

Tanzanian-German Development Cooperation

Improved Access for the Poor to HIV/AIDS related and Reproductive Health Services and Strengthening the National Health Insurance Scheme

Ex Ante Poverty Impact Assessment

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Treatment
CHF	Community Health Fund
CHMT	Council Health Management Team
CCHP	Comprehensive Council Health Plan
CSSC	Christian Social Service Commission
DAC	Development Assistance Community
DHS	Demographic and Health Survey
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GTZ	German Technical Cooperation
HBS	Household Budget Survey
HIV	Human Immune Deficiency Virus
HF	Health Facility
HDI	Human Development Index
HSSP	Health Sector Strategic Plan
JAST	Joint Assistant Strategy Tanzania
KfW	German Development Bank
MDG	Millennium Development Goal
MOHSW	Ministry of Health and Social Welfare
MMR	Maternal Mortality Ratio
MOF	Ministry of Finance
NGO	Non-Governmental Organisation
NHIF	National Health Insurance Fund
NMSF	National Multisectoral Strategic Framework
NSGPR	National Strategy for Growth and Poverty Reduction
OECD	Organisation for Economic Co-operation and Development
PIA	Poverty Impact Assessment
PMTCT	Prevention of Mother to Child Transmission
POVNET	DAC Network on Poverty Reduction (OECD)

PRS	Poverty Reduction Strategy
PLHIV	People living with HIV
TACAIDS	Tanzanian Commission for AIDS
TGPSH	Tanzanian German Programme to Support Health
THIS	Tanzania HIV Indicator Survey
UNDP	United Nations Development Programme

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Executive Summary

The Poverty Impact Assessment was conducted looking at an intervention under planning and therefore assessing ex ante possible poverty outcomes and impacts. This allowed informing the second mission in September 2007 to choose based on the findings a preliminary design leading to a greater impact on poverty and approaches most effective and efficient to reduce poverty.

The agreed **objective of the intervention** is to increase the **access of poor people to good quality maternal health services, including PMTCT and to safe male circumcision services** through the use of special health insurance cards **managed by a strengthened NHIF/CHF system.**

It was agreed to strengthen the systems and structures of NHIF to move it towards being an efficient and modern social health insurance organisation working in both the formal and informal sector and link it effectively with CHFs and other community-based schemes. This will enable also poor population groups to be members of a social health insurance scheme, and with that have continuous access to health services of good quality provided by private and public facilities.

About 36 per cent of Tanzanians were living below the poverty line in 2000/01; only 3 percentage points less than the 39 per cent estimated in 1991/92. This slight decrease covers both food and basic needs poverty.

The intervention is in line with the National Strategy for Growth and Poverty Reduction and the Strategies of the MOHSW. The NSGPR aims at increasing the income of the poor, cutting down child and maternal mortality, mainly through equitable access to health care which is regarded as essential, and to halt the further spread of the HIV epidemic.

The health sector is recognised as one of the three key sectors for the reduction of poverty contributing to an essential asset enabling the people to participate in economic growth: this is health.

The health sector strategy aims at achieving better access for the poor and vulnerable, equitable service delivery, output based performance monitoring and fostering partnership between the different service providers of the public and private sector.

Reducing maternal mortality is one of its major objectives. With 576 maternal deaths per 100 000 live birth it is very high.

HIV/AIDS is considered to be one of the most impoverishing factors Tanzania is facing affecting mainly people in their productive age.

The country is confronted with a generalised HIV epidemic. The overall infection rate of the adult population between 15 to 49 years of age is estimated to be 7 per cent.

The HIV Strategy describes as important preventive strategies PMTCT and male circumcision. Presently only 12 per cent of women have access to PMTCT.

Through the planned intervention more poor women in first two, later four selected regions covering a population of 5.6 million will have effective access to quality maternal health care including PMTCT and ART if necessary and leave the facility after delivery healthy with their healthy newborn.

Based on the population size and HIV prevalence estimates of 2006 and assuming 50% coverage after the three years of the intervention 113 000 poor women will undergo a safe delivery, 645 maternal deaths will be avoided as well as the transmission of an HIV infection to 1230 children.

Maternal mortality in the respective regions will be reduced significantly. This also has an impact on the national maternal mortality ratio.

The calculation of the reduction of maternal morbidity is not possible due to the non availability of data.

Through effective implementation of PMTCT more children will be born free of HIV. Under five mortality of children will be further reduced as well, because HIV infected children have a limited life expectancy.

ART treatment of 1644 HIV infected pregnant women will increase their life expectancy and therefore contribute to halt the increase of the number of orphans, who often face extreme poverty.

Circumcision of 30 000 men prevents new HIV infections by reducing the risk for acquire an HIV infection for these men by 50% and so contributes to halt the further spread of the HIV epidemic.

The impact of both interventions on the reduction of the overall HIV prevalence rate is difficult to assess, because other effective interventions are also implemented at the same time. The contribution of this specific intervention is relevant but its extent cannot be estimated exactly.

These women will be able to continue participating in the day to day economic and social community life and to contribute to economic growth. This leads to the reduction of poverty. The impact of the intervention on poverty reduction is not limited to the fact only that poor population groups have not to pay for the services offered. The ongoing participation in and contribution to the economic and social life and economic growth possible because of continuous good health is of equal importance. It is difficult to give figures for this impact and exactly measure the contribution of the intervention to poverty reduction, being only one of others. However, scientific studies strongly support the importance of good health for poverty reduction.

The vulnerability of the targeted population for external shocks is reduced, because they are members of a health insurance scheme, which avoids use of essential assets when in need of these specific health services and with this avoids falling back into poverty or extremer poverty.

A population based baseline and a follow up study covering the population of the catchment areas of involved HFs could support the effectiveness of this intervention and help to estimate its impact on poverty reduction.

The foreseen intervention is now limited to selected services, which are of great relevance but also should pave the way to a comprehensive health insurance of poor people in the whole of Tanzania in a social health insurance scheme, which will reduce their vulnerability further and improve their health, an essential asset to participate in economic growth.

This is the outcome of the second aspect of the intervention, which is the strengthening of the national health insurance scheme and the community health fund and linking of both.

While the support of access to specific services for poor population groups is limited to selected regions the support of strengthening the NHIF and its expansion to an increasing number of people will improve the situation of poor population in the whole country by creating the possibility for them to become members.

Although the extent of this outcome cannot be measured exactly it goes far beyond the limited impact reflected in the above mentioned figures.

This structural component of the project with its nationwide outcome contributes also to its cost effectiveness.

Another important outcome of improved access to services through a health insurance membership is the empowerment of women and the empowerment of whole communities to ask for quality of services.

In the possession of the insurance card and improvement of quality of services women will be empowered to search health care when they feel it is needed independently of the money provided by the head of household.

As the details of the service to be delivered are known to them, they are enabled to actively ask for what they are entitled to receive. The described inequalities of service provision by health workers to poor and wealthy people will be reduced.

Participation in a social insurance scheme offers the members the opportunity to actively ask for good quality of services and contributes to practising their democratic rights.

Health facilities receive payment for services delivered through the NHF and can continuously improve and keep quality of services through reinvestment in the infrastructure as well as in payment of staff.

Because of the extent of the coverage as well as the primary and secondary outcomes and impacts the intervention is under the given condition cost effective compared to others targeting HIV related and reproductive health services for poor population groups. It also can ensure that the poor are reached, what is hardly the case for other interventions actually implemented.

The project is at risk not to result in the intended outcomes and impacts, because

- insurance cards might not reach the poor,
- services might be provided to a limited number of poor only,
- service providers might not use the reimbursed money for improvement of quality of services
- service providers might not provide all elements of a service of high quality
- transport costs might overweight the advantages of good quality of care and prevent women from seeking care
- good governance of the NHIF might worsen
- Government is reluctant to take over subsidies after the external support comes to an end.

Therefore it is strongly **recommended for the design process to:**

- Carefully and in detail define the service packages for the planned interventions following the national guidelines to ensure quality of services provided.
- Develop criteria for monitoring the implementation of these services to ensure good quality of services provided; criteria have to be included into the quality monitoring approach of NHIF as well as into the supervision of the CHMTs
- Develop a baseline study to be repeated at the end of the intervention to estimate the outcome/impact is achieved
- Assess and describe the physical needs for quality service provision and make their availability a criterion for accreditation of a health facility in the NHIF
- Develop criteria to identify the poor together with community and local government leaders based on the experiences made with the existing but not well functioning waiver system
- Design mechanisms for insurance card distribution to ensure the participation of all poor in a district and involve the community in identifying the poor
- Define a mechanism for accreditation of HFs with a high percentage of poor in their catchment area
- Strengthen fraud control of HFs through control mechanisms of NHIF
- Design a system to monitor the importance of transport cost for women's access to care and foresee the possibility to also provide funds for transport, if necessary
- Clearly define through an institutional assessment the capacity development needs for NHIF and improve it while proceeding
- Make regular external audits of the NHIF mandatory for the support to ensure continuous good governance.
- Plan early discussions with Ministry of Finance in coordination with MOHSW to ensure continuous payment of subsidies for the poor members of the social health insurance scheme.

The assessment is based on data collected through national surveys of a high quality resulting in valid data. The main source builds the Household Budget Survey, which is conducted every seven to ten years. The latest data were collected in 2001.

Since then a lot of economic changes to the better have taken place, which are not reflected in the data. This is a limitation of the data used.

1.0 Background and Rationale for the Study

1.1 Tanzanian German Cooperation and Tanzanian Strategies

A long standing bilateral cooperation exists for the health sector between the Government of the United Republic of Tanzania and the Government of the Federal Republic of Germany. All actors of German bilateral cooperation active in the sector work together in the Tanzanian German Programme to Support Health (TGPSH) which has a common goal with the ongoing Tanzanian health sector reform: "To improve the health and well-being of all Tanzanians, with a focus on those at most risk and to encourage the health system to be more responsive to the needs of the people".

The main areas of support are reflected in the six components of the programme:

1) human resources for health, 2) district and quality management, 3) reproductive and sexual health, 4) multisectoral AIDS control, 5) private public partnership and 6) health financing.

Germany is part of the sector wide approach in health and the JAST and an important partner in the ongoing sector dialogue for harmonisation of development partners' support.

KfW finances activities in the field of health infrastructure, social marketing of condoms and contraceptives, and contributes to the health sector basket.

The HIV epidemic and its consequences is recognised by the Tanzanian Government and internationally as a central problem for further development and poverty reduction; so is the link between sexual and reproductive health and AIDS.

The Government of Tanzania is committed to reduce poverty and to reach the Millennium Development Goals (MDGs).

The health sector is concerned and the key sector for reaching MDG 4 (to reduce child mortality), MDG 5 (to improve maternal health) and MDG 8 (to combat HIV/AIDS). It contributes with reaching these goals also to the reduction of poverty (MDG 1).

Sector specific and national strategies reflect this situation in an appropriate way.

The MOHSW has committed itself also to develop a national social health insurance system and move slowly from a tax based financing of health care to social health insurance and established the National Health Insurance Fund (NHIF) and the Community Health Fund (CHF). The further extension of these schemes and linkage between the statutory social security scheme NHIF and the community based social protection mechanism CHF is an objective of major importance.

Following its international commitment the German Government has allocated EUR 13 million to improve access of the poorer population to HIV/AIDS related and Reproductive Health (RH) Services in Tanzania and contributes with this to reaching the above mentioned MDGs.

1.2 Appraisal of Intervention Options during first KfW Mission

A first mission took place in June and was expected to identify innovative and effective ways to improve reproductive health and HIV/AIDS-related services. These may include developing new approaches and would look at new ideas to make existing schemes more effective at reaching the poor or other specific target groups.

The following programmes and systems were to be considered as possible areas, institutions and modalities for support:

- sector budget support activities and the health sector basket financing
- ring-fenced HIV Fund - TACAIDS
- extended cooperation with PSI Tanzania in social marketing
- cooperation with the Clinton Foundation and provision of transport subsidies
- access of youth to reproductive and sexual health
- The National Health Insurance Fund and Community Health Funds

All options were reviewed in the light of the policy framework in Tanzania, including the Multisectoral Strategic Framework on HIV/AIDS, the Health Sector Strategic Plan, the Health Sector Strategy for HIV/AIDS and the National Policy for Growth and poverty Reduction.

Through an intensive consultation process including government representatives from Ministry of Health and Social Welfare (MOHSW), the Tanzanian Commission for AIDS (TACAIDS), national NGOs and all development partners concerned the interventions to be supported were decided on

to be:

“Improved access of the poor to HIV/AIDS related and Reproductive Health Services and strengthening social health insurance” with the

- **primary objective:**
 - to give poor women access to Antenatal Care (ANC), Prevention of Mother to Child Transmission (PMTCT), safe delivery and post natal care,
 - enable poor people living with HIV to stay healthy through access to continuous monitoring and
 - give poor men access to safe circumcision services
- using special NHIF/CHF cards and the
- **secondary objective:** to support strengthening and expansion of social health insurance through NHIF and CHF and link the two systems.

Excluded were:

a) General/Sector Budget Support and Basket Funding.

These funding mechanisms do not allow “ear-marking” e.g. the allocation of funds for specific services and/or target groups for example the poor. It is also difficult to ensure that innovative approaches are developed and implemented.

GFATM is providing significant funds to the districts. As a consequence MOHSW recommends that CHMTs do not allocate extra funds for HIV/AIDS related activities in the CCHPs, which are to a great extent financed through the basket.

Thus ensuring improved HIV & RH services and reaching the poor could not be guaranteed: although it is recognised that these services are within the health plans and strategies.

b) Ring-fenced HIV Fund – TACAIDS

This fund has been designed to support multisectoral approaches in controlling HIV/AIDS and attempts to find a mechanism to earmark and track spending on HIV activities and measuring their impacts within the context of budget support, although earmarking contradicts budget support.

It seems to be technically very difficult to structure this and make it acceptable to all parties and implementation is still pending.

As it is not primarily funding the activities of MOHSW reaching the objective of improved quality of health services and better access for the poor would be very challenging.

c) Social Marketing and PSI

Social Marketing Programmes exist in Tanzania for subsidized condoms, contraceptives, water purification tablets and impregnated mosquito nets. The German Government has supported PSI-managed social marketing programmes since 2005.

Social marketing does not enable the poor to better access specific health services.

Therefore additional funding to the PSI-managed Social marketing scheme was not considered as falling within this intervention: Improved access of the poor to reproductive health and HIV/AIDS-related services.

Besides this difficulty sufficient funding is available through KfW and the GFATM until end of 2010.

d) Clinton Foundation and transport subsidies

The Clinton Foundation is supporting PMTCT in Mtwara and Lindi Regions and has been working closely with TGPSH. They are proposing to extend the support to ensuring safe delivery in health facilities.

Institutional delivery is the key intervention to reduce maternal morbidity and mortality and to allow implementation of PMTCT. However, studies have shown that an important barrier to delivering in health facilities is the cost of transport.

The Clinton Foundation was asked to write a proposal specifying methods and approaches to subsidise the cost of transport to health facilities for PMTCT and Safe Delivery within the overall context of their support. Until now, no proposal has been received. Due to time constraints a decision has to be taken now.

e) Access of youth to reproductive and sexual health services.

Consideration was given to increase the access of (urban) youth to good quality reproductive and sexual health services. The approach would have been implemented by working closely with a variety of public and private/NGO health care providers.

However, it was felt that there is no suitable strong national NGO available and no support for developing a parallel scheme.

1.3 International commitment

In a policy statement by the DAC high level meeting in Paris in 2001 all members expressed their commitment to reducing poverty in all its dimensions and achieving the seven international development goals.

In the Paris declaration from 2005 they additionally committed themselves to greater international harmonisation including the use of common agreed instruments. The declaration also contains a call to improve the ex ante impact assessment of donor interventions. The Poverty Impact Assessment (PIA), as it is called, focuses on the – intended and unintended – impacts on poverty achieved by the project.

The second mission to further design the above mentioned intervention took place in September 2007 and continued the process of consultation to review the results of the first visit and defined the proposed interventions more clearly and ensured that they were firmly within the policies and plans for health in Tanzania and would contribute to achieving the MDGs, poverty reduction and to reducing the spread of HIV.

Therefore it was envisaged to conduct an ex ante poverty impact assessment at the same time to allow based on the findings a design leading to a greater impact on poverty and approaches most effective and efficient to reduce poverty.

2.0 Methodology

The consultant used the Poverty Impact Assessment Method developed and tested by a team within POVNET and adopted by the DAC/OECD in March 2006. Modules and tables are used accordingly. No major changes were necessary or applied. However, the suggested tables do not allow accommodating all analysed outcomes, which are therefore only described in the accompanying text. These outcomes are positive and not primarily intended secondary and tertiary outcomes.

The assessment was made on the basis of existing data and documents listed in Annex 1, enriched with information received from key informants in Tanzania through interviews focusing on questions still not answered sufficiently by the data available and documents reviewed.

The following areas were explored:

- Outcomes for the different stakeholders based upon the concept of multi-dimensionality of poverty and an assessment of the intervention's broader implications for a range of stakeholders in terms of the OECD/DAC capabilities framework
- The potential impact on the MDGs
- The importance and inter-relationship of individual transmission channels through which changes are transmitted to the stakeholders
- Key assumptions and identification of potential risks; at the same time an assessment of the reliability of data/information used in the exercise and identification of key knowledge gaps
- The relation of the intervention and contribution to achievement of goals of the national Strategy for Growth and Reduction of Poverty (NSGRP), Health Sector Strategy (HSS) and National Multisectoral Strategic Framework for HIV/AIDS (NMSF)
- Suggestions for designing the intervention to assure the pro-poor impact and for appropriate monitoring procedures.
- Assessment of the project with regard to poverty reduction guidelines/policies of German DC. Assessment of the poverty orientation of the project as per German DC poverty classification.

3.0 Poverty Situation in Tanzania and the Relevance of the Interventions for the national Strategies

3.1 Income poverty

Despite progress in macroeconomic stability Tanzania remains to be one of the poorest countries in the world with a per capita GDP of about U\$660¹. According to the UNDP Human Development Index Tanzania has fallen from its 140th position out of 162 in 2001 to place 164 out of 177 in 2003.

Poverty estimates in Tanzania have been derived from data based on periodic household budget surveys, which were conducted every 10 years, latest in 2000/01.

Poverty incidence is defined as the percentage of people living below the basic needs poverty line. In Tanzania, the basic needs poverty line in 2000/01 was set to be TShs 7253 per adult equivalent per 28 days. An adults using less then 262 TShs per day for satisfying basic needs is considered to be poor. The food poverty line is defined as the percentage of people using less than TShs 5295 per 28 days for food supply.

Income poverty is high. Actual poverty estimates are based on the figures of the household budget survey 2000/01, which is for the first time also producing data for districts and not

¹ African Economoc Outlook, AfDB/OECD 2006

whole regions only, drawing a much better picture of the situation in Tanzania in regard to the different aspect of poverty and allowing better targeted interventions.

Trends are described by comparing it with the data from the 1990/91 survey.

These surveys indicate that about 36 per cent of Tanzanians were living below the poverty line in 2000/01; only 3 percentage points less than the 39 per cent estimated in 1991/92. This decrease covers both food and basic needs poverty (headcount ratio) and is not statistically significant.

The absolute number of people living in poverty has increased because of population growth and is estimated to be 11.4 million (below basic needs poverty line).

The incidence of poverty in rural areas decreased from 41 to 39 per cent; in Dar es Salaam the decrease was from 28 to 18 percent. Other urban areas, except Dar es Salaam, recorded a small decrease in poverty in the 1990s from 29 to 26 per cent of households.

There is a big gap of poverty between rural and urban population.

According to the household budget survey, 87 per cent of the poor are rural population and 81 per cent of the poor live in households where the main economic activity of the head of household is agriculture. Furthermore, 70 per cent of the employed work in agriculture.

Therefore the need to focus on reducing poverty in rural areas remains compelling.

Table 1: ²

DISTRIBUTION OF THE POOR IN TANZANIA

	Dar es Salaam		Other urban areas		Rural areas		Mainland Tanzania	
	91/92	00/01	91/92	00/01	91/92	00/01	91/92	00/01
Total population '000	1,313	1,845	3,094	4,405	20,154	25,650	24,561	31,900
Share of population	5.3	5.8	12.6	13.8	82.1	80.4	100.0	100.0
Number of poor:								
Food Poverty '000	179	138	464	581	4,656	5,233	5,305	5,965
Basic Needs '000	369	325	888	1,136	8,223	9,926	9,481	11,388
Percentage of poor:								
Food Poverty	3.4	2.3	8.7	9.7	87.8	87.7	100.0	100.0
Basic Needs	3.9	2.9	9.4	10.0	86.7	87.2	100.0	100.0

There has been a continuous increase of economic growth since 2001 with a GDP growing from 4.9 percent to 6.7 percent in 2004. But taking the population growth into consideration this increase is not yet big enough to reduce poverty significantly.

² Household Budget Survey Tanzania 200/01; National Bureau of Statistics; July 2002

Table 2: Income poverty indicators, baseline and target ³

Indicator	Baseline		Trend				Targets	
	Estimate	Year	2001	2002	2003	2004	PRS 2003	MKUKUTA 2010
% of the population below the basic needs poverty line	36	2000-01					30	19
% of the population below the food poverty line	19	2000-01					15	10
GDP growth rate (%)	4.9	2000	5.7	6.2	5.7	6.7	6	6-8
Agricultural growth rate (%)	3.4	2000	5.5	5.0	4.0	6.0	5	10
Inflation rate (%)	5.9	2000	5.2	4.5	3.5	4.1	4	4
% of working age population not currently employed	13	2000-01						7

Much of the growth is caused by macroeconomic reforms, which the country has introduced in the 1990's.

Unequal distribution of growth can minimise its impact on poverty reduction. However, analysis of the household budget surveys indicates that there has not been a significant increase in inequality in the 1990s. The most commonly used indicator of inequality, the Gini coefficient, increased from 0.34 in 1991/92 to 0.35 in 2000/01. Inequality appears to have increased to a greater extent in urban areas, especially in Dar es Salaam, where the Gini coefficient changed from 0.30 in 1991/92 to 0.36 in 2000/01. Other urban areas, apart from Dar es Salaam, experienced a small increase in the Gini coefficient in the 1990s from 0.35 to 0.36 between the two household budget surveys. On the other hand, the Gini coefficient in rural areas remained unchanged at the level of 0.33.

Table 3: Decomposition of changes in poverty (%) ⁴

	Country level	Dar es Salaam	Other urban	Rural
Poverty 1991	38.6	28.1	28.7	40.8
Poverty 2001	35.4	17.6	26.0	38.7
Change 1991/2001	-3.2	-10.5	-2.7	-2.1
Growth impact	-8.4	-18.4	-6.6	-5.3
Inequality impact	5.5	12.4	4.0	2.7
Residual	-0.2	-4.5	-0.2	0.6

The data also show that even small changes in inequality have adversely affected poverty reduction. The World Bank's analysis for the Country Economic Memorandum (2005) concluded that, whereas in the 1990s growth in Tanzania reduced poverty rates in all areas, changes in inequality mitigated the impact of this growth on poverty reduction.

³ National Bureau of Statistics 2002; Economic Studies

⁴ Poverty and Human Development Report 2005; REPOA Dar es Salaam

The percentage of households below the basic poverty line in the envisaged implementation Regions is 21 per cent in Mbeya, 36 per cent in Tanga, 38 per cent in Mtwara and 53 per cent in Lindi with huge variations between districts. In Mbeya for example in four of the eight districts 30 to 40 per cent of the population lives below the basic poverty line.

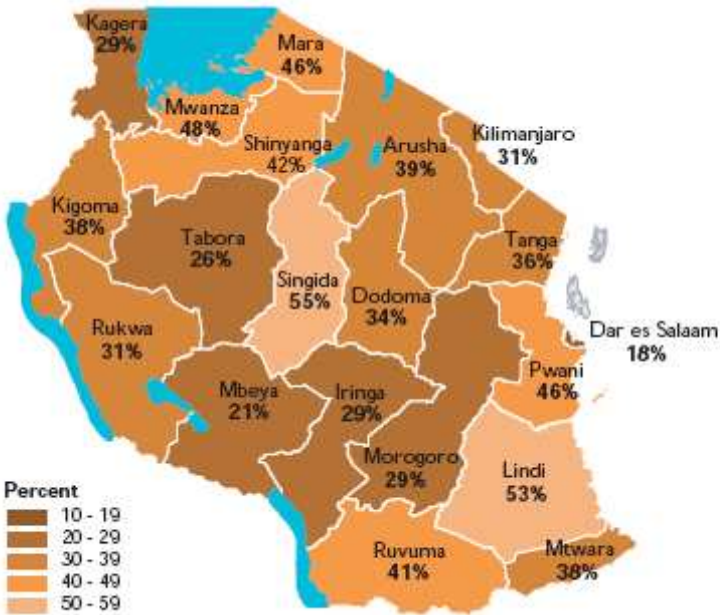


Figure 1: percentage of population below basic poverty line

The Human Development Index (HDI) for Mbeya is 0.54, Tanga 0.447, Mtwara 0.488 and Lindi 0.407 with the highest Index for Dar es Salaam=0.73 and the lowest for Rukwa=0.39. The lowest Human Poverty Index (HPI) is reported for Dar es Salaam with 21.4, the highest for Kagera with 50.9. Mbeya is to be found in the moderate middle zone with 28.7, Tanga has a slightly higher index with 40.7, Mtwara 36.8 and Lindi 47.2.

3.2 Non income poverty

The poorer part of the population carries a bigger burden of ill health than the non poor. Infant mortality rates for the two poorest quintiles are around 40 per cent higher than those of the least poor.⁵ Variations between regions and districts within regions are huge.

⁵ Fair’s Fair; Health Inequalities and Equity in Tanzania; Paul Smithson, November 2006

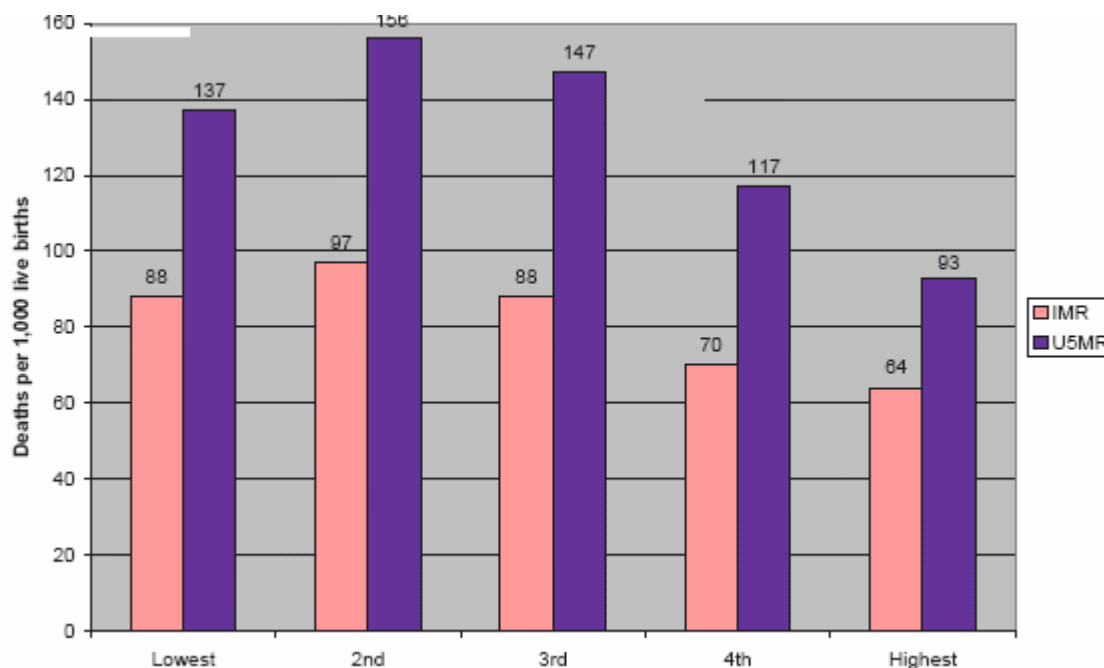


Figure 2: Infant and Under-Five mortality by Wealth Quintile

Those who are most in need of health care use it least.

There exists also a difference in treatment received by people reaching a facility depending on their degree of poverty.⁶ Even if the women seek care the poor women are less likely to receive the services to the extent available. Poorer people experience poorer treatment outcome.

Ill health is experienced by people as a loss of bodily well being, loss of labour power, decline in material wellbeing and personal safety and security. It can also lead to stigmatisation as a result of a medical condition.⁷

Increased and equitable access to good quality health services and its utilisation provides poorer population with the capabilities needed to participate in opportunities that economic growth offer.

The Tanzanian Government has recognised the importance of good health for poverty reduction and focuses with the National Strategy for Growth and Poverty Reduction (NSGPR) on the three main and interrelated areas: 1) growth and reduction of income poverty, 2) improved quality of life and social well-being, and 3) good governance and accountability.

Universal access to quality public services is a goal of the NSGPR and health one of three priority sectors.

Several studies in Madagascar and Indonesia show that access to and with that increased use of health care has a positive effect on income. A person, who cannot obtain medical care when being ill, suffers a loss of income, especially when the illness requires a period of inactivity.⁸

Tanzania has a remarkable wide distribution of health facilities with nearly 100% of urban and 75% of rural population living less than 5 km away from a health facility. However, there are many obstacles accessing quality health care including health care charges and

⁶ Fair's Fair; Health Inequalities and Equity in Tanzania; Paul Smithson, November 2006

⁷ Vulnerability and Resilience to Poverty in Tanzania; 2002/03 Tanzania Poverty Assessment: Main Report

⁸ Health, Education and poverty Reduction, Christian Morrison; OECD Development Centre, Policy Brief No 19

unofficial costs to be paid although several services are supposed to be delivered free of charge.

Other important factors are long distances and cost for transport and at the same time low quality of services provided.

This leads to discrepancies as observed for Mbeya Region where 93% of the population have access to a health facility but only 61% of people interviewed went for treatment in case of illness.

In 2003 73% of interviewed people reported that health care has become less affordable.

Acute and not planned payment for illnesses or prevention of illnesses reduces assets of poor people, further impoverishes them and increases their vulnerability.

Especially women who earn less and do not have decision making power over assets fail to search for health care when in need.

Limited financial resources for the primary care level, low payment of a limited number of health workers and structural problems lead to a low quality of care.

Users are not satisfied with the services offered. In case of illness people are less likely to seek care and spend money for transport and treatment related costs.

Women's health status continues to be compromised by inadequate family planning and maternal health care especially in rural areas. This has an impact on newborn and maternal morbidity and mortality.

Maternal mortality has not been significantly reduced during the last 20 years and remains very high with 576 deaths per 100 000 live births. This is related to a low rate of deliveries taking place in health facilities with skilled attendance. Data show a decline of the number of women delivering in health facilities from 53% in 1991 to 47% in 2004 although 98% of women attend antenatal care at least once during their pregnancy.⁹

Chronic disease conditions caused by unskilled or not attended delivery leads to stigmatisation by and expulsion from the community and further deprivation of rights and increased poverty of women.

Closely related to maternal mortality is newborn mortality which has not improved over the last years either.

Effective access to quality health care and especially to maternal health care is necessary to really improve maternal health.

Poverty is associated with poorer physical access to health services. They are disadvantaged in their effective access to health care.

The poorer half of the population lives further away from health facilities.

⁹ Demographic and Health Survey Tanzania, 2004.; National Bureau of Statistics.

% Population within 5kms of Health Centre/Dispensary by Poverty Quintile			
Poverty Quintile	DSM	Other Urban	Rural
Poorest	96%	97%	65%
Second	99%	97%	63%
Third	96%	97%	64%
Fourth	100%	98%	72%
Least Poor	99%	99%	77%

% Population within 10kms of Hospital by Poverty Quintile			
Poverty Quintile	DSM	Other Urban	Rural
Poorest	93%	97%	34%
Second	98%	97%	31%
Third	94%	97%	34%
Fourth	100%	98%	37%
Least Poor	100%	99%	42%

Source: World Bank reanalysis of HBS data 1991/92 and 2000/01

Table 4

With this situation transport costs become a relevant barrier for effective access. 37 per cent of women mentioned distance and need for transport to be a big problem.¹⁰ About 50 per cent did not seek care because of expenses and non availability of the necessary resources and at the same time low quality of services offered. There exists a substantial difference of utilisation of services in relation to poverty. Women from richer households are 2.8 times more likely to receive skilled assistance during labour. Poorer women are more than 7 times more likely to give birth at home and receive no postnatal check up for their infants.¹¹

¹⁰ Demographic and Health Survey Tanzania, 2004.; National Bureau of Statistics.

¹¹ Fair's Fair

Poor : Non-Poor Differences in Health Care Use, TDHS 2004/5

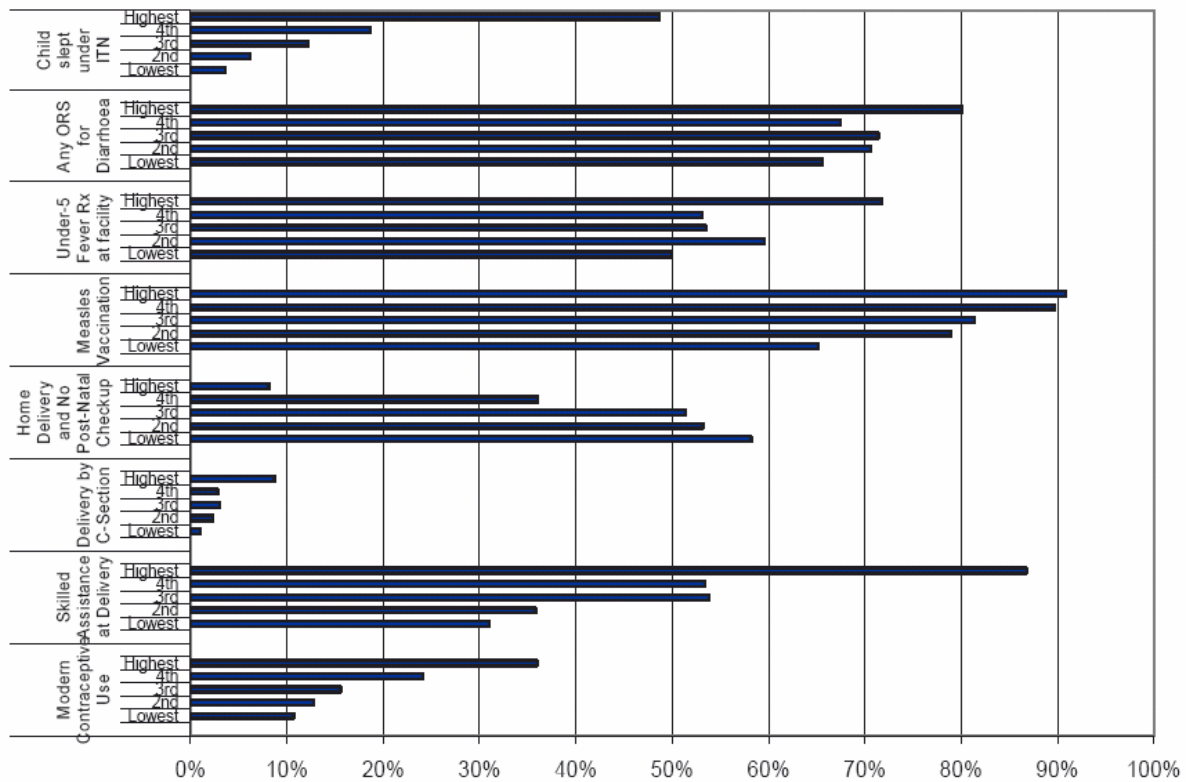


Figure 3

HIV/AIDS is considered to be one of the most impoverishing factors Tanzania is facing affecting mainly people in their productive age. Projections indicate that the economic growth will reduce by 8.3 per cent by 2015 and GDP by 4 per cent due to the HIV epidemic. HIV/AIDS contributes directly to poverty and hinders further development significantly.

Tanzania is facing a generalised HIV epidemic. The overall infection rate of the adult population between 14 to 49 years of age is estimated to be 7 per cent with a slightly higher infection rate in women (7.7% and 6.3% respectively). Huge variations between regions and between districts inside regions exist reaching from 13 per cent to 5 per cent between regions and 18 to 3 per cent inside regions.

Currently 1.3 million people including adults and children are living with HIV and AIDS. The number of infected children is growing mainly due to the transmission of the virus from their mothers during pregnancy, delivery and through wrong feeding procedures.¹²

Mbeya region foreseen for the implementation has the highest infection rates in the country with 13.4 per cent. The infection rate of the adult population is less in Tanga with 5.7 per cent, in Mtwara 7.4 per cent and Lindi 3.6 per cent.

¹² Tanzania HIV Indicator Survey 2004; National Bureau of Statistics

3.3 Policy Framework

The Government of Tanzania has committed itself to reaching the Millennium Development Goals (MDGs). This is reflected in the actual implemented National Strategy for Growth and Poverty Reduction which adopts an outcome-based approach focusing on three clusters:

1. growth, reduction of income poverty
2. improved quality of life and social well-being
3. good governance and accountability

This strategy focuses on the poorest and most vulnerable groups and makes a commitment to reduce inequities across geographic, income, gender, age and other groups.

It aims at increasing income of the poor, cut down child and maternal mortality, mainly through equitable access to health care which is regarded as essential, and halt the further spread of the HIV epidemic.

The health sector sees its role mainly in contributing to cluster two and with that indirectly to cluster one.

The Health Sector Strategic Plan (HSSP) highlights *“provision of quality health service”* and the greater integration of health services.

The strategy aims at achieving better access for the poor and vulnerable, equitable service delivery, output based performance monitoring and fostering partnership between the different service providers of the public and private sector.

Reducing Maternal Mortality is one of its major objectives. A `Road Map to Maternal and Child Health` was developed to further define how to reach this objective. One of the relevant strategies included is to increase the number of deliveries in health facilities.

To be able to sufficiently contribute to the prevention, treatment and mitigation of HIV and its impact an HIV health sector strategy was developed as well, which includes as one of the important preventive strategies PMTCT, male circumcision and the greater care for PLHIV not yet under treatment to extent the healthy period of their life. Actually only 12 per cent of women have access to PMTCT. PLHIV are not monitored on a regular basis and consequently often not treated in time, when ill with an opportunistic infection.

This HIV sector strategy also reflects the objectives of the National Multisectoral Strategic Framework for HIV/AIDS (NMSF), revised in June 2007.

All national strategies mentioned reflect very well the poverty situation in the country, its causes and how to improve the situation and contribute to poverty reduction and pro-poor growth as well as to reaching the MDGs.

The MOHSW has committed itself also to develop a national social health insurance system and move slowly from a tax based financing of health care to social health insurance and established the NHIF and the Community Health Fund (CHF). The further extension of these schemes and linkage between the statutory social security scheme NHIF and the community based social protection mechanism CHF is an objective of major importance.

3.4 Planned interventions

The agreed **objective of the intervention** is to increase the **access of poor people to good quality maternal health services, including PMTCT and to safe male circumcision services** through the use of special health insurance cards **managed by a strengthened NHIF/CHF system.**

During the second mission the number of interventions were reduced from those defined during the first mission to the following

- 1) improve access for poor women to ANC, PMTCT, safe delivery and postnatal care
- 2) Improve access of poor men to safe circumcision services
- 3) strengthening and expansion of social health insurance through NHIF and developing a linkage between NHIF and CHF.

To demand for the service the clients will use CHF/ NHIF special cards. By using NHIF and CHF for the provision and distribution of the cards a missing linkage between CHF and NHIF will be established, the organisation will be strengthened and expansion of social health insurance supported, preparing the way for a national scheme with (high) subsidies for the premiums to be paid by poor.

Public, private for profit and non profit health facilities will be included in service provision. Through NHIF health facilities of all categories will be entitled to ask for an advance payment to improve their infrastructure and buy consumables to improve quality of services. The advanced payment will be deducted later from the reimbursement of claimed cards.

The intervention will be limited to selected regions. Criteria for the selection should be:

- HIV prevalence rate
- population size
- percentage of poor population
- a good number of public, FBO and private providers are available to offer services in a reasonable condition
- structures of NHIF and CHF are established
- relation of HIV prevalence and percentage of men circumcised

The intervention is innovative and need in the initial phase the support of reasonably well developed systems in place. A very poor region with weak structures would need more technical support for the implementation than possible.

After once well developed and experiences gained the intervention can be transferred to other less developed regions as well.

Data on the number of private facilities offering services in a region are only available decentralised at the regional or even district level. More developed and less remote regions tend to have more private for profit providers.

The establishment of CHFs and number of members is in most of the districts limited to 1 up to 5 per cent. Only regions supported by the TGPSH reach 20 per cent of the population enrolled. Well established CHFs would support the successful implementation of the project.

No region combines all the selection criteria to a desirable extent.

Region	Poor population	Population size	HIV Prevalence	Circumcision rate	Degree of development
Singida	55%	1.08 mill	3.8%	90.9%	moderate
Lindi	54%	0.78 mill	3.6%	93.3%	moderate
Mwanza	48%	2.92 mill	7.2%	54%	good
Mara	46%	1.36 mill	3.5%	89%	moderate
Pwani	46%	0.88 mill	7.3%	96.9%	moderate
Shinyanga	42%	2.79 mill	6.5%	26.5%	moderate
Ruvuma	41%	1.11 mill	6.8%	68.9%	moderate
Arusha	39%	1.28 mill	5.3%	96.2%	good
Mtwara	38%	1.12 mill	7.4%	97.7%	moderate

Kigoma	38%	1.67 mill	2.0%	68.4%	moderate
Tanga	36%	1.67 mill	5.7%	95.0%	good
Dodoma	34%	1.6 mill	4.9%	96.9%	good
Rukwa	31%	1.13 mill	6.0%	31.8%	moderate
Kilimanjaro	31%	1.37%	7.3%	97%	good
Morogoro	29%	1.73 mill	5.4%	93.1%	good
Iringa	29%	1.49 mill	13.4%	37.7%	good
Kagera	29%	2.02 mill	3.7%	26.6%	moderate
Tabora	26%	1.71 mill	7.2%	42.8%	moderate
Mbeya	21%	2.02 mill	13.5%	34.4%	good
Dar es Salaam	18%	2.48 mill	10.9%	97.8%	good

Table 5: Regional Characteristics relevant for the intervention

Region	No of poor women deliver/year	Maternal death avoidable /year	Poor preg.women in need of ART/year	Children born negative through PMTCT/year	Poor men in need of circumcision
Singida	23 760	136	180	135	none
Lindi	16 848	97	121	90	none
Mwanza	56 064	323	807	605	15 151
Mara	25 024	147	175	131	none
Pwani	16 192	93	236	177	none
Shinyanga	46 872	269	609	465	200 000
Ruvuma	18 204	104	247	186	32 084
Arusha	19 968	115	211	158	none
Mtwara	17 024	98	251	188	none
Kigoma	25 384	146	101	76	44 739
Tanga	24 048	138	274	205	none
Dodoma	21 760	125	213	159	none
Rukwa	14 012	80	168	126	55977
Kilimanjaro	16 988	98	248	186	none
Morogoro	20 068	115	216	162	none
Iringa	17 284	100	463	347	60 000
Kagera	23 432	134	173	129	96 000
Tabora	17 784	102	256	192	59 554
Mbeya	16 968	97	450	337	64 796
Dar es Salaam					

Table 6: Regional estimates relevant for the intervention

The region, where most maternal deaths could be avoided through the intervention as well as the biggest number of poor pregnant women is in need of ART and avoided HIV infection of children born to these women is Mwanza, followed by Shinyanga.

Regions, where less poor women would deliver in a HF but where a big number of poor pregnant women are in need of ART and children could be born HIV free are Iringa, Mbeya

and Tanga. With the exception of Tanga in all regions mentioned a huge number of men are not circumcised.

Mwanza, Iringa, Mbeya and Tanga belong to the regions with a better infrastructure and a good number of private HFs, whereas Shinyanga is a very remote, difficult to reach and less developed region. It can be expected that only very few private providers offer health services in this region.

The biggest impact of the project could be expected, when implemented in Mwanza, Iringa, Mbeya and Tanga Region.

The TGPSH supports four regions, namely Mbeya, Tanga, Lindi and Mtwara Region. A synergy effect of the activities implemented by this programme component and the foreseen project can be expected in these regions, leading to a greater effectiveness of German development cooperation.

In all regions due to the support of TGPSH the enrolment rate of the CHF is already high and 20 per cent a good precondition for linking NHIF and CHF.

It is therefore proposed to start the programme in Mbeya and Tanga region and expand it if and when appropriate as the system develops to Mtwara and Lindi region.

However, for a possible extension of the support beyond the actual three years Mwanza and Iringa should be considered.

This programme will inform planners and policy makers on effective ways to identify the poor and on efficient ways to target subsidies to achieve the maximum benefit. The costs for these subsidies (for limited cards or full NHIF membership) will need to be taken over later by the Government, if the poor are to have access to social health insurance continuously. The planned interventions are in line and supporting the work of the MOHSW and the Tanzanian Government to reach the goals of the HSSP, NMSF and the NSGPR.

4.0 Poverty Assessment of the Intervention “Improved Access of the Poor to HIV/AIDS related and Reproductive Health Services and Strengthening Social Health Insurance”

4.1 Stakeholders and Target Groups

4.1.1 Target groups

4.1.1.1 Poor pregnant women

Poor pregnant women in four regions covering a population of 5.6 million people are identified by community based CHF agents in cooperation with community leaders through a well defined procedure following a given definition of being poor. They are provided with special health insurance cards to access comprehensive antenatal care including PMTCT, ART, safe delivery and post natal care of high quality at a dispensary and health centre and if necessary in a district or regional hospital.

The cards enable the women to access all components of the service of high quality as described in detail in the national guidelines and are clearly defined as a package of the NHIF. The details of the service to be delivered are described on the card.

4.1.1.2 Men not circumcised

Men not circumcised in one region with a high HIV infection rate and a low male circumcision rate covering a population of 2 million can access with a special health insurance card an operation for male circumcision as a standardised well defined procedure carried out of high quality by well trained staff and counselling on the risk still existing on getting HIV infected.

4.1.2 Stakeholders

4.1.2.1 Public, private for profit and non profit service providers

Public, private for profit and non profit service providers in four regions covering a population of 5.6 million people participate in the implementation and are accredited by the NHIF only, if they have participated in an assessment and fulfilled the criteria of a quality service provider. Their catchment area must cover a minimum number of poor.

The clients can select the facility they think of being most appropriate for them independently of their income and the location of and distance to the facility.

Service providers can receive advance payments to equip their facilities with all items and consumables necessary for good quality services and keep this standard through reinvestment of money reimbursed for the insurance cards. Infrastructure needed for the specific services is well defined and service providers given a well elaborated list based on an assessment.

Beside the improvement of working conditions additional staff payment possible because of a regular payment for service provision will increase staff motivation also important for the good quality of services.

4.1.2.2 National Health Insurance Fund (NHIF)

Special insurance cards are given by and reimbursed to the health facilities for the services provided in the above mentioned four regions through the NHIF.

NHIF has to monitor facilities accredited for service provision to ensure that services are offered and provided following the defined packages and high quality of care is kept.

Accreditation of facilities has to ensure that their catchment area covers a defined number of poor and they adhere to defined quality criteria.

NHIF employees must reimburse claims of HFs for services provided in a timely manner and control continuously for fraud.

The NHIF has to be supported to develop these new service packages and cost them.

Including these services into the NHIF scheme will also pave the way to a comprehensive health insurance of poor people in the whole country in a social health insurance scheme.

The extension of the membership to more people is not restricted to the four regions only but will include the whole country. To allow for this strengthening of the NHIF and capacity development is essential and will follow priority areas well defined after an institutional assessment of the NHIF.

4.1.2.3 Community Health Fund (CHF)

Community Health Fund (CHF) as a community based health insurance scheme will be linked with the NHIF. Ways on how to achieve this linkage will be developed. CHF agents as partners of NHIF are involved in the identification of the poor to be provided with the insurance cards for the specific interventions.

4.1.2.4 Medium size companies and cooperatives

Medium size companies and cooperatives in rural areas, who work together and depend on small scale rural producers like tea and coffee producers, milk farmers etc., are offered to insure those producers for a longer and defined period of time in the CHF/NHIF and allow them to access the special insurance cards and services.

4.1.2.5 Ministry of Health and Social Welfare (MOHSW)

The strategic plan of the MOHSW foresees the further development of a social health insurance scheme to replace continuously the tax based scheme. The MOHSW has to ensure that implementation is following the respective national policies.

The responsible personnel of the Ministry participate in package formulation, development of quality standards and needs assessment for essentials needed for service provision.

Table 1: Analysis of Stakeholders and Institutions

Stakeholders (target groups/ intermediaries) Institutions	Main tasks of stakeholder/ main role of institution	Interests and pro-poor agenda, Aspects that might hinder them to have a pro-poor agenda (details and risks)	Rating of their pro-poor agenda (+/-)	Mitigating and/or reinforcing measures
Public and private service provider	Provide quality services to all clients in need without making a difference; Reinvest funds received for service provision to improve/ keep level of quality of services in infrastructure and staff payment	Interest in attracting many clients with new insurance cards to increase their revenue; poverty reduction not their special agenda; they should give all clients coming equal attention and service provision	0	
NHIF	Provision of special cards for poor population groups; defining of new packages and costing; reimbursement of services provided through cards to HFs; accreditation of HFs; Development of accreditation criteria; quality control and fraud control; provision of advances to service providers; extension of membership to more people in the whole country; capacity development	Interest in increasing number of members and revenue collection; improvement of capacity; Pro poor agenda because many of potential members are poor	+	
CHF	Identification of poor and distribution of special cards	CHF main mandate and interest is to identify the poor for enrolment in an health insurance scheme	+	
Medium size companies and cooperatives	Enrolling the small scale rural producers they are depending on in a social health insurance scheme	Interest in healthy and productive small scale producers; as such interest in contributing to poverty reduction	+	
MOHSW	Ensure that national policies are taken care of and implemented properly; definition of packages and quality standards	Provision of pro poor services and poverty reduction overarching goal	++	

KEY	Strength/direction impact	++	+	0	-	--
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4.2 Transmission Channels used and overall Results by Channel

Taxes and Transfers

The project provides poor population groups with prepaid insurance cards to use special services provided by public and private HFs, covering the cost for the service.

At least 113 000 poor pregnant women in four regions will enjoy regular antenatal care and attendance during delivery in a health facility of good quality (outcome). Complications during delivery are prevented or treated properly and 645 maternal deaths are avoided. This will reduce the maternal mortality ratio of the four regions of implementation (impact) and also that of the whole country.

Drugs for PMTCT are taken by mother and child. Women are provided with full antiretroviral treatment (ART) if necessary.

Women will leave the HF healthy with their healthy newborns after delivery. Transmission of HIV to the new born child is prevented to the extent possible.

1230 children will be born free of an HIV infection. This will contribute to the further reduction of under five mortality, because the life expectancy of HIV positive children is reduced (impact).

ART treatment of 1644 poor HIV infected pregnant women will contribute to halt the increase of the number of orphans, who end often in extreme poverty (impact).

The maternal morbidity will be reduced as well. But missing data do not allow more concrete estimates of this impact.

Circumcision of 30 000 men in one region with a high HIV prevalence and low male circumcision rate prevents new HIV infections by reducing the risk for acquire an HIV infection for these men by 50% and so contributes to halt the further spread of the HIV epidemic.

The impact of both interventions on the reduction of the overall HIV prevalence rate is difficult to foresee, because other effective interventions are also implemented at the same time. The contribution of this specific intervention is relevant but its extent cannot be estimated exactly.

Women continue to participate in and contribute to the social and economic life of the community and contribute to economic growth. This leads to the reduction of poverty. Ill health status leading to stigmatisation and increased vulnerability are prevented. The impact of the intervention on poverty reduction is not limited to the fact only that poor population groups have not to pay for the services offered. The ongoing participation in and contribution to the economic and social life and economic growth possible because of continuous good health is of equal importance. It is difficult to indicate figures for this impact and exactly measure the contribution of the intervention on poverty reduction, being only one of others. However, scientific studies strongly support the importance of good health for poverty reduction.

The **risk** connected to the intervention is a) that special insurance cards will not reach poorer population groups.

This has to be avoided through well developed distribution mechanisms using a definition of poor based on the experiences made with the waiver system and involvement of the community leaders into identification of the poor.

b) that service providers concentrate more on these services and neglect others as well as those clients not presenting a card for these specific service, which would have an adverse effect on general service provision and consequently the health of the population.

This aspect has to be included in the monitoring conducted regularly by the NHIF as well as the regular supervision of the Council Health Management Teams (CHMT).

d) that transport costs are more important than expected and prevent women from accessing services to the extent expected.

A monitoring system has to be developed to recognise its relevance in time and transport costs made available if needed.

Assets

Financial assets

Men decide when financial household assets are to be spent for maternal health.¹³

Possessing these special insurance cards decreases women's dependence of their male partners and relatives and gives them the power to decide themselves whether to go to the HF to seek help or not.

Health insurance membership leads to the empowerment of women (secondary outcome).

The vulnerability of the targeted population for external shocks is reduced, because they are members of a health insurance scheme, which avoids the use of essential assets when in need of these specific health services and with this avoids falling back into poverty or extreme poverty (impact).

This impact is not limited to the poor in the four regions selected for the intervention only but will benefit the whole country.

The structural component of the project, the capacity development of the NHIF and linkage with the CHF leads to an increased number of poor being members of a social health insurance scheme in the whole country.

The extent of the impact on poverty reduction through the reduction of vulnerability cannot be estimated.

A baseline and follow up study of the population living in the catchment area of some of the supported facilities could help to answer the question

.

Human assets (Health)

Through the intervention 113 women and 30 000 men remain in a state of better health. They continue to participate in and contribute to the social and economic life of the community and contribute to economic growth. This leads to the reduction of poverty.

Ill health status, which leads to stigmatisation and increased vulnerability are prevented.

With the component of strengthening the NHIF to increase the number of its members the project offers the poor in the whole country to become members of a social health insurance scheme and supports equal access to health services, an important condition for better health with the consequence of an ongoing participation in and contribution to the economic and social life and economic growth. It is difficult to indicate figures for this impact and exactly measure the contribution of the intervention on poverty reduction, being only one of others.

However, scientific studies strongly support the importance of good health for poverty reduction.

A baseline and follow up study of the population living in the catchment area of some of the supported facilities could help to answer the question

¹³ Vulnerability and Resilience to Poverty in Tanzania, 2002/03

Access to goods and services

NHIF offers advance payments to service providers to improve quality of care. Through these payments and investment of the reimbursement of services provided for the insurance cards quality of services increases and is kept and attract more people which lead to higher attendance rates (output) and better health of the population (outcome).

The continuous income of the HFs does not only improve the specific services, which are part of the support but also other services provided, because improvement of the infrastructure and material supply will benefit other services as well (secondary outcome).

Official and unofficial payment for services and low quality of services cannot function as a barrier any more.

The **risk** is a) that funds reimbursed are not reinvested into the health facility to improve and keep quality of services.

NHIF through regular supervision has to control fraud as well as quality of services provided.

Also the regular supervision of the CHMTs includes the aspect of quality of services.

If quality standards are not kept accreditation must be withdrawn.

Authority

The capacity of NHIF to increase the number of members in whole of Tanzania is strengthened and a linkage established with the CHF. The capacity development of the NHIF follows the suggestions given after an institutional assessment of the organisation.

While the support of access to specific services for poor population groups is limited to selected regions the support of strengthening the NHIF and linking with CHF and its expansion to an increasing number of members will improve the situation of poor population in the whole country by creating the possibility for them to become members.

For the first time they have the power to demand good quality of services and have the choice of service providers whether it is a private or public one and independently of its location (secondary outcome).

As the details of the service to be delivered are known, people are enabled to actively ask for what they are entitled to receive. The described inequalities of service provision by health workers to poor and wealthy people will be reduced (secondary outcome).

Participation in a social insurance scheme offers the members the opportunity to actively ask for good quality of services and contributes to practising their democratic rights.

Risks are a) that Ministry of Finance (MOF) will not provide the necessary subsidies in the long term after the support has come to an end.

Timely negotiations with the MOF in cooperation with the MOH are of great importance.

b) that the actual good governance of NHIF worsens. Therefore an annual external audit of the NHIF must be made mandatory.

Table 2: Transmission Channels used and overall Result by Channel

Transmission Channels & Details		Transmission Channel Used	Output/Outcome/Impact by Transmission Channel Categories			
		Details	Short Term (+/-)	Medium Term (+/-)	Details	Risks
Prices	Production		0	0		
	Consumption					
Employment	Wages					
	Public formal		0	0		
	Private formal		0	0		
nsf	Informal		0	0		
	Taxes		0	0		

Transmission Channels & Details	Transmission Channel Used	Output/Outcome/Impact by Transmission Channel Categories			
	Details	Short Term (+/-)	Medium Term (+/-)	Details	Risks
Special insurance cards (Transfers)	Prepaid insurance cards for ANC, PMTCT services, ART, safe delivery and postnatal care, and male circumcision including counselling are provided	+	++	<p>Output: Major barriers are removed for effective access to important services and usage increased;</p> <p>Outcome 1: 113 000 safe deliveries of poor women and consequently healthy women and children;</p> <p>Impact 1: reduction of maternal mortality and morbidity and newborn mortality;</p> <p>Outcome 2: 8291 mother and child pairs are treated to prevent MTCT</p> <p>Impact 2: 1230 children born free of HIV infection;</p> <p>Outcome 3: 30 000 men undergo male circumcision;</p> <p>Impact 3: HIV risk reduction for these men by 50%</p> <p>Outcome 4: 1644 poor women under ART;</p> <p>Impact 4: halt of increase of number of orphans</p> <p>Impact of all outcomes: Reduction of HIV infection rate; estimate of extent not possible</p>	<p>1) Cards do not reach the poor. Action: Effective distribution mechanism following a definition of poor with participation of community leaders in selection of people receiving the cards;</p> <p>2) Service providers reduce attention for other services and clients without special cards with an adverse effect on general service provision and on health. Action: Supervision and quality control through NHIF and CHMTs</p> <p>3) Transport costs are more important</p>

Transmission Channels & Details	Transmission Channel Used		Output/Outcome/Impact by Transmission Channel Categories			
	Details	Short Term (+/-)	Medium Term (+/-)	Details	Risks	
					for access than assumed. Action:Close monitoring of influence of transport costs and provision if needed;	
Access	Health services	Reimbursement of services provided through NHIF	+	++	Output: Improved quality of services; higher attendance rate Outcome: better health of the population in four selected regions as well as in the whole country Impact: poverty reduction	Reimbursed funds are not reinvested to improve/ keep quality of services. Action:Quality and fraud control through NHIF;

Transmission Channels & Details		Transmission Channel Used	Output/Outcome/Impact by Transmission Channel Categories			
		Details	Short Term (+/-)	Medium Term (+/-)	Details	Risks
	Goods		0	0		
Authority	Formal institution	Strengthening capacity of NHIF and establish linkage with CHF	+	++	<p>Output: Increasing number of members including poor population groups in all of Tanzania;</p> <p>Outcome 1: equal access for the poor to quality health care;</p> <p>Outcome 2: Right of poor to demand good quality services and choose freely the provider to be used.</p> <p>Impact: better health; poverty reduction</p>	<p>Subsidies not taken over by Ministry of Finance.</p> <p>Action: Timely negotiations are important to reduce this risk</p>

Transmission Channels & Details		Transmission Channel Used	Output/Outcome/Impact by Transmission Channel Categories			
		Details	Short Term (+/-)	Medium Term (+/-)	Details	Risks
Assets	Financial	Health insurance membership and advance payment of health care	+	++	Output: independence of the poor from need of actual payment when of ill health; Outcome 1: empowerment of women to decide, when to seek care; Outcome 2: reduced vulnerability to external shocks Impact: reduction of poverty	A base line and follow up study can help to verify outcome and impact
	Natural Physical Social		0	0		
	Human	Health insurance membership and advance payment of health care	+	++	Output: access to quality health care for the poor; Outcome: 113 000 poor women and 30 000 poor men in good health in selected regions as well as poor in the whole country; Impact: poverty reduction	A base line and follow up study can help to verify outcome and impact

KEY	Strength/direction impact	++	+	0	-	--
		very positive	Positive	not significant	negative	very negative

4.3 Assessment of Stakeholders' and Target Groups' Capabilities

Human (Health)

The interventions improve and maintain the health of 113 000 poor women and their children through effective antenatal care, safe delivery, continuous ART and PMTCT and postnatal care and that of 30 000 men through circumcision and counselling and reduced risk of HIV infection in four regions of Tanzania.

This is a precondition for the engagement as an active member of the society.

With the component of strengthening the NHIF to increase the number of its members the project offers the poor in the whole country to become members of a social health insurance scheme and supports equal access to health services, an important condition for better health with the consequence of an ongoing participation in and contribution to the economic and social life and economic growth.

Economic

Health is an important asset enabling people to participate in economic development and in economic life. As the intervention increases and maintains the health of the target population in four regions and the poor in the whole country it has a positive economic aspect as well. NHIF offers advance payments to service providers to improve quality of care. Through these payments and investment of the reimbursement of services provided for the insurance cards quality of services increases and is kept and attract more people which lead to higher attendance rates.

The continuous income of the HFs does not only improve the specific services, which are part of the support but also other services provided, because improvement of the infrastructure and material supply will benefit other services as well.

Political

Strengthening the capacity of the NHIF will lead to extension of its coverage and increased number of members including the poor. This gives them the right to demand quality services and to choose the service provider they prefer, private or public independently of their income and of its location

As the details of the service to be delivered are known, people are enabled to actively ask for what they are entitled to receive.

Socio-cultural

Women have little decision making power over household assets. Being in the possession of insurance cards they become independent of their male partners and relatives and can decide freely when and if to go to a health facility.

Health insurance membership leads to the empowerment of women.

Protective-security

The vulnerability of the targeted population for external shocks is reduced, because they are members of a health insurance scheme, which avoids the use of essential assets when in need of health services and with this avoids falling back into poverty or extremer poverty.

Table 3: Assessment of Stakeholders' and Target Groups' Capability

	Outcomes in terms of capabilities									
	Economic (*/-)		Human (+/-)		Political (+/-)		Socio-cultural (+/-)		Protective Security (+/-)	
Beneficiary group Target groups	Short term	Medium term	Short term	Medium term	Short term	Medium term	Short term	Medium term	Short term	Medium term
Pregnant women	+	+	+	++	+	++	+	+	+	+
Uncircumcised men	+	+	+	+	+	+	0	0	+	+
Stakeholders										
Public and private providers	+	+	0	0	+	+	0	0	0	0
NHIF	+	+	0	0	+	+	0	0	0	0
Medium size employers	+	+	0	0	0	0	0	0	0	0

5.0 Assessment of results on MDGs and other strategic Goals

The intervention contributes to achieving MDG 1, MDG 4, MDG 5 and MDG 6

Table 4: Assessment of results on MDGs and other strategic Goals

Strategic Development Goals	Impacts	Details & risks
MDG1: Eradicate extreme poverty and hunger	+	Good health is one essential asset to participate in the advantages of economic growth. Through the improvement of health of selected population groups the intervention contributes to the reduction of poverty. The risk exists that special insurance cards do not reach the poor. Distribution mechanisms have to be designed carefully
MDG2: Achieve universal primary education	0	

MDG3: Promote gender equality, empower women	(+)	Through the cards women have decision making power to seek help in a HF when in need
MDG4: Reduce child mortality	+	Safe delivery improves the health of newborns. PMTCT leads to fewer children infected with HIV.
MDG5: Improve maternal health	++	Increased access to quality antenatal care and safe delivery in an HF are the most important factors for improved maternal health and reduction of maternal morbidity and mortality.
MDG6: Combat HIV/AIDS, malaria, other diseases	++	PMTCT reduces the number of children born with HIV. Male circumcision reduces the infection risk by 50%
MDG7: Ensure environmental sustainability	0	
MDG8: Develop global partnership for development	0	
<i>Pro Poor Growth</i>	+	Good health is one essential asset to participate in the advantages of economic growth. Through the improvement of health of selected poor population groups the intervention contributes to the participation of poor on economic growth.
<i>Protecting the vulnerable</i>	0	
<i>Peace, Security, Disarmament</i>	0	
<i>Human Rights, democracy and good governance</i>	0	
<i>Protecting the common environment</i>	0	

6.0 Assessment according to the Guidelines for Poverty Orientation for German Development Corporation

Criteria 1

Poor are part of the target population because special insurance cards are distributed to poor population groups. In the selected Regions Mbeya and Tanga 21 per cent, percent and 36 per cent of the population live below the poverty line, in Lindi 53 and in Mtwara 38 per cent.

Criteria 2

The interventions improve access to and usage of relevant health services and through that improve and maintain health as a relevant asset for participation in economic growth.

Criteria 3

The membership in a health insurance scheme offers the poor the opportunity to demand quality services and influence ways of service provision.

Criteria 4

The Government of Tanzania is committed to pro poor growth and poverty reduction as expressed in the NSGPR. The health sector has taken up this commitment in its sector strategy.

The project receives therefore for all aspects the identification **SUA**.

7.0 Suggestion for Monitoring the Intervention

The implementation has to be accompanied by regular monitoring of the expected outcomes and intermittent evaluation of the contribution to the suggested impact.

Existing monitoring instruments should be used to not overload personnel responsible for data collection and thus endanger validity of data used.

Data collected by the NHIF and MOHSW through their routine monitoring system can be used to follow up the outcomes.

Impact assessment should be based on the data collected through three main national surveys the Demographic and Health Survey (DHS), the Tanzania HIV Indicator Survey (THIS) and the Household Budget Survey

Relevant outcomes are:

- increased number of “healthy pregnancies” ; Indicator: no 113 000 safe deliveries of poor women in accredited health facilities
- increased number of circumcised men in Mbeya Region; Indicator: 20 000 poor men are circumcised
- strengthened health insurance schemes. Indicator: no of complete cards processed by the system in a defined period of time.

Relevant contribution to impact:

- Reduction of maternal mortality
- Reduction of HIV Mother to Child Transmission
- Decrease of HIV infection in men

The evaluation has to be based on the regional data, which will be made available through the named national surveys.

A population based baseline survey of the population living in the catchment area of selected Hfs included in the project could help to estimate the possible impact on poverty reduction, when repeated after the three years of implementation.

Annex 1: References

African Economic Outlook 2005-2006

DAC/OECD: The DAC Guidelines, Poverty Reduction. OECD 2001

DAC/OECD: Harmonising Ex Ante Poverty Impact assessment. DCD/DAC (2006)24. March 2006

DAC/OECD: Practical Guide to Ex Ante Poverty Impact Assessment, OECD 2006

Household Budget Survey 2000/01; Dar es Salaam, July 2002

Einar Braathen et al: Service delivery in Tanzania; Findings from Six Councils in Tanzania 200-2003, Special paper 06.20, Dar es Salaam 2007

Stefan Dercon et al: Extending Insurance? Funeral Associations In Ethiopia and Tanzania, OECD Development Centre, Working Paper No 240, December 2004

Leitfaden Armutsorientierung BMZ 1997

Mkukuta Monitoring Master Plan and Indicator Information, Ministry of Planning, Economy and Empowerment, 2006

Christian Morrisson: Health, Education and Poverty Reduction; OECD Development Centre, Policy Brief No 19

National strategy for Growth and Reduction of Poverty, Vice Presidents's Office, June 2005

Paul Smithson: Fair's Fair; Health Inequalities and Equity in Tanzania, Dar es Salaam November 2006

2006 Survey on Monitoring the Paris Declaration, Country Chapter Tanzania

Poverty and Human Development Report Tanzania 2005; Dar es Salaam

Poverty at the District level; Brief 2, Poverty and Human Development Report 2005

Promoting Pro-Poor Growth, Key Policy Messages, OECD 2006

Research and Analysis Working Group: Vulnerability and Resilience to Poverty in Tanzania, Causes, Consequences and Policy Implications, Main Report 2002/03

Buhl Solveig: Indo-German Development Cooperation, Natural Resources Management, A Preliminary Poverty Impact Assessment, Delhi, Eschborn 2006

Marc Wuyts: Developing Social Protection in Tanzania within the Context of Generalised Insecurity, Special paper No 06.19

Annex 2: List of Interview Partners

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