

AFRICAN DEVELOPMENT BANK GROUP



TANZANIA

**EVALUATION OF BANK ASSISTANCE TO THE HEALTH
SECTOR**

**OPERATIONS EVALUATION DEPARTMENT
(OPEV)**

22 November 2005

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LIST OF ABBREVIATIONS

ADB	African Development Bank
ADF	African Development Fund
Aids	Acquired Immune-Deficiency Syndrome
BADEA	Arab Bank for Economic Development
CCF	Christian Children's Fund
DANIDA	Danish International Development Assistance
DFID	Department for International Development (UK)
EU	European Union
EUR	Euro
FHRP	First Health Rehabilitation Project (ADB-financed health sector project)
FY	Financial Year
GOT	Government of the Republic of Tanzania
GTZ	German Technical Cooperation
HIV	Human Immune-deficiency Virus
KfW	Development Bank of Germany
MDG	Millennium Development Goal
NGO	Non-Governmental Organisation
OPEV	Operations Evaluation Department
OREFCO	Organisation and Efficiency Consultants (Tanzanian Auditing Company)
PER	Public Expenditure Review
POW	Plan of Work
QOC	Quality of Care (an indicator of the quality of health services)
QOE	Quality of Entry (an indicator of good project design)
QPR	Quarterly Progress Report
Tsh	Tanzanian Shilling
Sida	Swedish International Development Cooperation Agency
TAF	Technical Assistance Fund
TRHS	Three Regions Health Study (ADB-financed health sector project)
SWAp	Sector Wide Approach
UA	Units of Account
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNFPA	United Nations Fund for Population Activities
USD	U.S Dollars
WHO	World Health Organisation
ZHDRS	Zanzibar Health Development Requirements Study

EXECUTIVE SUMMARY

1. **Objective, Scope and Methodology of the Evaluation:** The evaluation objective is to review the Bank's health policy, strategy and interventions during the period 1989 to 2004 to identify good practices and shortcomings in order to draw up useful lessons for the Bank's future health interventions. The evaluation is based on documentary sources and interviews with Bank staff, country officials, development partners' experts, and stakeholders during the country visit. Two lending and two non-lending interventions were examined.

2. **Country Economic Context & Sector Policies:**... Following Independence, the macroeconomic environment in Tanzania declined from 1976 to 1985, and the Government restructured the centralised economy to become more market oriented. This led to improved macroeconomic stability and although some fluctuations were experienced, the current economic trend is generally positive. In the recent years, there have been significant efforts to develop and adopt prudent, forward-looking policies on sector and crosscutting issues such as poverty reduction, gender, environment, private sector involvement and community participation. In the health sector, the Government has developed sector plans under the Sector Wide Approach (SWAp) and is improving the health sector with external assistance. One third of the population lives in abject poverty, which limits access to health care services. The HIV/Aids situation is very critical, with about 2 million people living with HIV. Trained medical staff leaving the health sector hampers the health service delivery.

3. **Bank Sector Strategy and Relevance:** There is broad synergy between Bank and Country policies, both aiming at improving human capital in order to increase economic growth and reduce poverty. The Bank's health policy is much in line with other lead donors, as well as development banks such as the World Bank, but it is challenged by country specific problems such as poverty and the general lack of human resources in the health sector, as well as the daunting HIV/Aids pandemic. The Government's financing strategy is to combine the health sector input via the SWAp, and it urges the Bank to join these efforts in order to avoid duplicating effort. As the Bank is maintaining a project-based approach there is a clear difference in implementation strategy between the Bank and the Government. The health sector coordination and dialogue is well organised with the Government, leading the sector work assisted by several development partners, of which DFID, DANIDA and the World Bank are most actively involved. In terms of overall policy dialogue, the Bank has not played its potential role in the process of developing Tanzania's health sector policies and strategies. However, the Bank has to some extent been involved in overall country dialogue, both on Zanzibar and mainland Tanzania, and the participation is expected to improve as the Bank's country office opened last year.

4. **Evaluation of the Sector Interventions:** The interventions were evaluated according to the standard evaluation benchmarks of relevance, efficacy, efficiency, institutional development impact and sustainability. Numerical scores were given on the basis of these attributes. The overall average rating was high on relevance, satisfactory on achievement of objectives, institutional development as well as sustainability. The major shortcomings concern efficiency of implementation, which are less than satisfactory in all interventions. The overall rating of the Bank's support to the health sector is satisfactory and rated satisfactory for each of the interventions. At the same time it is noted that there is room for improvements in all interventions. The main problems with respect to efficiency were: inadequate communication between Bank and Borrower, rigid Bank procedures, very slow loan processing and disbursement, lack of participatory process in the project cycle, lack of

implementing capacity on the side of the Borrower and delays in release of counterpart funding. The evaluation of sector interventions has been supplemented by an overall evaluation and rating of other key aspects. Here Assistance Strategy is rated to be satisfactory while performances on the side of both the Bank and the Government are rated less than satisfactory. It seems likely that some of the problems in efficiency can be linked to the implementation strategy, which to be optimal requires a capacity increase both on the side of the Bank and on the side of the Borrower. The overall rating is satisfactory, with room for improvements in order to make future interventions more efficient.

5. *Main Lessons Learned:* a) Investments in the health care in rural areas can have a very high outcome even with limited amounts invested; b) use of international consultants, e.g., project director, project manager and project engineer, who are abroad, handicaps efficient operations due to communication problems; c) lack of use of participatory approach throughout the project cycle leads to reduced interventions performance and sustainability.

Recommendations:

6. *To the Government:* a) In order to address the serious staffing problems in the health sector, measures to provide staff accommodation, transport and other incentives should be increased; b) the Government should ensure that the project managers effectively manage and implement projects according to objectives, and utilise the private sector adequately notably for maintenance; c) Local resources should be realistically assessed at the project design stage and adequate capacity development plans institutionalised in future projects.

7. *To the Bank:* a) The Bank should join the SWAp in a way suitable to the Bank modalities for more direct participation in the health sector dialogue; b) the Bank should undertake health related studies in order to develop its technical competence and the speed of these studies must be considerably improved; c) Bank task managers need to have their work load reduced by rethinking working practices and/or employing more staff; d) the Bank should continue to prioritise funds to the level of the health centres and the dispensaries, and improve its participatory approach in order to improve health service delivery to the poorest.

1. BACKGROUND

1.1 Evaluation Objectives

1.1.1 The objectives of the health sector evaluation are to; a) assess the relevance of funded activities through projects over the years 1989-2004; b) assess the effectiveness of Bank support to the Tanzanian health sector in improving health system delivery and access to health services; and c) identify lessons from experience in order to strengthen Bank's future policies and procedures and improve quality of Bank operations.

1.1.2 The evaluation critically; a) analyses the extent to which the strategies of lending and non-lending activities of the Bank matches the health priorities of the country, and b) assesses the impact of the interventions of the Bank in the health sector showing linkages between the goals/objectives with the outcome indicators targeted by the Bank. Thus, the findings of this evaluation, lessons and recommendations would serve as inputs for the evaluation of the Bank Country Assistance Strategy in Tanzania as well as for future sector evaluation and studies.

1.2 Scope and Methodology

1.2.1 The evaluation primarily documents from past and recent lending and non-lending activities of the Bank in the health sector and evaluates the strategies employed over the years in order to draw the lessons from experience and provide recommendations for future interventions. The evaluation is based on a review of the available documents such as Appraisal Reports, Project Completion Reports, Country Portfolio Review Reports, Supervision Mission Reports and Annual Portfolio Reviews, of on-going and completed interventions in the health sector. The evaluation takes into account the evolution of the Bank with respect to the changing emphasis on the development agenda such as crosscutting issues - governance, gender, poverty, environment, HIV/Aids, community participation and regional integration. It also takes into account the impact of policy documents introduced at different periods, and the evolving operational guidelines and procedures adopted over the years in managing the portfolio of the Bank.

1.2.2 The methodology includes interviews with staff of the Bank, the Government, implementing agencies, development cooperation partners and other stakeholders who have first or second hand knowledge of the Bank's projects. The methodology relies on field missions in Tanzania from 6th to 17th December 2004 to share the views of the various stakeholders in the sector and to assess results. Interviews and focus group discussions were carried out with end-users, notably the health staff and members of the public, who have been the main targets of the health sector investments¹. Adequate documentation was in the main provided for the projects evaluated on Zanzibar and, to a lesser extent, on the mainland.

1.3 Socio-economic Context

1.3.1 Tanzania is a vast country of 945,000 km². The population was estimated to be about 37 million in 2003 with an annual increase rate of 2.3%. Total fertility rate slightly declined from 6.3 in 1991 to 5.6 in 1999.

¹ The Evaluation Team would like to thank all individuals and organisations that collaborated and cooperated in the Evaluation.

1.3.2 Following the independence of mainland Tanganyika in 1961, Tanzania came into existence in 1967 after the union of Tanganyika and Zanzibar. The Government adopted a socialist path that puts more emphasis on the alleviation of illiteracy, poverty and diseases than on the productive sectors. From 1976 to 1985, the country experienced a severe economic decline. Subsequently, the government undertook a macro-economic reform from the static to a market oriented economy. The inflation went significantly down from 36% in 1990 to 5% in 2002². The Gross Domestic Product (GDP) per capita (in 1995 international price) increased from USD 519 in 1985 to USD 540 in 1990. It then decreased to USD 503 in 1994 before it increased again to USD 540 in 2001. The more recent data confirm this economically optimistic picture and show an annual increase of GDP per capita (at constant 1992 prices in Shilling) of 3.8% between 2001 and 2003.

1.3.3 Poverty and increasing inequalities remain a major concern for Tanzania's development. Calculations based on data from 1991/1992 and 2000/2001³ surveys show a statistically non-significant decrease of the basic needs poverty ratio from 39% to 36% while the absolute number of poor increased by nearly 2 million. Tanzania's Poverty Reduction Strategy Programme has guided donor interventions through enhanced consultative meetings and cooperation, since the year 2000, in an effort to address the poverty challenge. Growth in Tanzania is generally hampered by the low tax base and domestic revenue and GDP ratio of around 12%, which makes it difficult to reduce poverty based on own resources. Tanzania's external debt stood at almost US\$ 7 billion by end of 2002. Recent decrease in external debt is due to the HIPIC initiative. Recorded unemployment stood at 2.3 million in 2001 or 13% of the total labour force. In Dar-es-Salaam alone, 46% were unemployed, constituting a major problem for the youth.

1.3.4 Health problems in Tanzania are mainly attributed to infectious/communicable diseases. Over 70 percent of life lost is due to 10 major diseases with malaria, tuberculosis and anaemia accounting for a large proportion of deaths. For children, the major killers are malaria, anaemia and pneumonia. Water borne diseases are also common in Tanzania; more so in rural areas, where the use of contaminated water is prevalent. By far the most challenging communicable disease at present is HIV/Aids. By the end of 2002, about 2 million people were living with HIV. Among them, 400,000 - 500,000 were at the stage of requiring drugs to mitigate the severity of the disease. The HIV/Aids problems increase the burden on the provision of health services in the country as those patients occupy 40-50 % of hospital beds. In 2002, 12,675 HIV/Aids patients received various services in health facilities throughout the country. There is, however, a concern whether the expenditure priorities in health accurately reflect the disease burden. For instance, a study carried out at district level, showed that malaria accounted for 30% of years of life lost but received only 5% of health spending in 1996. Conversely, tuberculosis, which was responsible for less than 4% of life lost, attracted 22% of health expenditure⁴.

1.3.5 Chronic malnutrition remains a widespread problem, with 44% of children moderately to severely stunted. 83.8% of households use iodised salt, which is below the WHO standard of 90% and goitre affects 8% of Tanzanians⁵.

² ADB, *Selected Statistics*, 2004.

³ More recent data are not available to this mission.

⁴ Scott, C., *The Role of Statistics in evidence-based Policy-Making*, Paris 21, January 2005, p. 29.

⁵ www.tanzania.go.tz/economicsurvey1/2003/part4/health.htm.

1.3.6 Many health facilities are unable to provide adequate health care due to manpower shortage. Causes of this phenomenon are numerous such as physician brain drain and insufficient supply of some categories such as Clinical Officers and Public Health Nurses. The shortage of health personnel is more acute in rural areas.

1.3.7 Tanzania has approximately 105 nursing and allied health-training institutions. Out of these, the Government owns 70 whereas 35 are owned by religious organizations, the majority of which train nurses at certificate and diploma levels. For many years, the Muhimbili University College of Health Sciences of the University of Dar-es-Salaam was the only medical school training doctors, dentists and pharmacists. The College has now expanded to a yearly intake of 200 medical doctor students.

1.3.8 Tanzania has a high but decreasing population growth rate, from 3.4 in 1990-1995 to 2.3 in 1996-2002, and the life expectancy at birth has decreased from 50.2 years in 1980 to 43.3 in 2002⁶. The decrease has been continuous since 1987 and the main reason of the decrease is attributed to HIV/Aids.

1.4 Country's Historical Relations with the Bank

1.4.1 For more than three decades, the Bank has invested in lending and non-lending operations in Tanzania. The first project financed by the Bank in 1971 was about UA 3.0 million for Oil Pipeline and Tankage Facilities. Tanzania is one of the first countries to receive debt relieve on the HIPC.

1.4.2 Up to the end of 2003, the total cumulative approvals for Tanzania stood at close to UA 810 million for 91 interventions. This is 2.4% of the Bank total cumulative loans and grant approvals for Africa up to 2003. Over a five year period, 1999-2003, the Bank's total loan and grant annual approvals to Tanzania was of average around 41 million but with big variations from around UA 8 million in 2000 to approximately UA 119 million in 2001. The cumulative distribution of Bank approvals by sector for the period 1967-2003 is given below in percentage for Tanzania and in total for Africa⁷.

Table 1. Loan and Grant Approvals by Sector, 1979-2003

Sectors	Tanzania		Africa		Difference	
	(Million UA)	%	(Million UA)	%	%	
Social Sectors	75	9.2	3,901	11.7	-2.5	
<i>Health Sector</i>	18	2.2	1,217	3.7	-1.4	
<i>Education Sector</i>	50	6.2	2,195	6.6	-0.4	
Agriculture and Rural Development	144	17.8	6,132	18.5	-0.7	
Power/Energy	68	8.4	3,134	9.4	-1.0	
Telecommunications	28	3.5	911	2.7	0.7	
Water Supply and Sanitation	90	11.1	2,500	7.5	3.6	
Transport	213	26.3	5,325	16.0	10.3	
Industry and Mining	32	4.0	1,928	5.8	-1.8	
Financial Sectors	10	1.2	4,503	13.6	-12.3	
Multi-Sector	149	18.4	4,881	14.7	3.7	
Total	809	100.0	33,215	100.0	0.0	

Source: African Development Bank, *Compendium of Statistics on Bank Operations*, 2004.

⁶ ADB, *Selected Statistics*, 2004.

⁷ ADB, *Compendium of Statistics on Bank Operations*, 2004.

1.4.3 The health sector in Tanzania has received 2.2% of the total approvals to the country compared to the similar health sector share of total approvals for Africa of 3.7%. The social sectors in total received relatively less support in Tanzania compared to Africa. The opening of the Bank Country office in Dar-es-Salaam last year has signalled increased collaboration between the Government of Tanzania and the Bank.

1.4.4 The Bank's net signed cumulative assistance to Tanzania's social sectors up to the end of 2004 is shown in table 2. Within the social sectors, the health received approximately one quarter of the total social sector support, while education received the biggest support with around two thirds.

Table 2. Bank Assistance to the Social Sector of Tanzania (in UA as at December 2004)

Sector	Instrument			%	Status		
	Loan	Grant	Net Signed		Completed	Ongoing	To start
Health	2	2	18 132 574	24	1	3	
Education	5	2	48 382 086	65	2	3	2
Poverty Alleviation, Micro-finance	1	0	8 000 000	11	0	1	0
Total Social Sector	8	4	74 514 660	100	3	7	2

African Development Bank

2. REVIEW OF THE BANK'S ASSISTANCE STRATEGY

2.1 The Bank's Health Sector Policy

2.1.1 The Bank has since its start paid attention to development of human resources in its Regional Member Countries. Over the years, the Bank has developed and published a series of policies to guide its assistance in the social sectors, see Annex 2. Bank lending to the health sector began in 1975 and a *Health Sector Policy Paper* was adopted in 1987. The paper analyses the major problems affecting health in Africa, highlights the relationships between health and socio-economic development and establishes guidelines for health sector financing. For African health administrations lacking capabilities to effectively plan and manage health programmes, that the health policy was intended to finance, the projects aimed at improving skills of government officials involved in planning and management of health programmes by training and short-term technical assistance.

2.1.2 The health policy was revised in 1996 to respond more adequately to new challenges such as the HIV/Aids pandemic, rapid population growth, and increase in female-headed households and it insisted on the need for participation of all stakeholders. The Bank's health policy acknowledges the fact that public health programmes were often organised and managed vertically and that a large share of public funds went to curative care at urban-based hospital at the expense of the mass of the rural populations. It therefore considers that the adoption of primary health care would offer the greatest opportunity for African countries to improve access to health in a more cost-effective and sustainable way. It recognises the need for participation of end-users, beneficiaries, private sector and NGOs in the preparation of projects.

2.1.3 The *Annual Portfolio Review* of 1998 noted an increased commitment to social sector development, as articulated under the African Development Fund V and VI, and an improvement of the relevance and quality of lending in the health sector. The *Review of Bank's Experience in Rural Health*, carried out in 1999, found that health care services absorbed 71.5% of the Bank financing in the health sector and that Primary Health Care and Preventive Services received only 2.3% and 2.6% respectively. It also found that 80% of the funds supported investments in infrastructure. It underscored several shortcomings hampering the development of better health in rural areas notably; a) inadequate budget support for recurrent costs in rural health centres and district hospitals; b) staff shortages due to unsatisfactory working conditions; c) imbalances favouring the urban curative sector; d) ineffective human resources development policies and; e) lack of communication with referral hospitals.

2.1.4 To sum up, the Bank has identified the following priorities in the health sector; a) promotion of reproductive health, family planning, maternal health and safe motherhood, nutritional measures to fight HIV/Aids, and behavioural change; and; b) support to institutional reforms including decentralisation, investment in research, training, and infrastructure, development of managerial capacity, appropriate infrastructure and equipment for better health services delivery; and c) development of its partnership with international organisations, and facilitation of dialogue on health development with Regional Member Countries.

2.1.5 It could be argued that although the Bank's health policy is corresponding to other lead donors and development banks like the World bank, the Bank appears to be hesitant in bringing itself to the forefront concerning policy improvements and if so, the Bank is not in full meeting its development obligations. One example is on HIV/Aids, where Africa is the worst hit continent, which could lead the Bank to focus more thematic attention and resources to establish a knowledge based reference centre on best practices and to define the future strategies needed.

2.2 The Bank's Strategy for the Country

2.2.1 The interventions of the Bank in the health sector are based on the strategies defined in its policy documents towards the Regional Member Countries. Before 1996, the interventions were based on the *Economic Prospects and Country Planning* documents. Since 1996, the interventions have been defined in the *Country Strategy Papers*. During the first planning phases of Bank interventions in 1987-1994 and in the first Economic Recovery Programme supported by the Bank in the early nineties, the relative share of funding to the social sector was reduced⁸.

2.2.2 The Bank's Country Strategy Paper for 1996-1998 noted that the decrease in government expenditures on health had been followed by drastic services deterioration during the period 1980-1987. The Bank stressed the need for rehabilitating primary health care facilities and training of health personnel.

2.2.3 In the 1999-2001 Country Assistance Strategy Paper, the Bank noted the need to provide further support in the social sector by building on the existing interventions and to channel the assistance through sector development programmes in total coordination with the

⁸ The First Economic Recovery Programme was supported by the Bank in the early nineties.

other donors. In the health sector, the priority was accorded to strengthening the provision of primary health care and preventive services, including the campaign against Aids. The Bank was also keen on directing some of its assistance to well targeted social safety net programmes for the poor.

2.2.4 In the Country Assistance Strategy Paper 2002-2004, the Bank's health sector support includes a focus on the need to mainstream the First Health Rehabilitation Project into the Government's Health Sector Development Programme. Support to health interventions would be channelled through sector development programmes, and would be co-ordinated with other development cooperation partners such as the World Bank. The Update Paper underlines the Bank's full participation in the consultative process leading to the Poverty Reduction Strategy Paper in 2002.

2.2.5 Comparing the above Bank assistance strategy for health with actual project follow-up before the late nineties leaves the impression that the Bank was rather late in implementing its country strategies. The explanation appears to be linked to earlier attempts to start up the Muhimbili Teaching Hospital Rehabilitation in consequence of the 1989 approval of the study on the hospital. The Muhimbili project was in fact approved in December 1990 under multiple funding of which the Bank took 71% of UA 30 million. However, this project never materialised and was cancelled in September 1996 and is not in this evaluation.

2.3 Government's Policies and Strategies

2.3.1 The first National Health Policy of Tanzania was published in February 1990. Since independence and until then, the Ministry of Health did not have a written policy but health services were considered an integral part of the national development plans. The overall objective of the National Health Policy was to improve the health status of Tanzanians notably by a) reducing infant and maternal morbidity and mortality; b) enhancing the access to health services in rural and urban areas; c) providing national trained health staff; d) sensitising the community on preventable health problems and; f) increasing inter-sectoral awareness towards health problems.

2.3.2. Tanzania was among the first Heavily-indebted Poor Countries (HIPC) to produce the Poverty Reduction Strategy Paper (PRSP) in 2002 after an extensive consultation with stakeholders on the priority interventions and policies for poverty reduction. The Bank participated in the consultation process and provided inputs into the process. The orientation of the PRSP is consistent with the Bank's own Vision, which focuses on rural development, human capital formation, governance and crosscutting issues of environment and gender. The PRSP is also oriented towards achieving the Millennium Development Goals. The Government has finalised the second PRSP called the National Strategy for Growth and Reduction of Poverty.

2.3.3 The Poverty Reduction Strategy Paper defines the health policy within the overall poverty reduction strategy and it has a number of important health objectives. In order to raise the productive life of Tanzanians, the government has placed special emphasis on reducing morbidity, improving nutrition, and strengthening access to health services and safe water. The national challenge is to arrest the decline in life expectancy due to HIV/Aids, and to raise it from 43 in 2002 to 52 years by the year 2010. By 2003, the government had intended to pursue policies and programmes, which notably would lower the infant and maternal mortality rates and reduce under-five mortality, by fighting against the main diseases including malaria and HIV/Aids.

2.3.4 The Second Health Sector Strategic Plan (2003 – 2008) published in April 2003 put more emphasis on service delivery and better quality of health supply on the community level. To this end, the focus of the plan is on the district level where most of the essential health services are provided. The thrust of the first three years (2003-2005) is to improve significantly the quality of those essential health services, make Council Health Management Teams and district health providers more accountable to the local communities, and strengthen community ownership.

2.3.5 Although the distribution of health expenditures in Tanzania is still not in favour of the poor, the Government is attempting to prioritise its funding in favour of the districts and rural areas through the mechanism of the Resource Allocation Formula (RAF). The President's Office, the Ministry of Health, and the development partners in the health basket worked out the RAF, as part of the PRSP. The RAF is for recurrent cost and is applied to the basket funds for curative and preventives health care spending in order to allocate funds where they are most needed. Until 2003, 50 US cents per capita were allocated to the 213 municipal councils. However, this meant that the highly populated areas got a disproportionate amount of health funds. The new RAF brought into effect in January 2004 now applies the Poverty Map and the following criteria with a weighting to decide on prioritisation of funds available for health spending in a municipality according to eight specific criteria.

2.3.6 The ability to reach the poorer segments of society is considered crucial for Tanzania both in terms of poverty reduction and in terms of access to good health services. Up to now, the Government's policy has not been able to redress the poverty challenges and the fear is that the burden of the HIV/Aids will increase these challenges. Published data show that Tanzania will have difficulties in meeting health Millennium Development Goals as it is unlikely by 2015 to: a) halve the proportion of underweight among under five years olds; b) reduce the maternal mortality by three quarters and; c) reduce under five mortality by two thirds.

2.4 Relevance of the Bank Assistance Strategy

2.4.1 The Bank assistance strategy and policies have been highly relevant to the health priorities of Tanzania. It is in line with the Bank's and the Government goal of promoting sustainable economic growth and reducing poverty in Africa notably by investing in human capital development. The Bank's members, including regional and non-regional countries, share this goal, which also has been assumed by the international community through the Millennium Development Goals to be attained by 2015.

2.4.2 The Government and the Bank have poverty reduction as the overriding goal, which means that the objectives of health support and policies are corresponding. They both share the aim of improving the human resource base and reduce poverty as specified in the Tanzanian Poverty Reduction Strategy. However, as for the health sector, the Bank approach differs from the Government's in implementing health sector investments. The Bank seems reluctant to conform fully to the Government's institutional arrangements for the health sector.

2.4.3 Relating to the health policies of the Bank and the Government, despite the Bank's stating in its health policy documents that it will target HIV/Aids, as is the case for the Government policy, little attention has been paid to HIV/Aids aspects in the First Health Rehabilitation Project. However, the Bank interventions have been relevant because they have increased the capacity of the health care services in terms of quantity and quality.

3. EVALUATION OF RESULTS: LENDING OPERATIONS

3.1 Lending Operations to the Health Sector

3.1.1 The Bank has supported 2 lending interventions in the health sector and one of these, a study, has been completed. The *Study of the Emergency Rehabilitation Requirements for the Muhimbili Referral Teaching Hospital*⁹, which was approved in 1989, and was to be completed in about 6 months, paved the way for a proposal to rehabilitate the hospital. A joint Government and DANIDA mission had in 1987 identified nine possible project packages for improving the health service delivery. One of the packages was the proposed rehabilitation of the hospital.

3.1.2 The rationale for studying the Muhimbili Referral Teaching Hospital was to assess the needs and future direction of the country's premier teaching and referral hospital, in the effort to harmonise and improve health services. The study resulted in a project proposal in December 1993 that was however cancelled after approval. The study eventually led to the approval of *The First Health Rehabilitation Project in March 1997*. The effective date for the commencement of the project was 10 September 1999. The approved loan was not to exceed 15 million UA.¹⁰ The objective was "to provide expanded and improved delivery of primary health care services and support to the integrated control of endemic diseases". The project has five major components; a) health facilities; b) institutional support and training; c) support to national HIV/Aids; d) integrated prevention and control of endemic diseases in Zanzibar and; e) project management. The project, which was re-appraised, is contributing to the total renovation and upgrading of the country's most important hospital, the University Teaching Hospital, with more than 2,000 beds. Nurses and doctors need to be trained and many of the poor and disadvantaged continue to depend on government health infrastructure. A significant portion of the re-appraised project is going on infrastructure and maternal and child health investments at dispensary level and district hospital level.

3.1.3 One of the components in the First Health Rehabilitation Project covers the support to Zanzibar, The major activities and areas of activities in Zanzibar relate to communicable diseases, construction of latrines, drugs subcontracted to WHO, procurement of anti-malarial drugs that can fight drug-resistant malaria and other illnesses, and professional development for nurses and other health staff.

Table 3. Health Lending Interventions (in UA as at December 2004)

Project Title	Approval	Signed	Start	Completion	Approved	Net Signed	Disbur. %
Study-Muhimbili Ref. Teach. Hosp.	23-Mar-89	30-May-89	13-Aug-92	7-May-97	589,473	472,574	100
First Health Rehabilitation Project	12-Mar-97	8-May-98	24-Jan-00		15,000,000	15,000,000	37
Total Lending					15,589,473	15,472,574	39

Source: ADB Data.

⁹ ADB, *Terms of Reference - Study of Emergency Rehabilitation Requirements for Muhimbili Referral and Teaching Hospital* (March, 1989).

¹⁰ The loan was financed by ADB (42.2% of total cost of the project); OPEC (37.4%); and BADEA (18.9%), for a total amount of UA 15 Million.

3.2 Relevance

3.2.1 The two Bank lending interventions in the health sector are highly relevant, as they constitute appropriate responses to health challenges of Tanzania. The study of the Emergency Rehabilitation Requirements for the Muhimbili Referral and Teaching Hospital answered a need identified by the Government and the study contributed to identifying actions to be undertaken.

3.2.2 The First Health Rehabilitation Project has supported the deeply needed construction of new health facilities and rehabilitation of existing ones. In fact the large majority of the stock of health facilities were in a very poor state. The institutional support and training under the project contributes to address the problems of insufficient human resources in the health sector, especially the provision of in-service training of different cadres of front line and primary health care. Given the high epidemic prevalence of HIV/Aids, the project support to national HIV/Aids, is highly relevant, although the level of support to HIV/Aids could have been much higher. The relevance of Integrated Prevention and Control of Endemic Diseases in Zanzibar component was also very high given the high endemicity of diseases, such as malaria, schistosomiasis, and helmenthiasis. Overall, the Bank interventions in the health sub-sector are relevant to the Poverty Reduction Strategy Programme. They respond to the needs for access to health services in a country where people in average have to travel 10 km before reaching health infrastructure. The interventions constitute an appropriate answer to the Government's health policy that aims at improving the health status of the rural and urban population in reducing mortality and morbidity, and improving, *de facto*, life expectancy. The construction or the rehabilitation of mother and child health units, the training of health personnel, the provision of furniture and equipment and the construction of staff accommodation constitute very relevant actions towards better access to health and the decrease of mortality and morbidity.

3.2.3 Construction/rehabilitation of mother and child health units can potentially decrease preventable maternal deaths. But there are still a number of concerns in the design of the interventions. To give one example, the Bank has financed the maternity ward of Kitunda dispensary that is functioning without any water supply.

3.3 Achievement of Objectives

3.3.1 It is too early to assess properly the achievement of objectives because most of the components are still being implemented. Some of the objectives of the First Health Rehabilitation Project are already being on the way to achievement. For example, one of the three wings at Muhimbili Hospital has been completely renovated, the new mortuary has been completed and is expected to be in operation mid 2005, the incinerator has been installed, and the other two wards have been renovated. In the Mainland, the Muhimbili Hospital is still being renovated, health dispensaries are still to be constructed and equipment such as fridges for mortuaries and beds for maternal and child health wards have not yet been procured or delivered. No maternal and child health or dispensary renovation have taken place yet in Zanzibar; some but not all of the boreholes have been sunk; and some latrines have been constructed, but far fewer than planned for. Health in-service training has been delayed, and is still to take place.

3.3.2 The impact of opening a new Child Health Unit, or rehabilitating it, on the access to health service is illustrated by the case of the dispensary of Kitunda where the delivery has been multiplied by 4 after the opening of the new maternity ward as illustrated by the

following table. In fact, during the first quarter when the dispensary had no maternity ward, the number of women delivering was 18, after the maternity ward had opened in June 2004, the number was 80 in the second quarter and 75 in the third quarter.

Table 4. Kitunda Dispensary Attendance (quarterly data)

Reasons for attendance	First Quarter	Second Quarter	Third Quarter
Antenatal Clinic Attendance	264	284	272
Pregnant Women Receiving Tetanos Vaccine	119	184	210
Delivering Before the Maternity was Functional	18	80	75
Clinic First Attendance by New Borns	174	220	271
DPT3 Vaccine	184	164	223
Measles Vaccine	183	196	142
News Cases Joining Family Planning	48	54	78
Low Weight Babies	0	0	0
Total outpatients Clinic Attendance	1581	2224	2045

Source : Data collected during the visit to the dispensary on the 8th December 2004.

3.4 Efficiency

3.4.1 Efficiency has been affected by problems of Quality at Entry, which was low. It has also been lowered by delays caused by a series of interlocking problems including cumbersome procurement procedures, less than optimal communication with Bank desk officers working with the health portfolio, and use of international consultants for long term assignments. Possible duplication of efforts, especially regarding construction of maternal and child health units in some areas, is a problem due to the Bank portfolio not having been included inside the basket – the sector wide planning approach. The fact that the Bank was not present physically in Tanzania has meant that quick and to the point support to Government officials was not readily available.

3.4.2 In general, implementation and performance in all components and sub-components of the health interventions are deemed to be unsatisfactory due to different problems including delays, inadequate communication, bureaucratic tendering and procurement procedures, lack of optimal two-way dialogue in design and implementation process, inappropriate design of certain key sub components like latrines and boreholes, and staggered disbursements due to co-financing by several financing institutions on the same project.

3.4.3 The First Health Rehabilitation Project was not very cost effective due to the delay of 3 years (1997-2000/2001) between the two appraisal reports and the implementation of the project during which the loan was subject to inflation. Due to the delays described above the general picture of the health sector projects is that they have not been efficient. One example is in Zanzibar, where the procurement of drugs through WHO has added to the costs and delayed timely arrival of anti malarial drugs.

3.5 Institutional Development Impact

3.5.1 Although all in-service training has been useful, not all have been completed under the health sector projects, and several key staff are still waiting for their applications to study to be approved and financed by the Bank. Due to the high attrition rates of health staff in the Tanzania's public sector, it is difficult to assess exactly the degree of institutional development.

3.5.2 For the First Health Rehabilitation Project, three main activities consisted in institutional strengthening, that is in-service training, management training and maintenance training for technologists. For in-service training, the project carried out 25 Trainings-of-Trainers courses and 134 tutors courses, which has a multiplier effect on the health sector as trainers and tutors become responsible for training other people. For the management training, 2 candidates have attended one year overseas training and they are at their duties after a successful completion of the studies. As the maintenance training for technologists is concerned, 4 candidates benefited from a short-term training in Mombassa, Kenya. Two outstanding fellowships for a long-term training and 4 short-term fellowships were waiting for a no objection from the Bank to go ahead with the activity. On the other hand, the project has planned and carried out capacity building for infrastructure for technicians and trained them to help ensure the improvement of maintenance.

3.5.3 The Muhimbili support has had an institutional impact, and has contributed to making the sector institutional set-up more effective and relevant to health planning. Nevertheless, as recognised in a Bank health review study¹¹, the focus has been much too top down and there has not been enough attention paid to the grassroots level. If all the training of district health staff is promptly carried out and if staff stay in their jobs in the districts, the potential impact on strengthening the decentralisation process in the districts being supported by the Bank under the First Health Rehabilitation Project are quite high.

3.6 Sustainability

3.6.1 Sustainability of investments in the social sectors constitutes a serious concern. Due to low domestic resource mobilisation, the Government budget has continuously registered deficit since mid 1970s. Therefore, development partners finance an important share of the investments in the social sectors, which implies that sustainability is dependent upon effective commitment from development partners until the Government has increased revenue sufficiently.

3.6.2 In terms of infrastructure and equipment, there is a need for an increase in the training of relevant staff, including managers, on the importance of maintenance and on the skills required. More importantly, preventive and corrective maintenance culture should be institutionalised in health sector institutions at all levels.

3.6.3 The Bank supported interventions have contributed towards sustainability through staff training in-service training, management training and maintenance training for technologists. For in-service training, the project realized 25 trainings of trainers and 134 tutors courses, which has a multiplier effect on the health sector as trainers and tutors become responsible for training other people. For the management training, 2 candidates have

¹¹ Review of the Bank's experience in the financing of rural health projects, pp 4-6.

attended one year overseas training and they are at their duties after a successful completion of the studies. As the maintenance training for technologist is concerned, 4 candidates benefited from a short-term training in Mombasa Kenya. Additional training is planned during the remaining time of the project.

3.6.4 In summary the sustainability of Bank supported interventions is considered satisfactory but with ample room for improvements.

4. EVALUATION OF RESULTS: NON-LENDING OPERATIONS

4.1 Economic and Sector Work/Policy Dialogue

4.1.1 The Bank has financed two studies in the health sector under Technical Assistance Fund grants: The *Zanzibar Health Development Requirements Study* and the *Three Regions Health Study* were approved respectively in December 1997 and in July 1999. Both the Government of Zanzibar and the Ministry of Health of Tanzania expressed satisfaction with the study and its findings, mainly because it allowed them to plan for improved health services. The major objectives of the study were to improve health status in Zanzibar and to strengthen Zanzibar's medium term health sector strategy. The objectives of the study have been achieved and have paved the way for the next stage of health planning in Zanzibar, the Private Health Sector Study.

Table 5. Bank Non-lending Intervention in the Health, (in UA as of December 2004)

Project Title	Approval	Signed	Start	Completion	Approved	Net Signed	Disbur. %
Zanzibar Health Dev. Requi. Study	3-Dec-97	8-May-98	20-Oct-99	30-Jun-04	910,000	910,000	97
Three Regions Health Study	14-Jul-99	19-Nov-99			1,750,000	1,750,000	19
Total Non-lending					2,660,000	2,660,000	46

Source: ADB Data.

4.1.2 The aim of the *Three Regions Health Study* was to assist the Government in reviewing and strengthening Tanzania's district and medium-term health sector strategy and the preparation of plans of action. The study was to identify major constraints and priority areas in the provision of health services in three under served regions, namely Mara, Mtwara, and Tabora.

4.1.3 Because of events affecting both the bidding process and the relocation of the Bank from Abidjan to Tunis, the contract with the selected consultants was not signed until November 2003 and actual field activities for Phase I started in February 2004 only. In Phase I of the Study, a comprehensive analysis of the district health care system was conducted. Despite delays, the study has now progressed and produced a substantial report, thereby concluding Phase I. The first phase of the study has been sent to all districts and donors, and promises to be a useful tool in health planning and financing. In terms of economic and sector work, the Bank has contributed to this study and other development cooperation partners such as DANIDA has expressed interest in the outcomes of the Three Regions Health Study to help co-ordinate their aid efforts in the health sector, but have expressed some frustration at the study's delay for several years. Phase II of the study will allow the next stage focusing on, decentralised health planning.

4.1.4 The two non-lending health study projects have been relevant to the improvement of government health planning and health policy, and ultimately could contribute in some measure to the improvement of access to health services. The studies experienced significant

delays both in starting and in implementation. It is apparent that the Ministry of Health's capacity to implement the studies through the Project Implementation Unit has been a problem.

4.1.5 As for policy dialogue, the Bank has been part of some of the cross-sectoral level country policy dialogue like the Tanzania Poverty Reduction Strategy. However, in view of the lack of a country office, the participation has in reality been limited. The Bank was not involved in most of the discussions at sector policy level. One example is the discussions and negotiations leading to the earlier mentioned resource allocation formula for the decentralised levels, districts and below. These funds from the health sector basket are crucial to the hospitals and medical centres and they are made available via the districts. The emphasis was on securing the poorer districts a larger share than previously. The other major health donors participated with Government but the Bank was absent. This constitutes a missed opportunity for the Bank to be an active part of policy dialogue on ongoing health initiatives and new financing instruments. Expectations are that the Bank's participation in economic sector work and policy dialogue will be effective with the Bank's new country office.

4.2 Resource Mobilization/Co-financing

4.2.1 Co-financing has taken place in the First Health Rehabilitation Project, where OPEC, BADEA and the Government are joining the Bank in funding the project. The Bank will also provide Tanzania debt relief under the enhanced HIPC Initiative¹². The Government contributes to funding the interventions by providing staff and office facilities.

4.2.2. The health sector is receiving support from a range of donors and resources are mobilised as part of the SWAp and the aid coordination linked to health sector work plans. For the last 4 years, the leading donors have been DFID, DANIDA, USAID and World Bank. The Bank is in this respect not a significant donor in the health sector, with a total of around 2% of the total donor support. The Bank is, however, commonly viewed as a key player and is invited to play a more proactive role in the health sector.

Table 6. Donor Disbursements to Health, 2000/01-03/04

Development Partners	Tanzanian Shillings	%
DFID	55,328,960,819	20.8
DENMARK	42,472,521,388	16.0
USAID	37,174,883,580	14.0
IDA	29,772,212,855	11.2
GERMANY	22,558,438,343	8.5
IRELAND	15,238,304,452	5.7
NETHERLANDS	15,008,321,215	5.7
UNICEF	13,506,657,276	5.1
SDC	11,314,442,155	4.3
JAPAN	5,908,887,530	2.2
CANADA	5,743,645,482	2.2
ADF	5,501,947,956	2.1
NORWAY	2,955,848,149	1.1
OTHERS	2,924,772,205	1.1
TOTAL	265,409,843,406	100.0

Source: Ministry of Finance, weighted average rate: US\$ 1= Tsh 968.4

¹² ADB: Country Strategy Paper, 2002-2004, 5th May 2003.

4.3 Aid Coordination, Harmonization and Results Orientation

4.3.1. Tanzania is aid-dependent. In FY 2002/03, aid supported 45% of the Government budget, accounting for 87% for the development budget and 24% of recurrent budget. Since 2002, efforts have been made to improve the predictability of budget support, to move away from complicated conditionalities of project funding, and to improve transparency. Towards this end, the Ministry of Health and a group of donors have agreed on a process to lead to a SWAp, which has been developed to overcome the shortcomings of the traditional project approach to development.

4.3.2 The Tanzania Assistance Strategy – in support of the Tanzania Poverty Reduction Strategy - constitutes the framework guiding development cooperation. It sets out government priorities for building capacity using national, rather than parallel, aid management systems. Some of the shortcomings of the project approach are: a) high transaction cost of individual projects; b) multiplicity of donor project implementation units; c) variations in donor conditionalities; d) variations in donors' procedures; and e) donor-driven accountability systems¹³. Another shortcoming of project approach is illustrated by the burden of missions upon the Government administration. For example, in FY 2003/03, there were more than 500 missions involving Government and development partners¹⁴.

4.3.3 However, experience suggests that the SWAp may not be suitable for all countries. Some initial conditions including accountability management capacity and an effective Government-led sector coordination must be met before it is adopted as an effective development strategy¹⁵. Presently, the Bank is not participating in the SWAp. The Bank has not been actively involved in health sector coordination, until recently mainly due to the absence of a Country Office.

4.3.4 Tanzania has made tremendous progress regarding aid coordination and harmonisation during the last decade¹⁶. The Poverty Reduction Strategy Paper, the Public Expenditure Review and the Poverty Reduction Budget Support processes, have brought mutual trust and confidence to the relationship. There is recognition, however, that these processes must be rationalized and harmonized in order to reduce the transaction costs of policy dialogue and coordination. The Government and donors have agreed on an action plan for implementing and monitoring the Tanzania Assistance Strategy.

4.3.5 An important forum for coordination among donors at the country level is the Development Assistance Committee Group with monthly meetings. The major health sector related coordination and harmonisation of aid is, however, linked to the SWAp and in this forum the Bank is not present. The Bank would be able to contribute to the health sector development process by joining the SWAp and at the same time this would add to the results orientation of its interventions by harmonising plans and procedures. Since the Bank is now present in Tanzania, it will collaborate more effectively with the DAC Group and participate actively in the on-going processes.

¹³ The United Republic of Tanzania, 2003a, 2003b. Undated.

¹⁴ The United Republic of Tanzania, 2003a, p. 22.

¹⁵ ADB, *Revised Guidelines for Bank Group Operations Using Sector Wide Approaches (SWAPs)*, ADF/BD/WP/2003/88/Rev.2, 27 April 2004.

¹⁶ Since the crisis between the Government and the Donor Community in 1995 regarding high-level corruption on the Government side and intrusiveness on the Donor side. See, Pitman, G. and al. (2005), 76-80.

5. CONTRIBUTORS' PERFORMANCE

5.1 Borrower and Executing Agencies

5.1.1 The Government and its health sector agencies are faced with a range of challenges in implementing the Bank interventions. The projects designed and agreed upon are in reality much too optimistic, especially in view of the limited resources and institutional capacity to implement the investments in the health sector. This unfortunate trend creates frustration on both sides. When projects are constantly delayed, there is a shared responsibility on the side of the borrower and the Bank approving the funding.

5.1.2 The Government and the Ministry of Health's behaviour are paramount to increase the investment in the health sector and to improve the quality of health services in order to cope with the health challenges. According to the Poverty and Human Development Report 2002, given the health problems faced by Tanzania, including malaria, HIV/Aids, and other communicable diseases, the per capita amounts of allocations for health services are below the threshold that is sufficient to cause a meaningful impact on health indicators. In 2002, per capita health expenditure in Tanzania was estimated to be USD 6 and the health expenditure represent 4.4% of GDP compared to 10% recommended by WHO.

5.1.3 The available documentation, site visits and interviews carried out point to a performance that is less than satisfactory on the side of the Government. Management and staffing of the Project Implementation Unit, whose role is essential to implementing the health studies and the First Health Rehabilitation Project, and for supervising the contractors and consultants carrying out the various activities, has not met the required standards. The performance of the Project Implementation Unit on mainland Tanzania is poorer than that of the Project Implementation Unit on Zanzibar, which is judged to be satisfactory¹⁷.

5.1.4 The generic problems continuing to affect the Borrower's performance include; (a) conditionalities leading to delays in fulfilment of conditions for loan effectiveness; (b) delays in procurement and disbursement; (c) problems of communication between Executing Agencies and the Bank; (d) shortage of counterpart funding. To some extent, these implementation problems are a result of weak institutional capacity in Tanzania and they are linked to the shortcomings of the implementation project approach. The role of the constituted Steering Committee that should supervise the proper management, performance and adequate staffing of the Project Implementation Unit has not had a sufficiently high profile, or sufficient high-level government backing, and the work of the Steering Committee has therefore not been adequate.

5.1.5 The unsatisfactory performance of the Project Implementation Unit in mainland Tanzania appears to be due to insufficient management capacity of the unit, which experienced a high turn over of key managerial staff. However, it is also partly caused by contractors who sometimes renege on agreements or delay their activities. This makes the work of the Project Implementation Unit staff very difficult. The delays in construction have been partly due to delays in disbursing Bank Group funds, and partly a result of the co-financing agreement in the case of First Health Rehabilitation Project. The delays in disbursements have slowed down progress.

¹⁷ The Zanzibar PIU is composed of well-organized core ministry staff and this may have contributed positively to performance.

5.1.6 Whilst the Government's implementation of Bank supported interventions has room for improvement, the Government has been good in identifying relevant needs and in harmonising the assistance from Development Partners, including the Bank. Good harmonisation and an open policy dialogue can ease the burden of the public sector in implementing Bank supported projects and the new Bank office could prove an opportunity for increased efficiency.

5.1.7 To sum up, low performance could be mainly explained as a result of the Government accepting conditionalities without having enough capacity to fulfil them in due time.

5.2 The Bank

5.2.1 With regards to health sector interventions, the Bank has performed well in identifying actions allied with Government priorities. However, the Bank support has been hampered by slow communication and irregular payments, heavy disbursement procedures and weaknesses in project monitoring, and supervision. This is mainly linked to the fact that the task managers are often overburdened with several projects to address in different countries and by inefficiencies in internal institutional procedures, including lack of responsibility delegation. Thus implying that the task managers' ability to respond in time is further reduced. This leads to a lack of capacity in the Bank, which further adds to reducing attempts for the required participatory process in all cycles of the interventions.

5.2.2. At the same time, it could be argued that the Bank's approach of not joining in with other donors in basket funding arrangements, joint procedures and joint efforts towards institutional strengthening is contributing to the Borrower's implementation problems. The interventions are based on unfounded assumptions on institutional capacity and behaviour, which leads to frustrating results¹⁸. In reality, the Government has only limited capacity to attract and retain sufficient human resources in the sector, which affects the performance.

5.2.3 During the period of health sector interventions, the Bank has discussed ways to improve performance, ranging from more institutional building included in project, more frequent and thorough supervision mission, better project preparation and increased dialogue with Government¹⁹. However, as the track record stands now, the Bank appears too optimistic in funding interventions based on conditions and timing, which most often prove unrealistic.

5.2.4 Despite having financed important health interventions in Tanzania, the Bank has effectively been a spectator rather than a catalyst in the health sector reform process. The Borrower appreciates the Bank's assistance and sees the Bank as its Bank, regardless of the frustrations listed above. This should in fact provide the Bank with a unique opportunity to play a much larger role in capacity building, sector dialogue and institutional development.

5.3 Other Donors and Co-financiers

5.3.1 The health sector in Tanzania has been given a very high priority under the Poverty Reduction Strategy Programme. There has been noteworthy progress in the development of a sector strategy. A sector-wide development programme is in place, enabling major external contributions to flow into the sector, through a joint basket fund mechanism. Major donors in the health sector include DFID, DANIDA, the World Bank; USAID, Irish Aid, Netherlands,

¹⁸ This is also recognised in World Bank interventions, World Bank, 2005, p. 130.

¹⁹ ADB, *Country Strategy Paper*, Revised Version 1993-95, May 1993.

Germany and Swiss Aid (table 6). Judging from government comments, the donors perform well in the health sector and the majority channel support through the SWAp. Under the SWAp, support is found in various forms, as direct budget support, earmarked funds and to some extent also special project support. However, by following the SWAp, the transparency, the accountability, the predictability and the effectiveness of the support is increased. Implementation under the SWAp will remain anchored on the Government and hinged on its institutional capacity, as is the case for the bank-supported projects.

5.3.2 DFID, which places all its funds in the basket, supports several social sectors including health through its support to the Poverty Reduction Strategy Paper. Important areas of DFID support include treated bed nets, which is a fully private sector initiative to combat malaria, and research into health problems.

5.3.3 DANIDA support is concentrated in four sectors: health, agriculture, roads, and industry. Under the Second Health Sector Support Programme, DANIDA supports the health sector with a major contribution in provision of essential drug kits for all rural dispensaries in Tanzania. Infrastructure and upgrading of rural based dispensaries also figure prominently in the Second Health Sector Support Programme. In addition to participating in the SWAp, DANIDA also supports individual projects implemented by NGOs, such as the Aids prevention project in Hanang District²⁰.

5.3.4 A range of other donors are involved in the sector work (table 6), like the European Commission supports the health sector through basket funding. From the beginning, efforts were mainly directed to the control of sexually transmitted diseases. The European Commission supported control study in Mwanza, referred to as the Mwanza Trial, proved that the successful control of sexually transmitted diseases could lead to a significant reduction in HIV transmission. However, the European Commission continues to support the fight against HIV/Aids through the support to five NGO projects totalling EUR 8 million.

5.4 Other Stakeholders (Civil Society, Private Sector)

5.4.1 As mentioned above, the private sector, including NGOs, is increasingly becoming important in the provision of health sector but its involvement is relatively small compared to the Government. There are no dependable studies on the magnitude and performance of the private sector in the health sector.

5.4.2 Among the large group of NGOs working in Tanzania are Oxfam and Action Aid. Oxfam has been working in Tanzania since the late 1960s. Both organisations work with communities on development projects linked to poverty reduction and health.

5.4.3 The above illustrates the variety and complexity of the health sector financing and thus the task of the Government in coordinating and harmonising efforts. The challenge of steering the health sector efficiently is huge and most donors and NGOs participate actively in the harmonisation, thus easing the burden of Government.

²⁰ Danish NGO, Svendborg Adventkirke.

6. OVERALL ASSESSMENT

6.1 Cross-cutting Aspects

6.1.1 Health activities are intrinsically gender oriented. By increasing the capacity of health care delivery, women benefit most as they use health facilities more than men. As shown in the case of Kitunda dispensary, which is in a rural area surrounding Dar-es-Salaam, most of the activities relate to women and children (table 4). The Bank supported studies aim to improve access of women to health services including antenatal, maternity and post-natal maternal health services. The more recent Bank Health Sector policy papers show increasing awareness of a gender dimension in health. However, a gender dimension is lacking in the design of the sanitation and vector control sub-component of the Zanzibar First Health Rehabilitation Project, which has led to inappropriate design and location of latrines and boreholes.

6.1.2 Environmental aspects are taken into consideration when the Ministry of Health prepares the location assessment for the construction of health facilities, in order to avoid negative impacts towards the surrounding population. In fact, some of the activities financed have been shown to significantly improve environmental conditions. For example, until now the Muhimbili hospital did not have an incinerator and it was usual to deposit hazardous waste in dams visited by scavengers. The project has financed an incinerator, which is capable of incinerating hazardous waste, thus protecting the environment from hospital waste.

6.1.3 The Bank interventions are fully in line with the Tanzania Poverty Reduction Strategy. In addition to the Muhimbili Teaching Hospital, the interventions have mainly benefited rural and peri-urban areas where most of the poor live. The Three Regions Study maps out priority areas and the results could assist the Government to improve the health status of the population.

6.2 Counterfactual

6.2.1 At the country level, the net effect of the Bank interventions could be considered to be insignificant. The Bank contribution to the health sector represents only 2% of international assistance to the sector (table 6). Tanzania being an aid-dependent country, it could still be difficult for the Government to substitute the financing. The health sector needs in terms of financing are much higher than the financing possibilities. Had the Bank not intervened, the health sector capacity to satisfy health demand in the areas of Bank intervention would have been reduced, and this would adversely affect the population.

6.2.2 Generally, it is not an easy task to find data allowing calculation of the net effect of an intervention. The data collected in the dispensary of Kitunda shows that the net effect of the Bank interventions has been very high. Before the opening of the maternity ward, the number of deliveries was 18 and this figure has subsequently been multiplied fourfold. The number of antenatal clinic attendance increased by 7.6%, the number of pregnant women receiving tetanus vaccine increased by 55%, and the total outpatients clinic attendance increased by 40.7%.

6.3 Overall Assessment of Bank Assistance to the Sector

6.3.1 Although there is room for improvement, the overall rating of the Bank interventions is satisfactory. The performance of the Bank's assistance to the health sector is mainly

hampered by delays in implementation. The repeated failure in keeping time limits on project implementation suggests that a substantial part of the loan portfolio is based on a culture of under-estimating challenges and over-estimating the Borrower's and the Bank's institutional capacity to effectively undertake the agreed activities. The Government is pretending to meet unrealistic implementation deadlines and the Bank is pretending to believe in the optimistic implementation plans.

6.3.2 The summary of the evaluation criteria of the Bank supported health projects is presented below, while more detailed information is available in annex 3, Table 11. The rating is based on the Bank's scoring methodology ranging from 1 (highly unsatisfactory) to 4 (highly satisfactory). Each of the interventions is rated satisfactory. The interventions are highly relevant, substantial in terms of institutional development and sustainability is likely. The main problem in all health sector interventions is that of efficiency, which rated poorly as shown in Table 7 below.

Table 7. Rating of Bank Health Sector Interventions

Project name	Relevance	Efficacy	Efficiency	Institutional development	Sustainability	Outcome rating score	Comment
Lending:							
Study-Muhimbili Referral Teaching Hospital	4	3	2	2	3	3	Satisfactory
First Health Rehabilitation Project (ongoing)	4	3	2	3	3	3	Satisfactory
Average Lending	4	3	2	3	3	3	Satisfactory
Non-lending:							
Three Regions Health Study (ongoing)	4	3	2	3	3	3	Satisfactory
Zanzibar Health Development Requirements Study (ongoing)	4	3	2	3	3	3	Satisfactory
Average Non-lending	4	3	2	3	3	3	Satisfactory
Average rating	4	3	2	3	3	3	Satisfactory
Comment	Highly relevant	Satisfactory	Inefficient	Substantial	Likely	Satisfactory	Satisfactory

6.3.3. Other key aspects of the health sector evaluation have also been examined, based on the rating 1 to 4, and comments to these aspects are found below in Table 8. The assistance strategy is rated as satisfactory whilst the performance of both the Bank and the Government is rated less than satisfactory.

Table 8. Rating of Other Health Sector Aspects

Rating of other key areas:	Score	Comments
Assistance Strategy	3	Relevant as health needs are high, poverty reduction based and largely congruent with Gov. Policy, but in reality too project focused, insufficient participation in sector dialogue and not enough attention to HIV/Aids.
Bank Performance	2	Positive in identifying health needs, positive image but performance is hampered by project concept (despite the Government's and other key development partners efforts towards a sector concept). Too optimistic project design, overburdened task-managers, bureaucracy, in-effective communication and lack of a systematic participatory approach.
Government Performance	2	Good in developing and promoting the SW Ap, in mobilizing donors, but too optimistic and not proactive in relation to Bank interventions, insufficient resources for effective implementation and supervision.

6.3.4. When combining the ratings of the health sector interventions, table 7 above, with the rating of other key aspects, table 8 above, the overall average rating is satisfactory. The

overall rating of lending, non-lending and other key aspects is thus positive with an average of 3. At the same time, however, it is noted in this report that the evaluation proves that there is room for improvement in several areas, as detailed in this report.

Table 9. Overall Rating of Health Sector Assistance

Overall	Score	Comments
Assistance Strategy	3	Satisfactory
Lending	3	Satisfactory
Non-lending	3	Satisfactory
Bank Performance	2	Un-satisfactory
Government Performance	2	Un-satisfactory
Overall rating	3	Satisfactory

6.3.5. In summary, the overall evaluation is satisfactory but improvements, mainly in the Bank's and the Borrower's efficiency, would further upgrade the evaluation.

7. LESSONS LEARNED AND RECOMMENDATIONS

7.1 Lessons Learned

7.1.1 Investment in health care in rural areas may have a very high outcome even if the investment is limited. The Kitunda dispensary, where the total clinic attendance by outpatients has increased by 40.7% after the opening of the dispensary, supports this lesson (3.3.2; 6.2.2).

7.1.2 The use of international consultants, e.g., project director, project manager and project engineer, who are abroad, handicaps efficient operations due to communication problems. The national counterpart cannot make decisions before having the authorization from headquarter and instructions from abroad. This entails delay. It would be better to hire the services of a local consultancy firm. This could also increase the national capacity building provided quality assurance is well addressed (3.4.1).

7.1.3 Lack of use of participatory approach throughout the project cycle leads to reduced interventions performance and sustainability (3.4.2; 5.2.1).

7.2 Recommendations

To the Government

7.2.1 In order to address the serious staffing problems in the health sector compounded by HIV/AIDs among health staff, the Government should find measures to increase incentives including accommodation and transportation in order to attract and retain adequate health staff. It is also recommended that more hospital managers be trained in order to relieve doctors and other medical staff from administrative and management responsibilities (2.1.3; 3.2.2).

7.2.2. The Government should ensure that the project managers effectively manage and implement projects according to objectives. It should ensure that its investments in the health sector are followed by good maintenance as well as follow-up systems to obtain optimal use. The private sector ought to be involved in improving maintenance (4.1.4; 5.1.3; 5.1.5).

7.2.3. Increased use and capacity of local resources should be realistically assessed at the project design stage and adequate capacity development plans integrated in implementing institutions (5.1.4; 5.1.5).

To the Bank

7.2.4. The Bank should join the SWAp in a manner suitable to the Bank modalities. This would reduce the stress on the borrower's administrative capacity and give the Bank the chance for a larger impact via a more direct participation in the health sector dialogue. Against the context of the increasing number of people living in poverty and increasing or stagnating health problems in rural areas and among the poorest Tanzanians, the Bank's support in health has been (and is) necessary, but coordination with other development cooperation partners needs to be increased (2.4.2; 5.2.2).

7.2.5 The Bank should upgrade health related studies in order to develop its technical competence and should develop policies and strategies that are efficient in dealing with regional membership countries health situation. To improve the impact of Bank supported health studies, which have a potentially important role to play in planning health service improvements, the speed of the implementation of the studies must be considerably improved (2.4.3; 4.1.4).

7.2.6 To improve efficiency and impact, the Bank should upgrade its participatory approach in line with its policies, reduce the work load of task managers, as well as increase the quality of its appraisal procedures and the training of staff in implementing agencies. The Bank should appoint a social sector specialist as part of the country office staff (5.2.1; 5.2.3).

7.2.7 The Bank should continue to prioritise funds to the level of the dispensary and below in order to improve health service delivery for the poorest areas that suffer highest morbidity and mortality rates. In so doing, the Bank ought to take maximum advantage of a structured participatory approach, thus involving all relevant stakeholders in the project cycle (2.6.6; 6.2.2; 7.1.1).

ANNEXES

ANNEX 1. LIST OF DOCUMENTS CONSULTED

Documents referring to Health Study Projects:

1. ADB. *Terms of Reference. Study of Emergency Rehabilitation Requirements for Muhumbili Referral and Teaching Hospital.* (March, 1989) unbound report, 15 pp, with annexes.
2. ADB. *Proposal for an ADF/TAF Grant of UA 1.75 Million to Finance the Three Regions Health Study (Mara, Mtwara, and Tabora),* 24 June, 1999, unbound report, 17 pp, with annexes.
3. United Republic of Tanzania. *Health System Assessment of Mara, Mtwara, and Tabora. Phase I Report. Volume I: Consultancy Service for the Three Regions Health Study (Mara, Mtwara, Tabora).*
4. United Republic of Tanzania. *First Health Rehabilitation Project.* Submitted to: The Permanent Secretary, Ministry of Health, Dar es Salaam, Tanzania 30 September 2004.
5. United Republic of Tanzania. *Three Regions Health Study.* Status Report. Unbound, 2 page mimeo. No date.
6. United Republic of Tanzania. *Three Regions Health Study.* Quarterly Project Progress Report. Report No. 19. Reporting period 1 July 2004 – 30 Sept. 2004. Unbound, 8 page mimeo.
7. ADB. *ZHDRS. Proposal for and ADF/TAF Grant of UA 0.91 Million to Finance the Zanzibar Health Development Requirements Study* (5 November 1997).

Documents relating to First Health Rehabilitation Project (FHRP):

8. Appraisal Report. *Muhimbili Teaching Hospital Rehabilitation Project.* Republic of Tanzania. 4 Nov. 1993. Unbound report, 44 pages plus annexes.
9. Appraisal Report. *First Health Rehabilitation Project.* United Republic of Tanzania. African Development Bank. Sept 1997. Unbound report, 34 pages plus annexes.
10. Status Report, December 2004. *First Health Rehabilitation Project.* 4 pages, unbound mimeo. No date.
11. Zanzibar Revolutionary Government. African Development Bank. Project Quarterly Progress Report. *First Health Rehabilitation Project. Zanzibar Health Development Requirements Study.* 1 April-30 June 2002.
12. Zanzibar Revolutionary Government. African Development Bank. Project Quarterly Progress Report. *First Health Rehabilitation Project. Zanzibar Health Development Requirements Study.* 1 July-30 September 2002.

13. Zanzibar Revolutionary Government. African Development Bank. Project Quarterly Progress Report. *First Health Rehabilitation Project*. Zanzibar Health Development Requirements Study. 1 Oct.-31 December 2002.
14. Zanzibar Revolutionary Government. African Development Bank. Project Quarterly Progress Report. *First Health Rehabilitation Project*. Zanzibar Health Development Requirements Study. 1 Jan.-31 Mar. 2003.
15. Zanzibar Revolutionary Government. African Development Bank. Project Quarterly Progress Report. *First Health Rehabilitation Project*. Zanzibar Health Development Requirements Study. 1 April-30 June 2003.
16. Zanzibar Revolutionary Government. African Development Bank. Project Quarterly Progress Report. *First Health Rehabilitation Project*. Zanzibar Health Development Requirements Study. 1 July-30 Sept. 2003.
17. Zanzibar Revolutionary Government. African Development Bank. Project Quarterly Progress Report. *First Health Rehabilitation Project*. Zanzibar Health Development Requirements Study. 1 Oct. – 31 Dec. 2003.
18. Zanzibar Revolutionary Government. African Development Bank. Project Quarterly Progress Report. *First Health Rehabilitation Project*. Zanzibar Health Development Requirements Study. 1 July-30 Sept. 2004.
19. Auditors' Report to the Ministry of Health and Social Welfare-Zanzibar in Respect of *FHRP*. October 2004. 5 pages, unbound, mimeo.
20. Status Report December 2004. *FHRP*. 2 pages, unsigned, unbound, PIU, Dar es Salaam. 2004.

ADB Strategy / Policy Documents:

21. ADB. Operations Evaluation Department. *Tanzania: Country Assistance Evaluation. Approach Paper*. Draft of February 10, 2005. No author, 15 pages, unbound.
22. ADB. *Revised Guidelines for Bank Group Operations Using Sector Wide Approaches (SWAPs)*, ADF/BD/WP/2003/88/Rev.2, 27 April 2004.
23. African Development Bank. Republic of Tanzania. *Review of Bank Assistance to the Power and Telecommunications Sectors*. OPEV. Nov. 2004. 27 pages plus annexes, unbound report.
24. ADB. *Guidelines For Country Assistance Evaluation*. Operations Evaluation Department. No author, no date, 7 pages, unbound.
25. ADB. *Strategic Plan 2003-2007*. Aug. 2004. Bound report, 70 pages.
26. *Review of the Bank's experience in the financing of rural health projects*. Presentation note. 19 Feb. 1999. Report, unbound.
27. *Review of the Bank's experience in the financing of rural health projects*. Addendum: Comments of the Operations Complex. 29 March 1999.

28. ADB. *Health Sector Policy Paper*. January 1987 (reprinted Oct. 1988).
29. ADB. *Health Sector Policy Paper*. September 1994. 31 pages, unpublished report.
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31. ADB. *Tanzania: Country Strategy Paper 1996-1998*: 37 pages, unbound. 5 Feb. 1996.
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34. ADB. *Republic of Tanzania: Country Strategy Paper 1999-2001*. Update: September 2002.
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General Health and Aid Documents:

38. Government of the Republic of Tanzania. *The Poverty Reduction Strategy Paper (PRSP)*, 2000 (GOT, October 2000), Dar es Salaam.
39. Government of the Republic of Tanzania 2001. *The United Republic of Tanzania Poverty Monitoring Master Plan – Tanzania*. Dar es Salaam, December 2001
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47. Neilson, S. and Smutylo, *The TEHIP “spark”: Planning and Managing Health Resources at the District Level*. Final Report. April 2004.
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49. Rajani, R. et al. *Situation analysis of children in Tanzania*. Tanzania Online (TZ-Online), 2001.
50. Roy Bahl et.al. *Developing a System of Inter-governmental Grants in Tanzania*, 2003.
51. *Second Health Sector Strategic Plan (HSSP) (July 2003-June 2008)*. Ministry of Health, Tanzania, April 2003, 23 pages, plus annexes, unbound report.
52. Government of the Republic of Tanzania. *Action plan for the implementation of the Tanzania Assistance Strategy*. June, 2003, mimeo.
53. *Tanzania Joint Annual Health Sector review. 15-17 March, 2004*. Golden Tulip Hotel, Dar'Salaam. 1 April 2004. No author, unbound report, 13 pages plus annexes.
54. UNDP 1999. *Tanzania Development Co-operation Report*, 1999. UNDP Tanzania. 1999.
55. UNAIDS, Tanzania. www.unaids.org.
56. United Republic of Tanzania, *Tanzania Assistance Strategy, Annual Implementation Report*, Report 2002/2003, November 2003a.
57. United Republic of Tanzania, *Tanzania Assistance Strategy. A Medium Term Framework for Promoting Local Ownership and Development Partnerships, Undated*.
58. United Republic of Tanzania, 2003, *Action Plan for Implementation of the Tanzania Assistance Strategy*, 2003b.
59. United Republic of Tanzania, *Household Budget Survey 2000/01*, July 2002.
60. Urassa, E. et al. "*Operational factors affecting maternal mortality in Tanzania*". Dept. of Obstet. and Gynae., Muhimbili Medical Centre; Dept. of Obstet. and Gynae., Uppsala Univ.; Dept. of Epidemiology and Public Health, Umea University, Sweden.
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64. World Bank. *Improving Health, Nutrition and Population Outcomes in Sub-Saharan Africa*. 2005.
65. Zanzibar Revolutionary Government. Ministry of Health & Social Welfare. *Zanzibar Health Policy. A summary Jan. 2002*. Bound report, 22 pages.
66. Zanzibar Revolutionary Government. Ministry of Health & Social Welfare. *Zanzibar Health Sector Reforms. Priority Areas Plan of Action (2002-2003)*. Bound report, 34 pages.
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Others documents:

70. Scott, C. *The Role of Statistics in evidence-based Policy-Making*, Paris 21, January 2005.
71. Pitman, G. and al. (2005), *Evaluating Development Effectiveness*, Transaction Publishers.

ANNEX 2. BANK POLICY PAPERS RELEVANT FOR THE SOCIAL SECTORS

Table10. Relevant Bank Policy Papers

Policy Document	Year	Reference
Education Sector Policy	1986	
Health Sector Policy	1987	
Environment Policy	1990	
Women in Development Policy	1990	
Health Sector Policy	1996	ADB/BD/WP/96/52
Strategy and Assistance in Microfinance to RMCs	1997	ADF/BD/WP/97/48
Education Sector Policy	1999	ADB/BD/WP/99/92
Agricultural and Rural Development Policy	1998	ADF/BD/WP/99/105
Integrated Water Resources Management	2000	ADB/BD/WP/99/146
Policy for Cooperation with Civil Society Organizations (CSOs)	2000	ADB/BD/WP/2000/05 Rev.1
Population Policy and Strategies for Implementation	2001	ADB/BD/WP/2000/142
Gender Policy	2001	ADB/BD/IF/2001/62
Policy on Poverty Reduction	2001	ADB/BD/IF/2000/83
Environment Policy	2003	ADB/BD/WP/2003/116
Policy on Poverty Reduction	2004	ADF/BD/WP/2003/151/Rev.2
HIV/AIDS Strategy for Bank Group Operations	2001	ADB/BD/WP/2001/11/Rev.3
ADF Strategy and Assistance in Microfinance to RMCs	2001	ADF/BD/WP/2001/97/Add.5
Malaria Control Strategy	2001	ADB/BD/WP/2002/25/Add.2
Malaria Control Operational Guidelines	2001	ADB/BD/WP/2002/45
Policy on Involuntary Resettlement	2002	ADB/BD/WP/2002/98
Policy on Poverty Reduction	2002	ADB/BD/IF/2002/248
Guidelines for Bank Operations Using Sector Wide Approaches (SWap)	2003	ADB/BD/WP/2003/88
Guidelines on Development Budget Support lending (DSL)	2003	ADB/BD/WP/2003/182
Bank Group Post-Conflict Assistance Policy Guidelines	2003	ADB/BD/WP/2003/184
Gender Plan of Action	2004	ADB/BD/IF/2004/88
Guidelines on Communicable Disease	2004	ADF/BD/WP/2004/19/Rev.1/
Guidelines for the Implementation of Bank Group's Policy on Population	2004	ADB/BD/IF/2004/10
Operational Guidelines on User Fees in Health and Education	2004	ADB/BD/WP/2004/144

ANNEX 3. DETAILED RATINGS OF THE BANK'S HEALTH PROJECT PORTFOLIO

Table 11. Detailed Ratings

First Health Rehabilitation Project, Kitunda Dispensary, MCH Unit: Team Visit	Score	Comments (Team assessment/visit November 2004)
Relevance	4	There was no Mother & Child Unit before project, & no staff accommodation; staff needed training; project respected government policy.
Quality of Entry	2	Below average; lack of consultation about equip.& infrastructure preferences with staff; the fact that no water supply is available was not discussed in consultant's plans who did not communicate with staff
Efficacy (Achievement of objectives)	3	New MCH Unit & new staff accommodation were built; some equipment does not work in MCH Unit because there is no power supply, and no water for sinks / showers/ flush toilets; no hot water provision installed, making post natal hygiene difficult; training done. Number of institutional deliveries has increased due to the new MCH unit but poorly trained staff, lack of trained midwives, and non-functioning equipment mean that QOC has probably not improved sufficiently yet to positively affect Maternal Mortality Rate.
Efficiency	2	Very delayed civil & equipment installation.
Institutional Development	3	Training done at lower staff levels.
Sustainability	3	Some equipment does not work due to use of inappropriate technology (depends on electricity supply and water supply which are not connected). Roofs not finished with guttering (splash damage likely); Solar energy could have been used, and a dedicated borehole included in the MCH unit design, roof top tanks and guttering provision could have been installed for rainy season rainwater-harvesting.
Cross Cutting Issues	3	Gender good, females trained, and main beneficiaries are parturient females: environmental considerations are accounted for (septic tank). Regional integration does not apply here.
Total	20	
Average	3	
First Health Rehabilitation Project. Construction and upgrading of Muhimbili Referral and Teaching Hospital, Ward 1: Team	Score	Comments (Team assessment/visit in November 2004)
Relevance	4	Hospital ward needed rehabilitation & equipment. New mortuary, incinerator, etc needed; Staff needed training. Project respected government policy to improve tertiary level and teaching hospital capability.
Quality of Entry	2	Design good, but Bank staff did not communicate with PIU / MOH in a businesslike way; several years of delay; appraisal process top down; lack of consultation with MOH; confusion over procurement rules led to three years of delay; PIU did not manage consultants adequately.
Efficacy (Achievement of objectives)	3	Fair. Equipment handover & installation process are not yet completed (in November 2004); renovation good standard; Hospital authorities "could not wait any longer for ADB and went ahead with acquiring donor funds for rehabilitation of another ward". Mortuary and incinerator built but not yet commissioned and not yet used.
Efficiency	2	Inefficient. Poorly performing consultant who was not accountable to MOH or hospital staff. Delays led to damage and wastage of resources.
Institutional Development	3	Initially fair, some staff that were trained were transferred or have left Tanzania.
Sustainability	3	If the MRTH can assume operational and recurrent costs, then there is a fair chance of sustainability of the rehabilitated ward; the mortuary and incinerator equipment will require O&M, and hospital staff are in place and have been trained to maintain equipment.
Cross Cutting Issues	3	Good on gender because target women's health, and train females, but weak on environmental, ok on regional integration.
Total	20	
Average	3	

First Health Rehabilitation Project: Amana District Hospital, MCH Unit, Visit		
	Score	Comments (November 2004)
Relevance	4	Hospital needed rehabilitation & equipment. Staff needed training. Project respected government policy.
Quality of Entry	3	Good, the project fitted hospital management, infrastructure expansion, and training needs.
Efficacy (Achievement of objectives)	3	Training which has been done for maintenance staff good and appreciated; but management staff are still waiting to hear if their money has come through (e.g., director of Amana hospital has waited 16 months for a reply from ADB about her MSc course in UK for hospital management); New construction of MCH ward, high quality, but not big enough for average of 50 births per day, meaning that post-parturient mothers only stay 6 hours in a bed before being discharged; no new equipment installed; new beds "have not arrived, and other furniture has not come, so we have just used the old beds and furniture";
Efficiency	2	Very delayed civil & equipment installation, leading to opportunity costs while areas of hospital were temporarily closed.
Institutional Development	3	Staff not yet trained in hospital management; staff trained in maintenance, a valuable contribution to health services.
Sustainability	3	If the hospital assumes recurrent and operational costs, & introduces a preventive maintenance regime, & receives enough money through central government health grant to the district, then sustainability is possible. Since works have only just been completed, it is too early to assess sustainability definitively.
Cross Cutting Issues	3	Good on gender, poor on environmental aspects.
Total	21	
Average	3	
First Health Rehabilitation Project; Construction of boreholes and latrines in Zanzibar (vector control component of FRRP Zanzibar): Visit November 2004		
	Score	Comments (Visit in November 2004)
Relevance	3	Schistosomiasis and helmenthiasis vector control require latrines and boreholes but also require health education campaigns
Quality of Entry	2	Poor. The project has constructed some boreholes and latrines, the boreholes are not deep enough and are therefore dry and the latrines are incorrectly designed and not used by females (50% of the population). Households want individual, not communal latrines, but there is no design provision for individual latrines in project. The appraisal and negotiation procedures and loan disbursement did not enjoy a two-way dialogue; design faults present at appraisal stage were therefore carried into project and are having negative consequences now.
Efficacy (Achievement of objectives)	3	Just acceptable, but not all latrines are constructed, and not all boreholes sunk. Latrine price is reportedly three times the normal price in Zanzibar, leading to a reduction in impact (number of latrines built for money provided in the loan)
Efficiency	2	Delayed civil & equipment installation.
Institutional Development	2	Poor; villagers and community leaders were not trained in latrine construction techniques, nor in health education awareness, and women's groups have not been formed to promote hygiene awareness
Sustainability	2	Latrines observed are dirty, and closed on the women's side and unused. No toilet attendants have been trained, so sustainability (cleanliness and cost recovery for future emptying) seem unlikely. Equally there is no payment system and no water and sanitation committee set up and trained to operate and maintain in good order the boreholes. Even though robust, high quality fixtures have been used (Finnish steel taps and borehole tubes) the absence of village water committee makes sustainability unlikely in the long run.
Cross Cutting Issues	2	Good on gender, poor on environmental aspects (no soakaways and no laundry facility provision made at borehole sites); regional integration not an issue here.
Total	16	
Average	2	

Study of the Muhimbili Referral and Teaching Hospital	Score	Team assessment from interviews with MOH / PIU staff and desk review
Relevance	4	Relevant to study health problems in order to provide a knowledge base for improving future planning
Quality of Entry	2	Poor, little or no two way dialogue or respect of MOH's wishes and preferences. Confusion and delay surrounding contracting consultant to do studies.
Efficacy (Achievement of objectives)	3	Study was carried out and led to design of FHRP.
Efficiency	2	Study time was delayed but was completed.
Institutional Development	2	Poor PIU and Bank performance in organizing the Study and little institutional development impact
Sustainability	3	Sustainability is not an issue and therefore not relevant with studies, assuming that the study is circulated to the necessary audience.
Cross Cutting Issues	3	Good, half of study target group is women.
Total	19	
Average	3	
Three Regions Health Study	Score	Comments (Assessment by team, November 2004): Team assessment from interviews with MOH / PIU staff and desk review
Relevance	4	Relevant. In order to plan health delivery, it was necessary to analyze health needs in three representative regions of Tanzania. Other donors in sector (e.g., Danida) were waiting for the study to help them plan as well.
Quality of Entry	3	Acceptable.
Efficacy (Achievement of objectives)	3	Phase 1 of the Study has been completed (November 2004); Phase 2 outstanding.
Efficiency	2	Inefficient; 3 years delay to do part one of study.
Institutional Development	3	Project did not contribute to a stronger PIU, since outside consultants (from USA) have done the study independently of PIU / MOH staff.
Sustainability	3	A study does not have to be sustainable; however its findings need to be presented regularly and its findings made known to stakeholders to make the most of its potential influence.
Cross Cutting Issues	3	Gender is well covered and there is an improved understanding of gender violence and genital mutilation as a result of the study.
Total	21	
Average	3	
Zanzibar Health Development Requirements Study	Score	Comments (Based on Evaluation findings and assessment in November 2004)
Relevance	4	Relevant to expressed needs and policies, especially as regards analyzing health problems in Zanzibar
Quality of Entry	3	Average.
Efficacy (Achievement of objectives)	3	Good; study has been done and has led to the Private Health Sector Study which will begin in 2005.
Efficiency	2	Study was delayed and therefore less useful when finally completed.
Institutional Development	3	Fair. Some training was done for PIU staff in Study objectives and use of the Study findings.
Sustainability	3	Benefits of training diminished by transfers.
Cross Cutting Issues	3	Gender good because female health problems analyzed; environment good (since study showed the need for vector control and of improving environmental sanitation), regional integration not an issue.
Total	21	
Average	3	
First Health Rehabilitation Project, ov	Score	Comments (Overall team assessment of the above findings and assessments)
Relevance	4	Relevant to expressed needs and policies, especially as regards training for improving hospital management and upgrading infrastructure.
Quality of Entry	2	Poor, appraisal process excluded MOH, and hospital staff on the ground, and was top-down.
Efficacy (Achievement of objectives)	3	Infrastructure achieved partially, but equipment installation, quality and technology choice not always appropriate; some, not all training achieved.
Efficiency	2	Delayed and therefore cost inefficient civil works, delays led to equipment damage / deterioration. Training was efficient, but is still being delayed and thus reduces efficiency of staff to do their job.
Institutional Development	3	Fair. Some training was done for hospital maintenance staff and this strengthened hospital management capacity.
Sustainability	3	It is not yet known how sustainable infrastructure and equipment will be because hospitals and district health authorities have to increase their allocations for recurrent and operational costs. Technical staff have been trained in preventive maintenance.
Cross Cutting Issues	3	Gender good, environment not good, regional integration reasonable.
Total	20	
Average	3	