Project evaluation: summary report

Tanzania: Programme to Support Health

Title according to the commission:	Programme to Support Health
Project no.:	2012.2243.9
Country/region:	Tanzania
CRS sector:	12110
Overall objective:	Major preconditions for equitable and sustainable access to quality health services for women, men and young people are in place and lead to use of health services with improved quality.
Overall term:	04/2013-03/2016
Total costs:	14.130.000 EUR
Commissioning party:	BMZ
Lead executing agency:	Ministry of Health and Social Welfare (MoHSW)
Implementing organisations (in the partner country):	• Prime Minister's Office for Regional Administration and Local Government (PMO-RALG) • Regional and municipal health authorities • Regional referral hospitals, district hospitals and health centres. • National Health Insurance Fund • Tanzania Commission for AIDS • Civil society organisations • Private healthcare providers • Umbrella organisations (Christian Social Service Commission, Association of Private Health Facilities of Tanzania, Association of Tanzanian Employers)
Other participating development organisations:	In the context of the Providing for Health (P4H) Social Health Protection Network: World Health Organization, Swiss Development Cooperation, United States Agency for International Development und World Bank.
Target groups as per the offer:	The population of the Regions Mbeya, Tanga, Lindi und Mtwara of approximately 7.000.000 of which 75% live in rural areas; according to the National Bureau of Statistics approximately 33% of the rural population are poor.

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Project description
Tanzania has made important progress in improving the health of the population. According to the World Health Organization, life expectancy has increased by eleven years from 2000-2012 and is now at 61 years. Over this time period, child mortality has decreased from 162 to 52 per 1000 livebirths. Progress was much slower regarding maternal and new-born health. Mortality rates stand at 432 per 100.000 livebirths and 20 per 1000 respectively. As most of these deaths are preventable by good health care, the numbers are sensitive indicators for limited access to and quality of services. Qualified human resources for health are lacking in rural areas especially. Sufficient medicines are not available and health services are not client-oriented. Private, mostly faith based health care organisations are included in the provision of basic health care through service agreements. However, these service agreements are often not paid timely by the public sector. Social health protection is not well-developed. Currently there are private insurances, the National Health Insurance Fund for employees in the formal sector and the Community Health Funds for the informal sector. According to the National Health Insurance Fund, 19.4% of the population were covered by one of these insurance schemes in 2014.

Decentralisation by devolution in the health sector is progressing slowly and lagging behind progress for example in education. At the central level, the Ministry of Health and Social Welfare and the Prime Minister's Office for Regional Administration und Local Governments are not sufficiently cooperating and coordinating. At decentral level, capacity for planning and management are still limited. Citizen participation is not well established. Despite a coherent policy and reform system, preconditions for sustainable and equitable access to quality health services are not established. The Technical Cooperation (TC) measure evaluated aims at establishing these preconditions through work in five activity areas: 1) social health protection and health financing; 2) decentralised health governance; 3) quality management with a focus on sexual and reproductive health and rights; 4) partnerships with the private sector; and 5) cooperation with civil society organisations. It is one of two TC modules in the 'Tanzanian-German Programme to Support Health' which combines TC with Financial Cooperation (FC). Contributions to essential national strategies (health financing, human resources for health, quality improvement, and public private partnerships) and concurrent capacity development for implementation of these strategies in four regions are the basis of the work. The module is implemented jointly with the partner organisations in Mbeya, Tanga, Lindi und Mtwara.

Overall rating according to the OECD-DAC criteria:	Individual rating of the OECD-DAC criteria:
To determine the TC measure's overall rating, calculate the average of the individual ratings: 14 – 16 points: very successful 12 – 13 points: successful 10 – 11 points: rather successful 8 – 9 points: rather unsatisfactory 6 – 7 points: unsatisfactory 4 – 5 points: very unsatisfactory	Relevance: very successful (14 points) Effectiveness: successful (13 points Impact: rather successful (11 points) Efficiency: successful (12 points) Sustainability: successful (12 points)

Overall the development measure is rated as '**successful**' (12.4 points).

Relevance
The population in Tanzania is not satisfied with the current health care. Client satisfaction surveys indicate that many patients have bad experiences when treated at the hospital. Especially in remote areas, there is a lack of qualified health staff and medicines are often not available. Women and men face financial obstacles and risk impoverishment in the case of illness. Out-of-pocket payments account for about 30% of total health sector resources which particularly affects the poorer segment of the population. The project addresses this situation for example by improving the availability of medicines, by supporting Local Government Authorities to recruit and retain qualified health care workers in remote areas, or by establishing complaint mechanisms and helping hospitals to improve hospital care.

The TC measure is aligned with Tanzania's national health strategy, the 'Health Sector Strategic Plan 2009-2015'. It contributes directly to the implementation of its key strategies: district health services; referral hospital services; central level support; human resources; health care financing; public private partnerships; maternal and new-born health; monitoring, evaluation, and research. Together with other partners, it contributed to the development of the Health Financing Strategy, which envisages Universal Health Coverage in the context of sustainable development goals. The expert team has supported the Public Private Partnership-Strategy and guidelines and the amendment of relevant legislation., the Human Resources for Health and Social Welfare Strategic Plan 2014-2019 and the National Health and Social Welfare Quality Improvement Strategic Plan 2013-2018.

The TC measure supports MoHSW at central level as well as health services and management in the four regions which are overseen administratively by PMO-RALG, thereby contributing to effective decentralisation in the health sector.

Furthermore, the TC measure contributes to achieving the Millennium Development Goals with regard to maternal and child health, and to combatting HIV, Malaria and other diseases. It is in line with German Development Policies in health and social protection. Its poverty orientation is reflected through technical inputs into the Health Financing Strategy. A concept and an action plan were developed that could serve as a basis for the Tanzania Social Action Fund to ensure that the poorest are members of the Community Health Funds. Health financing, quality improvement and public private partnerships are also relevant in the context of East African Integration; health is one of two priorities of cooperation between Germany and the East African Community.

The TC measure is rated as '**very successful'** for the criterion relevance.

Effectiveness

The module objective reads: 'Major preconditions for the equitable and sustainable access to quality health services for women, men and young people are in place and lead to use of health services with improved quality'. Achievement of the objective should be measurable on the basis of the indicators presented in the table below. The indicators as formulated in the project proposal were not sufficiently specific and relevant and have therefore been slightly modified for the evaluation.

Objectives indicator	Target according to the offer	Current status according to the project evaluation
1a. The number of management criteria[1] which have been met by the Community Health Funds in eight districts increased from zero criteria in 2012.	4 out of 5 criteria are met by the Community Health Funds in eight districts.	The first criterion (separation of service provision and financing) has not been met in any district and will not be met by the end of the project. Two districts fulfil all of the remaining four criteria.
1b. Enrolment in Community Health Funds has increased compared to 2012.	50% increase compared to the baseline in 2012	The enrolment trend is very positive. In one district, the indicator has not quite been achieved (but will very likely be achieved before the end of the development measure). There is only one further district where achieving the indicator is questionable.
2. Compliance of Comprehensive Council Health Plans of eight districts with national guidelines has increased according to three criteria[2].	Criterion i: = 8 districts Criterion ii > 0 districts Criterion iii > 3 districts	Criterion i: 8 districts Criterion ii: 3 districts Criterion iii: 2 districts It is uncertain if this indicator can be fully reached because the governance structures in most districts still require substantial support from central and regional level before they can be considered as functional.
3. The proportion of planned quality improvement activities that are implemented increased from 33.2% in 2013 (across 12 selected hospitals).	80 %	61 % Implementation of activities relies on financial resources which are not yet sufficiently targeted to QI in all hospitals; it is therefore possible that the project will not fully meet the target despite good progress.

[1] Criteria are: i. separation of service provision and financing; ii. Membership data systems; iii.at least annual matching funds application; iv. at least two full-time coordinators per district; v. access to selected hospital services under an extended benefit package.

[2] i. MoHSW confirms that standards are reached to qualify promotion; ii. CSOs, church and private service providers participated in the planning process; iii. plans have been approved by the governance structures.

4. Guidelines and implementation strategy for public private partnerships in the health sector have been endorsed.	Guidelines and implementation strategy for public private partnerships in the health sector endorsed.	Guidelines and implementation strategy for public private partnerships in the health sector have been approved by MoHSW and private sector partners; they were published and made available to all four regions. In addition, the Public Private Partnership-Act was revised and approved.
5. Eleven supported CSOs have made measurable progress on a scale from 0 to 10 regarding three of five management criteria (two of which are of gender relevance) since an initial assessment in 2013.	i. Financial management: >5.2; ii. Proposal writing: very weak >1.8 iii. Reporting: >3 iv. Integration of crosscutting topics (gender, disability, human rights) in their activities: > 4.7 v. Balanced gender ratio in the management committees: >4.4.	At the time of evaluation, no recent rating was available. Observations suggest that civil society organisations made gradual progress in financial management, proposal writing and integration of cross-cutting topics. Report-writing and gender-balance in the management committees remain weak. It is expected, that the indicator will be reached to a large degree by the end of the project.

It proved difficult to obtain consistent data from national partners. This may, to a certain extent, compromise the robustness of the project evaluation.

The overview shows that the degree of achievement of the objectives varies. However, many positive effects that are not captured by indicators can be observed and underline that the project has made good progress towards achieving its objective. The range of observed effects include the introduction of improved management systems (e.g. membership and data management system for Community Health Funds, quality assessment of hospital care on the basis of specific, measurable, achievable and relevant indicators) and the establishment of communication and learning forums (e.g. public private health forums; country-wide launch of the modular District Health Management Training Programme). Technical support also induced and supported important improvements such as active participation of private sector umbrella organisations in policy dialogue, better participation of civil society organisations in the national coordinating mechanism for the Global Fund, and active recruitment and retention of health staff through Local Government Authorities. No unintended negative results were reported or observed.

The TC measure is rated as **'successful'** for the criterion effectiveness.

Overarching development results (impact)

The project is contributing to the joint objective of Tanzanian German Cooperation in the health sector which aims to improve the health of all Tanzanians with consideration of vulnerable and disadvantaged population groups. Achievement of this objective is measured at programme level in terms of infant, child and maternal mortality, HIV prevalence among pregnant women and some process indicators (e.g. skilled birth attendance, availability of health workers, social health insurance coverage). According to MoHSW, the number of professional health workers in the public sector has increased from 35.202 in 2008 to 66.348 in 2014 and health insurance coverage has increased from 9 to 19.4% in the same period (Data from National Health Insurance Fund). It is plausible, that the project has contributed to both of these changes through its support for social health protection and human resource management at national level and in selected councils and districts. For the other indicators, no data is available to measure changes during the evaluated period. However it is quite plausible that the project contributed to improved health status and related factors such as gender equity, poverty reduction and the human right to health. For example, it has played an important role in policy dialogue and provided technical input into the Health Financing Strategy, which addresses the root causes of health inequities from the financing perspective. Implementation of the strategy will reduce financial barriers towards the utilisation of health services when needed and reduce financial risks of ill health. Community Health Funds allowed women working in the informal sector to benefit from health care which they could not afford in the past and thereby contributed to gender equity. This was observed e.g. during the cooperation with Olam International Ltd.'s Cashew Nut Factory in Mtwara, where over 90% of casual workers are women. Project support to Comprehensive Community Based Rehabilitation in Tanzania in advocacy and research on the inclusion of persons with disabilities in social security systems has promoted the right to health for persons with disability.

In some thematic areas, the TC measure has shown how to gear local interventions to achieving broader impact. For example, the practical model for staff tracking and retention which was developed with project support has been

documented as a national good practise in a reader published in 2014 by MoHSW with support from the Japan International Cooperation Agency. Practical manuals on the approach were developed and distributed. The approaches can be applied anywhere in the country. In contrast, other activities of the project are not yet likely to achieve broad impact. The current focus of support on only two districts per region bears major limitations. Members of the Regional Health Management Teams remarked that the limited focus created frustration and a sense of deprivation in districts that were not supported. It also contradicted their role to ensure service delivery across all districts. In view of equitable access to health care, portability of coverage across districts is an important next step in improving Community Health Funds. This involves technical challenges (e.g. cross-district validity of the membership-card) and challenges related to broader Community Health Fund design and financial management (e.g. harmonisation of benefit packages, risk equalisation). Any selective approach limits the opportunities for taking the necessary next steps towards improving Community Health Funds towards a more significant impact.

The TC measure is rated as '**rather successful'** for the criterion impact.

Efficiency

The project evaluation assessed efficiency by discussing the relationship between resources on the one hand side and outcome and impact (as described above) on the other as well as the interplay between these resources. The resources included different categories of project staff (national and international short and long term experts, development advisors and integrated experts, funds provided to partner organisations, the procurements made and the Human Capacity Development interventions (for example training, participation in conferences or coaching). The evaluation team did not attribute monetary values to resources or results. Alternatives for the selected interventions were selectively discussed during the evaluation. The assessment was based on the project proposal, the capacity development strategy, and the operational plans triangulated with observations of different interview partners.

In view of the overall project, the linkages between the individual, organisational and systemic levels of capacity development appear to be the key factor for the efficient use of resources: Efficiency was very high where the project supported capacity development at all levels and harvested synergies across these levels. This was for example the case in the activity area 4 (partnerships with the private sector), in which all intended changes materialised. Efficiency was somewhat compromised when the project was not able to achieve such synergies. This happened to some degree in activity areas 3 (quality management) and 5 (cooperation with civil society organisations): Quality improvements were achieved but were limited to the selected (twelve) hospitals because the interventions were not sufficiently embedded with policy advice and the network of relevant actors. Direct support to a very small sub-set of eleven civil society organisations in Mtwara had limited effect and no impact because design and implementation did not include sufficient capacity development at the systemic level.

The relationship between objectives and means at each level of capacity development was found adequate in most cases: At the individual level, the project has employed long-and short-term experts as advisors and financially supported technical training and coaching on-the-job. This has led to increased local capacities in all areas of activity. National partners report that this combined approach has been more useful with comparable or even lower cost than training alone. For example, working with a team of experts based in the intervention regions has proven a good model to maximise innovation and learning in management and improve the Community Health Funds with relatively limited resources.

At the organisational level, project support for planning and management processes through advisory services, manuals (for example human resource management) and structural improvements (for example computer assisted hospital management systems) have been largely adequate to reach the intended changes. Some challenges were observed regarding the deployment of Development Advisors and Integrated Experts. In some cases, lack of a clear responsibility for objectives aligned with partner needs led to premature rupture of contracts and/or limited leverage of their advisory services.

At the systems level, the project provided technical inputs for the development of strategies and policies addressing key reform issues of the health sector. The project's flexibility and ability to quickly adjust to requests from partners and arising opportunities were important elements of efficiency. National partners emphasized that this approach was efficient in view of the uncertainties and the complexity of the health sector in Tanzania. The project also fostered exchange and networking for example between civil society organisations and local government authorities, during the public private health forums or by promoting peer-based training on the job.

The project has optimised the use of resources by partner inputs and coordination with other donors. MoHSW and the subordinate authorities provided specialist personnel to implement agreed activities. Moreover, staff got leave for the period of further training and qualification at approximately 15 expert-months a year. Premises provided for further training were provided by the partners. In addition, several project interventions were designed to increase efficiency of partner resources. For example, the computer assisted hospital management systems increased revenues of hospitals by improving revenue control. The principle vehicles of coordination with other donors were the technical working groups of MoHSW and the P4H Social Health Protection Network. In general, these structures helped to avoid duplication. However, they appear to be underused for strategic coordination in view of generating synergies across the interventions of different

donors. For example, different donors (including Germany, Japan, and the United States of America) have supported utilisation of objective quality measurement instruments for many years and results based financing or payment for performance are developed in parallel. However, so far donors and MoHSW did not combine these efforts to achieve coherent quality reporting and payment mechanisms which reward quality. P4H has helped TGPSH to achieve objectives at the impact level in the activity area 1 (social health protection and health financing). However, in view of assessing the project's efficiency, this constitutes also a risk of double-counting effects of P4H and TGPSH. At implementation level, the project has cooperated with different donors to optimise the use of resources as opportunities arose. One example is cooperation with the local technical advisor for QI from JICA in Mtwara.

Efficient use of resources by coordination within German Development Cooperation was considered to some degree within the overall programme design and throughout implementation. Community Health Fund enrolment rates are boosted through the FC interventions in Mbeya and Tanga. Within the FC-Module, pregnant women become members of the National Health Insurance Fund during the last months of pregnancy and the entire family is awarded Community Health Fund membership for one year after delivery. It has already been agreed between the Governments of Tanzania and Germany that FC funded interventions will be extended to Mtwara and Lindi. It can be expected that important efficiency gains could be realised if FC and TC further improve their coordination and plan their activities jointly to maintain enrolment beyond the first year after delivery and to harness Community Health Funds as a stepping stone towards the single national health insurance. Beyond the health programme, there was punctual cooperation in the water sector in Tanga, where waste water management improved the overall quality of health service delivery in one hospital.

The TC measure is rated as **'successful'** for the criterion efficiency.

Sustainability
Sustainability of results is depending on how well advisory content, approaches, instruments, methods and concepts are anchored in the partner system. Positive examples are the Public Private Partnership-Act, the Public Private Health Forum, the District Health Management Training Programme or the comprehensive documentation of the Workplace Programmes in the Private Sector which include a 'Workplace Manual for Coordinators' developed with the International Labour Organization and the Association of Tanzanian Employers. The draft Health Financing Strategy and implementation plan are achievements that will leave their marks, even if the policy processes ahead may mean delays and modifications.

For other intervention areas, sustainability is still questionable. For example, even if good initiatives regarding Community Health Funds will have been taken across the intervention districts, including the introduction of a new computer-based spreadsheet tool for management, these may not automatically be maintainable. Lessons learned still need to be captured and harnessed in order to allow for the creation of a minimum sustainable spread. In quality improvement, the implementing consortium has developed an Excel-based software which will allow continued measurement of quality of care in hospitals without dependency on the software that is currently in use. Project staff has also participated in a taskforce, which aims to establish a national list of indicators to measure quality of care. However, so far there are no agreed perspectives on how the task force should proceed, what exactly should be the output and how this output will be used. Several approaches supported by the module (on-the-job-training with the training skills matrix, quality coaching, QI focal persons, leadership training) have a good potential to maintain and increase the momentum for continuous quality improvement. However, they need to be fully integrated in the routine of national actors. This would require that they will be documented, disseminated and endorsed by MoHSW and supported by key development partners. The new-born care interventions so far conducted as part of the activity area quality management will be continued and expanded in the new TC-module 'Improving Maternal and New-born Health'.

The capacity development for civil society organisations in Mtwara has opened a door to sensitise local authorities to the needs of young people, but major investments that are not planned for at the national level would be required to make a tangible contribution to improved adolescent health.

The project takes risk factors into account, that may influence the longer term sustainability of results but they are to some degree beyond the influence of the project (e.g. sector funding, political will).

The TC measure is rated **'successful'** for the criterion sustainability.

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