decentralisation with general powers accordingly being devolved to the municipal or regional authorities. The individual health care facilities at the local level or at the level of the central region have so far remained isolated sectoral units. The fact that they are not linked to (previously non-existent) rural communities or independently operating prefectures or regions restricts particularly important compensatory measures in the difficult Togolese context. As well as additional protection against possible operating inadequacies, opportunities for poor people who are ill to receive support are also lacking, for example.

The central, interrelated risks for the long-term developmental policy impact of the project were invariably seen as connected with adequate staffing, appropriate repairs, sufficient availability of generic medicines and, given the fact that costs will not be covered in the foreseeable future, sufficient budget allocations. There is still a sufficient supply of generic medicines. Owing to the decrease in state budget funds, however, an inadequate but well-qualified staff cannot be maintained at present from the very inadequate funds for maintenance and further staff training and supervision. Although there is an adequate supply of medicines, the other risks therefore still apply. Owing to the self-induced “crise socio-politico-économique” in Togo, neither materials nor finance are available for the technical maintenance and repairs at all facilities in the coherently designed system to enable the relevant service units to be kept in operation. Together with the financing deficits in the areas of staffing (operation, supervision and further training), in the current underlying conditions the financing basis for the health care system in the region is insufficient.

We assess the achievement of the development goals as follows:

- The programme objective of achieving appropriate use of the health care facilities newly set up or rehabilitated has been achieved at present, given the relatively high use of the hospitals and municipal health care stations, which, as shown by the indicators, make up for the usage deficits at rural stations. However, given the financially induced staffing deficits, but particularly the deficits in maintenance and supervision, we do not consider the current indicator values for the user rate and bed occupancy rate sustainable, meaning that an inadequate degree of effectiveness has been achieved (rating 4).

- The improvement in the health care facilities has been achieved with appropriate resources (production efficiency). Most of the health care services are provided efficiently. Certain avoidable operating costs are incurred in poorly utilised health care stations and because of the ambitions (which can sometimes save patients’ lives) of some hospitals, which try to conduct operations better than in the scheduled standard. However, absolutely vital running costs for maintenance and repairs, supervision and the regional health service cannot be funded. We therefore assess the project’s development policy efficiency as clearly inadequate (rating: 5).

- The improvement in the health care services for the target group was relevant. The impact of the project on the target group is also significant as better treatment is available for as long as the improved services are provided. The construction measures carried out were the essential preconditions for the improvement. Only through a programme designed to provide a decentralised or largely autonomous health care system has it been possible despite the unfavourable underlying conditions to make the improvements over several

years. Given the lack of sustainability, however, the relevance and significance of the project are assessed as insufficient (rating 4).

The cooperative project "Rehabilitation and basic health care centres in the central region" is classified overall as having a slightly insufficient degree of developmental efficacy (rating 4).

Conclusions and recommendations

- Major risk is involved when project designs are set up to achieve global improvements in the restrictions imposed by the underlying national institutional and financial conditions when these are known to be unfavourable. This is particularly true of systems in the area of the social infrastructure, which normally require transfers from outside to ensure that they will be able to function over the long term. However, particularly in the case of projects relating to the social infrastructure, costs are rarely presented in such a way as to make the need for specific amounts of subsidies and the period of their disbursement explicit. It is, however, vital to give due consideration to a sustainable charge for use.
- When designing a basic health care programme, the feasibility of financing the total future operating costs of the planned system from the various sources must be realistically estimated, with national performance being taken into account. If the risks of underfunding were found to be relatively high, less expensive alternative models or designs or other financing models should be considered.
- This programme in the health care sector shows once again that even with the idea of decentralised operation, sectoral approaches hardly go beyond their own sectoral setting. Precisely when the project is concerned with basic services, there are frequently opportunities to integrate them successfully into the general local or regional administration if this truly is "decentralised", in other words deals with the people from its own area and has independent room for manoeuvre. This kind of integration generally improves the financing basis or risk spread for a deficient social area because the local people put pressure on the decentralised decision-making bodies if they are elected to office. Conversely, the lack of relevant local or regional structures, as in this case, is an additional indication of the high risk incurred in a programme of this kind.

Assessment criteria

Developmentally successful: Ratings 1 to 3	
Rating 1	Very high or high degree of developmental efficacy
Rating 2	Satisfactory degree of developmental efficacy
Rating 3	Overall sufficient degree of developmental efficacy
Developmental failures: Ratings 4 to 6	
Rating 4	Overall slightly insufficient degree of developmental efficacy
Rating 5	Clearly insufficient degree of developmental efficacy
Rating 6	The project is a total failure.

Criteria for the evaluation of project success

The evaluation of the "developmental efficacy" of a project and its classification during the ex post evaluation into one of the various levels of success described in more detail below concentrate on the following fundamental questions:

- Have the **project objectives** been achieved to a sufficient degree (project **effectiveness**)?
- Does the programme generate sufficient **significant developmental effects** (programme **relevance** and **significance** measured in terms of the achievement of the overall developmental policy objective defined beforehand and its effects in political, institutional, socio-economic and socio-cultural as well as ecological terms)?

- Are the **funds/expenses** that were and are being employed/incurred **appropriate** with a view to achieving the objectives and how can the programme's microeconomic and macroeconomic impact be measured (**efficiency** of the programme design)?
- To the extent that undesired **(side) effects** occur, can these be tolerated?

We do not treat **sustainability**, a key aspect to consider when a project is evaluated, as a separate evaluation category, but rather as an element common to all four fundamental questions on project success. A project is sustainable if the project-executing agency and/or the target group are able to continue to use the project facilities that have been built for a period of time that is, overall, adequate in economic terms, or to carry on with the project activities independently and generate positive results after the financial, organisational and/or technical support has come to an end.