United Republic of Tanzania

FY 2017 Ex-Post Evaluation of Technical Cooperation Project Report

"Project for Capacity Development for Regional Referral Health Management / Project for Capacity Development in Regional Health Management Phase II"

External Evaluator: Tomoko Shibuya, IC Net Limited

0. Summary

The aim of this project through Phase 1 and Phase 2 (hereinafter collectively referred to as the "Project") was to develop the capacity and functions of Regional Health Management Teams (RHMTs) in all 21 regions (increased to 25 regions during the Project) of Tanzania, by developing training programs on managerial practices including Supportive Supervision (SS), for the Ministry of Health and Social Welfare[1] (hereinafter referred to as the "Ministry of Health (MOH)") conducting SS to RHMTs, and for RHMTs conducting SS to Council Health Management Teams (CHMTs) and Regional Referral Hospitals (RRHs), while also clarifying the institutional framework, thereby contributing to the capacity development of RRHs and CHMTs as well as the improvement of health management at the regional level.

The Project had challenges in its design for Phase 1. The Project was launched when the structure of MOH for RHMT had not been established, and a wide range of plans, such as the strengthening of cooperation among the central, regions, and districts and the development of the capacity of RHMTs, were to be developed in three years, a limited period. However, the Project is highly relevant as its purpose is consistent with the policy and development needs of Tanzania and Japan's ODA policy with regard to "Development of administrative managerial capacity for providing public services with the progress in decentralization."

The roles of RHMTs are to inform CHMTs and RRHs of the national policy, have them develop appropriate plans, and carry out activities according to the plans through SS. The Project clarified the roles and largely established a structure to enable RHMTs to function. The supervision capacity of RHMTs also improved. However, one of the Indicators to determine the effectiveness of the Project "The annual average number of opportunities that RHMTs conduct SS to CHMTs and RRHs", which is one of the most important indicators, was not achieved. As a result, although the Overall Goal Indicator "Approval rate of Comprehensive Council Health Plans (CCHPs)" was achieved, the "Submission rate of Comprehensive Hospital Operation Plans (CHOPs)" was not achieved. According to a hearing survey of CHMTs and RRHs in five regions, the importance of RHMTs had been partly recognized but limited. Considering all the matters above, the effectiveness and impacts of the Project are fair.

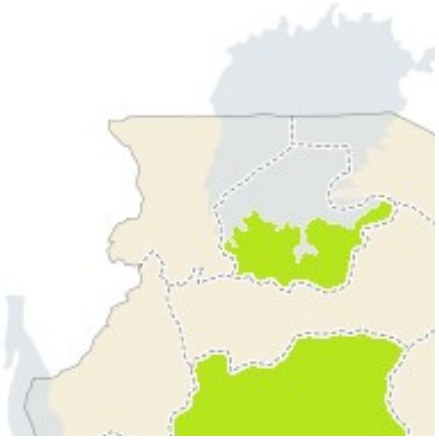
The efficiency of the Project is high as its cost and period are within the plan.

[1] During the Project, the name of the ministry was "Ministry of Health and Social Welfare," but it changed to "Ministry of Health, Community Development, Gender, Elderly and Children" at the time of the ex-post evaluation. In this report, it is described as "Ministry of Health (MOH)" for both during the Project and at the time of the ex-post evaluation.

As for sustainability, the Project does not have a new regional health system or a mechanism to strengthen the roles and functions of RHMTs because of a structural change after Project completion and a high percentage of resignations, turnover, and transfers. Problems have been observed with regard to the policy background, organizational, technical, and financial aspects. Therefore, sustainability of the Project effects is low.

In light of the above, this Project is evaluated to be partially satisfactory.

1. Project Description



Project Locations

Dodoma RHMT weekly conference

Note: The Project was intended for all over Tanzania.
Note: The green parts are regions subject to the field survey for the ex-post evaluation.

1.1 Background

In Tanzania, health sector reform has been carried out since 1994 to promote a shift from central government-led health administration to district government-led health administration, in order to provide basic health services to the public. In the reform, it was expected that CHMTs would take the lead in providing health services based on the council health plan and managed and supervised primary healthcare facilities. On the other hand, RHMTs had not been formulated as a team in some regions, and although they were established before 2008, they were not authorized by law. The health policy developed in 2007 stipulated the necessity of RHMT in all regions, and it was approved as an organization based on the policy in 2008 when the Project was launched. However, the development of an environment and a system to enable RHMT, as a branch organization of the central government, to disseminate the policy throughout districts and to provide administrative support to the districts, had lagged.

With the progress in decentralization, Japan was requested by the government of Tanzania to develop the administrative capacity of RHMTs based on its experience in implementing

"Morogoro Health Project (MHP)" from April 2001 to March 2007.[2] According to the request, Japan decided to implement the "Project for Capacity Development in Regional Health Management" for six years from April 2008[3] with the aim of developing the managerial capacity of RHMTs.

1.2 Project Outline

		Phase 1[4]	Phase 2[5]
Overall Goal		Regional Referral Health Management (RRHM) is improved to provide sustainable health services.	Managerial performance of Regional Referral Hospital Management Teams (RRHMTs) and Council Health Management Teams (CHMTs) is improved.
Project Purpose		Regional Health Management Teams (RHMTs) are strengthened in order to provide quality regional referral health services.	Performance of all RHMTs in supporting CHMTs and RRHMTs is improved.
Output(s)	Output 1	Management skills of RHMTs to respond to changing environments and new technologies are strengthened.	Management skills of RHMTs in supporting CHMTs and RRHMTs are improved.
	Output 2	Supportive Supervision from RHMTs to CHMTs is integrated and functions.	Roles and functions of RHMT to support CHMTs and RRHMTs are institutionalized and consolidated.
	Output 3	Central Supportive Supervision (Central Management Supportive Supervision; hereinafter "CMSS") from the central to RHMTs is institutionalized in MOH & PMORALG.	Guidelines and tools for RHMTs to perform their functions are developed.[6]
	Output 4	A coordinated mechanism in responding to local issues among central and regional levels is strengthened.	
Total cost (Japanese Side)		351 million yen	354 million yen
Period of Cooperation		April 2008–March 2011	November 2011–October 2014

[2] In MHP, regional and district administrators cooperated to examine and analyze health issues of regional residents, and the issues were reflected in annual regional and district plans, considering consistency with the national plan and the participation of local stakeholders (personnel related to local governments). Through the process of preparing a budget and implementing the project, efforts were made to develop the capacity of RHMTs and CHMTs as well as strengthen the cooperative relationship between regions and districts.

[3] The scheduled project period was three years initially but changed to six years in total because of the formulation of Phase 2.

[4] In phase 1, the description of PDM version 5 (developed in October 2010) in Japanese is partially different from the one in English. This ex-post evaluation was conducted based on the English version, which contains records of signatures of MOH and JICA to confirm the PDM.

[5] In phase 2, the description of PDM version 3 (developed in October 2013) in Japanese is partially different from the one in English. This ex-post evaluation was conducted based on the English version of PDM version 3 (developed in 2013 October). In the terminal evaluation, "More than 70% of CHOPs are submitted to MOH and PMORALG by FY 2016/17" was used for Overall Goal Indicator 2, instead of "More than 70% of CHOPs are approved in the first submission at the Basket Fund Committee (BFC) meeting by FY 2016/17." The possible reason is the project could not obtain "approval rate," because the participants of CHOP assessment training were not involved in the CHOP assessment process, and there was no assessment process during the project implementation period as mentioned in the project completion report.

[6] In phase 2, the PDM version 3 (developed in October 2013) in English mentioned that "Guidelines and tools for RHMTs to perform their functions are improved," while the one in Japanese said "Guidelines and tools for RHMTs to perform their functions are developed." The ex-post evaluation used the latter description in Japanese because the project focused on "development."

Implementing Agency	MOH, Prime Minister's Office, Regional Administration and Local Government (PMORALG)[7]	MOH
Other Relevant Agencies / Organizations	None	None
Supporting Agency/Organization in Japan	Foundation for Advanced Studies on International Development, Moe Consulting Inc.	None
Related Projects	**[Technical cooperation]** "Morogoro Health Project (MHP)" (2001–2007) "Strengthening Development of Human Resource for Health" (November 2010–November 2014) "Health Systems Strengthening for HIV and AIDS Services Project" (October 2010–October 2014) "Project for Strengthening Hospital Management of Regional Referral Hospitals" (May 17, 2015–May 16, 2020) **[Expert]** Dispatch of Health Policy Advisor (March 2017–March 2019)	

Source: Materials provided by JICA

Figure 1 shows an outline of the Project. Through two phases, the Project aimed at the capacity development of RHMTs and effective support by RHMTs to CHMTs and RRHs. In other words, the Project aimed to have RHMTs promote the independent development of CHMTs and RRHs with the progress in decentralization, and improve health services in cooperation with CHMTs and RRHs. Phase 1 clarified the roles and functions of RHMTs and developed their capacity in the health system of Tanzania, through the development of CMSS by MOH to RHMTs. Based on the Outputs and experience in Phase 1, Phase 2 further developed the managerial capacity of RHMTs and, through SS by RHMTs to CHMTs and RRHs, developed the managerial capacity of CHMTs and RRHs.

Figure 1: Outline of Project Design

Note: Descriptions of the Outputs indicate those in Phase 2.

[7] In the restructuring of 2015, PMORALG was transferred and renamed President's Office-Regional Administration and Local Government (PORALG). In this report, subsequent discussions of events from 2015 will refer to PORALG.

Source: Created by the evaluator based on materials provided by JICA

1.3 Outline of the Terminal Evaluation

1.3.1 Achievement Status of Project Purpose at the Terminal Evaluation

It was believed that the Project Purpose would be achieved by the completion of the Project. Concerning one of the five Indicators of the Project Purpose, "The annual average number of RHMTs which conduct Supportive Supervision (SS) quarterly to RRHMTs and all CHMTs with standardized tools reached 75% for RRHMTs and 90% for CHMTs by FY2013/14," the achievement of the numerical target on SS to CHMTs was "challenging." However, it was evaluated that the numerical target on SS to RRHs would be achieved. As for "All RHMT Annual Plans are submitted on time and approved by MOH by June 2014," the achievement of the numerical target (100% of RHMTs) was "challenging." However, as the Indicators on the capacity of RHMTs on plan creation had been achieved at the time of the terminal evaluation, it was evaluated that the Project Purpose would be achieved by the completion of the Project.

1.3.2 Achievement Status of Overall Goal at the Terminal Evaluation (including other impacts.)

It was determined that the Overall Goal of the Project would be achieved within three to five years after the completion of the Project. At first, the department of MOH in charge of CHMT of the time did not approve the involvement of RHMTs with the appraisal of CCHP[8]. However, the involvement of RHMTs in the appraisal process has been approved since 2014/15, which is the year when the project completed. Based on this, it was expected at the terminal evaluation that RHMT's assistance would be provided on a full scale after the completion of the Project, and the CCHP approval rate would increase in the first appraisal. As for good practices, it was confirmed at the terminal evaluation that they have been widely shared both at the national and regional levels.

1.3.3 Recommendations from the Terminal Evaluation

At the time of the terminal evaluation of Phase 2, the following recommendations were provided to the implementing agencies:

Table 1: Recommendations at the Time of the Terminal Evaluation

Implementing Agency	Recommendations
(1) Project Team	・ Development of a sustainable mechanism (exit strategy) of SS and training

[8] A structure to secure a certain level of quality of CCHP was set through the Project. By conducting appraisal of CCHP by RHMT after CHMT creates CCHP and sharing its score with CHMT, the structure will secure the quality of CCHP before it is submitted to MOH.

(2) MOH	・ Strengthening cooperation with PMORALG ・ Efforts to strengthen and continue the functions of regional health service units ・ Simplification of planning, report creation, and appraisal process of CCHP and CHOP ・ Avoidance of frequent updates of the district health plan creation program system[9] (PlanRep) ・ Transfer of authority in CCHP approval system from MOH to RHMTs ・ Strengthening RRH management assistance
(3) RHMT	・ Strengthening involvement of RHMTs (There are some CHMTs and communities directly communicating with the central government without the involvement of RHMTs.)

Source: Phase 2 Terminal Evaluation Report

2. Outline of the Evaluation Study

2.1 External Evaluator

Tomoko Shibuya, IC Net Limited

2.2 Duration of Evaluation Study

The ex-post evaluation study was conducted with the following schedule.

Duration of the Study: November 2017–December 2018

Duration of the Field Study: February 14–March 23, 2018; June 19–July 4, 2018

2.3 Constraints during the Evaluation Study

Since the completion of the Project in October 2014, the structure of the governmental organization related to health administration has changed twice. In 2015, the Division of Health, Social Welfare and Nutrition was established in PORALG, which has made the involvement of PORALG with RHMTs strong and has created a system requiring close cooperation between MOH and PORALG. In addition, after the presidential statement in November 2017, the jurisdiction over RRHs was changed from RHMTs under PORALG to MOH[10]. The field study for the ex-post evaluation was conducted during the transition period before such structural change. Therefore, the sustainability of the Project had to be evaluated through a description of the current state based on the limited information collected by the end of the second field study and future prospects for sustainability based on the description.

The hearing survey was conducted in MOH, PORALG, development donor, RHMTs and RRHs in five out of 26 regions, with two CHMTs in each region, and information was collected from at least two people in each organization. As people in the regions who cooperated with the hearing survey were selected from those well-versed in CCHP and CHOP, information obtained from them is considered to be opinions representing the organizations. The five regions where

[9] CCHP is required to be submitted by using software called "PlanRep." However, as PlanRep made many system errors, it was frequently updated.

[10] At the time, as budgets for RRHs were under PORALG, a full-scale change was made from the new fiscal year in July 2018.

the hearing survey was conducted were determined according to the RHMT performance ranking[11] obtained during the Project, and from considering the travelling process, regions representing all the regions after being classified into three groups (high, middle, and low) based on the degree of socioeconomic development estimated from urbanization and literacy rates. Dar es Salaam is the largest city in Tanzania, Dodoma is the capital of Tanzania, and Mwanza is the second largest city in Tanzania. As excellent human resources tend to concentrate in urban areas, survey results in the five regions may be overestimated. Moreover, questionnaires were distributed to all regions and answers were obtained from 12 regions. However, as qualitative information was insufficient,[12] only quantitative information was used.

As described above, the hearing survey was conducted in five out of 26 regions, and part of the questionnaires could not be analyzed. Therefore, it cannot be considered that information obtained through the hearing survey is opinions representing the target people of the Project.

3. Results of the Evaluation (Overall Rating: C[13])

3.1 Relevance (Rating: ③[14])

3.1.1 Consistency with the Development Plan of Tanzania

At the time of the planning of Phase 1, "Strengthening the roles of regions with the progress in decentralization" and "Establishment of RHMT in each region and strengthening its roles" were specified in the *Poverty Reduction Strategy I* (2005–2010; developed in 2005) and the *National Health Policy* (developed in 2007), respectively.

At the time of the completion of Phase 1 and the planning of Phase 2, the *Health Sector Strategic Plan Three (HSSP III)* (2009–2015; developed in 2009) and the *Poverty Reduction Strategy II* (2010–2015; developed in 2010) described that RHMT was, as a branch organization of MOH, an important organization in the health system for contributing to the improvement of the quality of health services at the regional or lower level. These documents were still effective at the time of the completion of Phase 2. Based on this, it was considered that the Project Purpose was consistent with policy documents, but the launch of the Project was a little too early for the following reasons.

Although the strengthening of the roles of regions was described in the policy documents with the progress in decentralization, the establishment of RHMT in each region was described for the first time in the *National Health Policy* developed in 2007, the year before the launch of the

[11] With the aim of improving the performance of RHMTs and increasing the motivation and organizational power of RHMTs of all regions, the performance ranking was introduced, with a commendation system based on the ranking, in the second year of Phase 2 of the Project.

[12] It is considered to be a cause that neutral answers were provided to the survey because the questionnaires distributed to RHMTs were not submitted to the evaluator but submitted to PORALG having jurisdiction over RHMTs, or the information could not be used for the evaluation because no specific data was provided due to insufficient understanding of the Project.

[13] A: Highly satisfactory, B: Satisfactory, C: Partially satisfactory, D: Unsatisfactory

[14] ③: High, ②: Fair, ①: Low

Project. In addition, the purpose of the Project was to substantially realize "Improvement of the local health administrative capacity through strengthening of the management and operation system at the regional level," which was specified in HSSP III as a prioritized policy. However, the document of HSSP III was developed in the year following the launch of the Project. Actually, through efforts of the Project, a responsible person controlling RHMT-related projects and having decision-making authority was assigned and the regional health service unit was established in MOH one year and four months after the launch of the Project. As described above, the implementation system of the Tanzanian side had not been established at the time of the launch of the Project, and it was not considered that planned activities could be sufficiently carried out.

3.1.2 Consistency with the Development Needs of Tanzania

In Tanzania, decentralization has progressed since the health sector reform in 1994, which has promoted a shift from central government-led health administration to district government-led health administration. Therefore, financial and technical support of the central government and donors was mainly provided on a priority basis to CHMTs, having a responsibility for health service delivery, and the capacity of CHMTs was higher than that of RHMTs. In addition, as there were many health policies and guidelines at the time of the planning of the Project, procedures to thoroughly inform districts, having a responsibility for health service delivery, of the health policies and guidelines were not consolidated. This resulted in the generation of problems. For example, local governments could not provide health services according to national healthcare standards, and the quality of health services varied depending on the capacity of CHMT. In Tanzania, having a vast national land, there was a great need to develop the capacity of RHMTs in order to disseminate policies and conduct SS to CHMTs while mediating between the central government and CHMTs.

3.1.3 Consistency with Japan's ODA Policy

The *Country Assistance Program for Tanzania* (developed in 2000) positioned the "Improvement of local basic medical technology, enhancement of the referral system, and residents' educational activities" as priority sectors, and JICA's Country-specific Program, which was an attached document of the *Country Assistance Program*, specified the importance of assistance for health administration reform. The *Country Assistance Program for Tanzania* (developed in 2008, the year the Project was launched) stated that it focused on the local health administration system against vulnerable health administration with the rapid progress in decentralization. The *Country Assistance Policy for the United Republic of Tanzania* (developed in 2012), established in the year following the launch of Phase 2, specified the development of the administrative and financial managerial capacity as its policy. In all these documents,

"Development of the administrative managerial capacity for providing public services" was set as the comprehensive assistance policy for Tanzania, with the progress in decentralization. Therefore, the Project was consistent with Japan's policy at the time of planning.

3.1.4 Appropriateness of the Project Plan and Approach

The project plan and approach were appropriate to a certain degree. As shown in Figure 1, Phase 1 promoted the strengthening of cooperation between MOH and RHMTs, improvement of the basic managerial capacity of RHMT employees, and strengthening of cooperation between RHMTs and CHMTs. Phase 2 focused on the capacity improvement of RHMTs and SS among RHMTs, RRHs, and CHMTs. In Phase 1, a responsible person in MOH controlling RHMT-related projects and having decision-making authority was not assigned at first, and it was difficult to assist newly established RHMTs. Considering such conditions, it was difficult to achieve the goal of Phase 1 in the period of three years because of a wide range of project contents as described above. Therefore, the change in project contents in Phase 2 was considered practical, considering the capacity and structure of MOH at the time.

In addition, as described in "3.2 Effectiveness and Impacts," Phase 1 had some planning issues. For example, the achievement could not be measured due to no numerical targets being set,[15] and the Indicators were not those to be determined objectively. The latter was pointed out at the terminal evaluation, but the PDM[16] was not changed by the completion of the Project. The PDM for some Output Indicators was also not changed after determining that target activities were not carried out. It is considered that a change in the PDM immediately before the completion of the Project was difficult as the change requires the agreement of stakeholders. However, it is desirable to set specific and collectible Indicators, including numerical targets, and promptly change the PDM.

As specific numerical targets were defined in Phase 2, it is considered that a practical PDM was created. However, the original roles of RHMTs are to control CHMTs and RRHs and support their plans and activities. Therefore, it was desirable to include Indicators to be achieved by RHMTs, such as a regular meeting between Regional Medical Officer (RMO) and District Medical Officer (DMO)/ Medical Officer in Charge (MOI), etc., in addition to SS.

In light of the above, the relevance of the Project is high as its implementation is sufficiently consistent with the development policy and development needs of Tanzania and Japan's ODA policy. However, there are still issues in the plan and approach of Phase 1.

---

[15] As examples of Indicators for which specific numerical targets were not included, there are: Output 1 Indicator 1 "Knowledge level of participants on training topics is improved," Indicator 2 "Number of RHMT members trained under the Technical Cooperation-Regional Referral Health Management (TC-RRHM) is increased," and Output 4 Indicator 2 "Opportunities of RHMT meetings at zonal level are increased."

[16] PDM (Project Design Matrix) indicates the basic plan of the Project.

3.2 Effectiveness and Impacts[17] (Rating: ②)

3.2.1 Effectiveness[18]

Both for Phase 1 and Phase 2, the purpose to be achieved by the completion of the Project was that RHMTs effectively provided support to activities of CHMTs and Regional Referral Hospital Management Teams (RRHMTs) and carried out activities at an appropriate time based on appropriate plans they developed.

3.2.1.1 Achievement of Project Purpose

[Phase 1]

At the time of the terminal evaluation, it was determined that the two Indicators of the Project Purpose were not indicators that can objectively measure changes of the capacity of RHMTs. Before the ex-post evaluation, there was an attempt to set supplemental indicators, but MOH did not have data of the time, and there is little qualitative information on the strengthening of the functions of RHMTs. Therefore, the achievement of the Project Purpose cannot be evaluated.

Table 2: Achievement of Project Purpose (Phase 1)

Purpose	Indicator	Result
Regional Health Management Teams (RHMTs) are strengthened in order to provide quality regional referral health services.	Capacity assessment results of RHMTs are improved between 2008–2011, to respond to demands of both the Central and Districts.	The performance of RHMTs cannot be determined objectively only by the score.
	Task assessment results of RHMTs are improved between 2008 and 2011.	

Source: Materials provided by JICA

In Phase 1, the policy dissemination guideline was not developed (Output 2 Indicator 3) and the involvement of PMORALG with CMSS was limited, but there were no major problems with the establishment of the structure of CMSS at the time of the completion of the Project. This resulted in the achievement of the institutionalization of CMSS, the coordination mechanism between the central and RHMTs, and the improvement of management knowledge of RHMT employees to some extent.[19] However, according to the hearing survey of MOH, RHMTs actually had enough knowledge to provide support to CHMTs at the time of the completion of Phase 1, but the capacity, structure, and tools had not been established. Of the activities carried out in Phase 1, those related to policy dissemination, CMSS, and the coordination and support mechanism between the central and RHMTs were not included in the PDM for Phase 2. In

[17] Sub-rating for Effectiveness is to be put with consideration of Impact.
[18] The development status of the Project Purpose and Outputs at the time of the ex-post evaluation should be described in the column for impacts, but is described in the column for effectiveness, in order to make a comparison with achievement at the time of Project completion.
[19] For details, refer to Appendix 1

addition, according to the hearing survey of the implementing consultants, the cooperation between the central and RHMTs was limited.

At the time of the ex-post evaluation, there were issues in maintaining the expression of effects of Phase 1. In Phase 1, for the delivery of standard health services, RHMTs prepared a policy dissemination package and distributed it to all regions in order to disseminate the health policy and guideline to CHMTs. At the time of the ex-post evaluation, RHMTs, CHMTs, and RRHs in five regions where the hearing survey was conducted, recognized that RHMTs had a role in disseminating the policy, and such role functioned to some extent. However, the policy dissemination package could not be found in all the five regions. In addition, there were many cases where the policy and guideline were directly shared between the central and CHMTs or RRHs in the five regions, without the involvement of RHMTs. It is necessary to reconfirm and improve the flow of policy dissemination.

Furthermore, CMSS to be conducted both by MOH and PORALG was conducted only by MOH, and the frequency of CMSS has been reduced year by year because of a budget shortfall. Although the Division of Health, Social Welfare and Nutrition was established in PORALG in 2015, Outputs of this Project, such as guidelines, structure, and tools for CMSS, etc., have not been taken over by MOH employees who were subject to CMSS capacity development to PORALG.

Table 3: Number of RHMTs where CMSS was conducted

During Phase 1	During Phase 2				After Project Completion		
2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
22	13	8	NA	NA	12	8	6

Source: Phase 1 Completion Report and questionnaire (MOH)

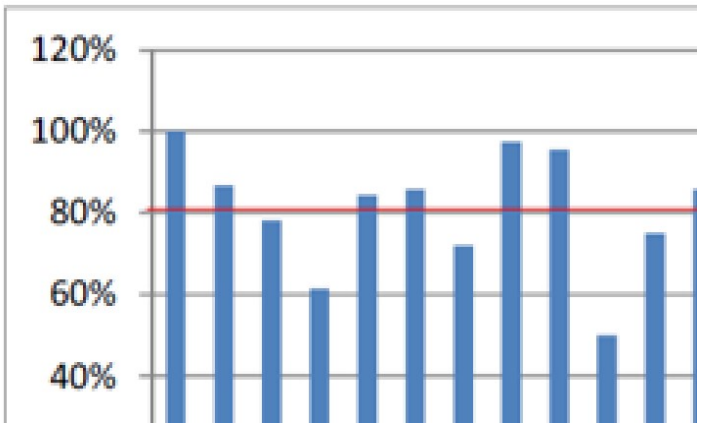
[Phase 2]

Table 4: Achievement of Project Purpose (Phase 2)

<table>
<tr><th>Purpose</th><th>Indicator</th><th>Result</th><th>Achievement</th></tr>
<tr><td>Performance of all RHMSs in supporting CHMTs and RRHMTs is improved.</td><td>The annual average number of RHMTs which conduct Supportive Supervision (SS) quarterly to RRHMTs and all CHMTs with</td><td>[SS to CHMTs by using tools]
・ At the time of Project completion and at the time of the ex-post evaluation, the rate of SS did not reach the target of 90%.
・ RHMTs started to use Regional Management Supportive Supervision (RMSS) tools for CHMTs (RMSS-C)[20] in FY 2012/13 fourth quarter.
Rate of RHMTs that conducted SS to all CHMTs by using tools
<table>
<tr><th rowspan="2"></th><th colspan="8">During Phase 2</th></tr>
<tr><th colspan="4">2012/2013</th><th colspan="4">2013/2014</th></tr>
<tr><th></th><th>Q1</th><th>Q 2</th><th>Q 3</th><th>Q 4</th><th>Q 1</th><th>Q 2</th><th>Q 3</th><th>Q 4</th></tr>
<tr><td>Rate of SS (%)</td><td>43</td><td>43</td><td>71</td><td>86</td><td>52</td><td>62</td><td>60</td><td>76</td></tr>
<tr><td>Rate of the creation of SS reports (%)</td><td>38</td><td>43</td><td>67</td><td>81</td><td>52</td><td>62</td><td>56</td><td>72</td></tr>
</table></td><td>At the time of Project completion: Not achieved
At the time of the ex-post evaluation: Not achieved</td></tr>
</table>

[20] RMSS-C includes the check list, progress confirmation sheet, SS register, and SS report.

	standardized tools reached 75% for RRHMTs and 90% for CHMTs by FY2013/14.	<table><tr><td></td><td colspan="8">After Project Completion</td></tr><tr><td></td><td colspan="4">2015/2016</td><td colspan="4">2016/2017</td></tr><tr><td></td><td>Q1</td><td>Q 2</td><td>Q 3</td><td>Q 4</td><td>Q 1</td><td>Q 2</td><td>Q 3</td><td>Q 4</td></tr><tr><td>Rate of SS (%)</td><td>NA</td><td>78</td><td>95</td><td>95</td><td>50</td><td>48</td><td>76</td><td>98</td></tr></table> 2015/16 annual average: NA (because data for Q1 is unknown) 2016/17 annual average: 68% Note: The gray parts indicate periods before the introduction of standardized tools. Note: Q1, Q 2, Q 3, Q 4 indicate the first quarter, the second quarter, the third quarter, and the fourth quarter, respectively. Source: Completion Report, questionnaire (MOH) [SS to RRHMTs by using tools] ・ The indicator did not reach the target of 75% at the time of Project completion. There was no data at the time of the ex-post evaluation. ・ The reason why the indicator was not achieved at the time of Project completion was due to a delay in the creation of RMSS tools for RRHs (RMSS-H) because the MOH's intention for CHOPs was unclear. ・ During training between November and December 2013, it was recommended to conduct SS from FY 2013/14 third quarter (January–March). Rate of RHMTs (in 21 regions) that conducted SS to RRHs by using tools <table><tr><td></td><td colspan="2">During Phase 2</td></tr><tr><td></td><td colspan="2">FY 2013/14</td></tr><tr><td></td><td>Third quarter</td><td>Fourth quarter</td></tr><tr><td>Rate of SS (%)</td><td>71% (15/21)</td><td>62% (13/21)</td></tr><tr><td>Rate of the creation of SS reports (%)</td><td>71% (15/21)</td><td>62% (13/21)</td></tr></table> Source: Completion Report Note: The Completion Report did not state the reason why 25 regions were not the target, but 21 regions were. It is guessed that new regions were not subject to the monitoring during the period listed.	
	All RHMT Annual Plans are submitted on time and approved by MOH by June 2014.	・ The rate of RHMTs that submitted their annual plans on time improved from 19% at the time of the submission of FY 2012/13 plan to 76% in FY 2013/14 and 72% in FY 2014/15. However, the target of 100% was not achieved. As the newly established four regions have been included since the submission of FY 2014/15 plan, it might be difficult to achieve the numerical target of 100%. ・ After Project completion, the rate of RHMT annual plans submitted on time was high, 92%, in two consecutive years. However, the target of 100% was not achieved. Rate of RHMTs that submitted their annual plans on time <table><tr><td colspan="4">During Phase 2</td></tr><tr><td>2011/12</td><td>2012/13</td><td>2013/14</td><td>2014/15</td></tr><tr><td>No information</td><td>19% (4/21)</td><td>76% (16/21)</td><td>72% (18/25)</td></tr></table> <table><tr><td colspan="2">After Project Completion</td></tr><tr><td>2015/16</td><td>2016/17</td></tr><tr><td>92% (23/25)</td><td>92% (24/26)</td></tr></table> Note: Until FY 2013/14, 21 regions, excluding new regions, had been the target. Source: Regional health service unit, Completion Report, questionnaire (MOH)	At the time of Project completion: Not achieved At the time of the ex-post evaluation: Not achieved

<table>
<tr>
<td></td>
<td>80% or more of RHMTs get a score of 70 or higher out of 100 points in the RHMT annual plan assessment by June 2014.</td>
<td>
Rate of RHMTs gaining 70 points or higher
<table>
<tr><th colspan="4">During Phase 2</th></tr>
<tr><td>2011/12</td><td>2012/13</td><td>2013/14</td><td>2014/2015</td></tr>
<tr><td>43% (9/21)</td><td>86% (18/21)</td><td>88% (22/25)</td><td>96% (24/25)</td></tr>
</table>
<table>
<tr><th colspan="2">After Project Completion</th></tr>
<tr><td>2015/16</td><td>2016/17</td></tr>
<tr><td>92% (23/25)</td><td>88% (23/26)</td></tr>
</table>
Source: Project materials, questionnaire (MOH)
・ The rate reached 86% in the FY 2012/13 plan and 96% in the FY 2014/15 plan, which exceeded the target of 80%.
・ The target score of 70 points has been achieved since Project completion.
・ According to the central government, which conducts appraisal, it is appreciated that RHMTs created and submitted their annual plans that were systematized during the Project. On the other hand, it is necessary to improve the plans as their quality did not reach the standard level.
</td>
<td>At the time of Project completion: Achieved
At the time of the ex-post evaluation: Achieved</td>
</tr>
<tr>
<td></td>
<td>60% or more of RHMTs submit the quarterly progress reports on time by October 2014.</td>
<td>
・ Since FY 2013/14, new regions that have taken basic training have been required to submit quarterly progress reports. The rate of submission was 88% in the first quarter and the second quarter. As a whole, the Indicator target of 60% or higher was achieved even in a busy season.
・ After Project completion, 60% or more of RHMTs submitted the quarterly progress reports on time in each quarter both in FY 2016/17 and FY 2015/16.
・ Since the establishment of the Division of Health, Social Welfare and Nutrition in PORALG, which has jurisdiction over RHMTs, a person in charge of RHMTs (called the “Guardian”) in the division has had a role in reminding RHMTs of the submission of reports and plans.
</td>
<td>At the time of Project completion: Achieved
At the time of the ex-post evaluation: Achieved</td>
</tr>
<tr>
<td></td>
<td>Over 80% of annually planned activities are implemented by 60% or more of the RHMTs at the end of FY 2013/14.</td>
<td>
・ At Project completion, 16 out of 25 regions (64%) carried out 80% or more of the activities scheduled in their annual plans and achieved the Indicator.
・ The remaining nine RHMTs had the capacity to carry out planned activities but could not carry them out mainly due to insufficient financial resources.
・ Although data on all the regions was not available at the time of the ex-post evaluation, 12 regions that provided answers to the questionnaire achieved the Indicator.
・
Implementation rate of planned activities (FY 2013/14 results)


Source: Completion Report
</td>
<td>At the time of Project completion: Achieved
At the time of the ex-post evaluation: Data unavailable</td>
</tr>
</table>

Implementation rate of planned activities in 12 regions (FY 2016/17 results)

Morogoro	Tabora	Katavi	Mbeya
62.50%	About 80%	81%	90%
Iringa	Mara	Shinyanga	Arusha
More than 90%	90%	80%	100%
Rukwa	Mwanza	Pwani	Dar es Salaam
85%	90%	80%	96%

Source: Questionnaire for all regions

Source: Materials provided by JICA, questionnaire (MOH and RHMT)

In Phase 2, in addition to the development and introduction of practical tools for conducting SS to RRHs and CHMTs, efforts were made to clarify the roles of RHMTs and improve their knowledge and skills for the creation and appraisal of regional health annual plans, CCHPs, and CHOPs. Activities to support CHMTs and RRHs were carried out by RHMTs, the quality of annual plans of RHMTs improved, and 60% or more of RHMTs carried out 80% or more of activities scheduled in their annual plans. However, the involvement of RHMTs with RRHs was limited. They just introduced tools for SS to RRHs. There are still issues in the effective implementation of support activities.

In light of the above, the Project Purpose was not fully achieved.

3.2.2 Impact

The Project originally aimed to have RHMTs promote the independent development of CHMTs and RRHs with the progress in decentralization and improve health services in cooperation with CHMTs and RRHs. This evaluation considered "Managerial performance[21] of RRHMTs and CHMTs is improved"[22] as the Overall Goal of Phase 1 and Phase 2 and determined, with the Indicators below, whether RRHs and CHMTs having responsibility for health service delivery carried out activities in an appropriate timeframe according to an appropriate plan developed based on their roles. Based on the judgment, it was checked how RHMTs subject to capacity development (Project Purpose) contributed to the Overall Goal.

The evaluation judgment placed emphasis on "SS by RHMTs to CHMTs and RRHs with standardized tools" (Indicator 1 of the five Indicators of Project Purpose for Phase 2), "Approval rate of CCHPs in the second appraisal" and "Submission rate of CHOPs" (Indicators

[21] As the Project did not define the word "Management," the ex-post evaluation defined it as "RRHs and CHMTs having responsibility for health service delivery carry out activities in an appropriate timeframe according to an appropriate plan developed based on their roles" based on details of activities and Indicators. As for good managerial practice, one of the Indicators of the Higher Goal, the ex-post evaluation defined it as "A means for effective managerial performance" rather than the achievement of the Higher Goal because the Project aimed at mutual learning among RHMTs.

[22] The Higher Goals for Phase 1 and Phase 2 are "RRHM is improved to provide sustainable health services" and "Managerial performance of RRHMTs and CHMTs is improved," respectively. It seemed that Phase 2 focuses on lower levels (districts and RRHs). However, considering that districts and RRHs actually provide health services, these Higher Goals are almost the same. Therefore, the ex-post evaluation considered the Higher Goal of the Project to be "Managerial performance of RRHMTs and CHMTs is improved."

1 and 2 of the three Indicators of Overall Goal), and information obtained through the hearing survey conducted in five regions for the ex-post evaluation.

3.2.2.1 Achievement of Overall Goal

[Phase 1 and Phase 2]

The achievement of the Overall Goal is as shown in Table 5 below.

Table 5: Achievement of Overall Goal

<table>
<tr><th>Purpose</th><th>Indicator</th><th>Result</th><th>Achieve-ment</th></tr>
<tr><td>Managerial performance of RRHMTs and CHMTs is improved.</td><td>90% or more of CCHPs are approved in the first submission at the Basket Fund Committee (BFC) meeting by June 2017. (Overall Goal Indicator 1)</td><td>・ Change of Indicator
As external factors (delay in sharing of CHMT budgetary ceiling) may affect the approval rate of CCHPs in the first submission[23], it was considered that the Indicator was not suitable for the measurement of the quality of CCHPs. So, in the ex-post evaluation, the Indicator was changed to “90% or more of CCHPs are approved in the second submission at the Basket Fund[24] Committee (BFC) held for approving funds.”
・ The approval rate of CCHPs in the second submission recorded 90% or more for the first time in FY 2016/17 after the completion of the project.
・ Support of RHMTs in creating CCHPs generally improved after Project completion.
・ Negative factors that affect the quality of CCHPs:
- Frequent changes in the version of Plan Rep;
- The quality of plans of health facilities that are lower organizations of CHMTs[25]; and
- RHMT’s lack of knowledge on CCHPs[26].
・ Positive factors that affect the quality of CCHPs:
- Positive support system by RHMTs (in Mwanza and Pwani in particular among the five regions) to CHMTs, such as RMO taking charge of a district, etc.
- Holding a briefing session for the creation of CCHPs with the participation of all CHMTs, and a commitment to focusing on plans and management of CHMTs[27] (Dar es Salaam)

CCHP approval rate
<table><tr><th colspan="4">During Phase 2</th><th colspan="2">After Project Completion</th></tr><tr><td>2011/12</td><td>2012/13</td><td>2013/14</td><td>2014/15</td><td>2015/16</td><td>2016/17</td></tr><tr><td colspan="6">1st appraisal</td></tr><tr><td>58%</td><td>0%</td><td>31%</td><td>20%</td><td>53%</td><td>78%</td></tr><tr><td colspan="6">2nd appraisal</td></tr><tr><td>84%</td><td>58%</td><td>85%</td><td>91%</td><td>87%</td><td>95%</td></tr></table></td><td>Achieved</td></tr>
</table>

[23] As the budgetary ceiling is announced after CHMTs submit CCHPs, it is appropriate to determine the Indicator based on the approval rate of CCHPs in the second submission.

[24] The Basket Fund is a method where the donor country and donor organization do not individually implement a cooperative project as part of aid coordination, but the government of a developing country and a donor organization consult with each other to implement a project by using a foundation they jointly established. Basket funders refer to donor countries and organizations that contribute funding to the Basket Fund.

[25] CHMT will create CCHP based on an annual plan submitted by a health facility over which it has jurisdiction.

[26] According to an opinion from CHMTs, the capacity and knowledge of CHMTs on CCHPs are equivalent to or exceed those of RHMTs.

[27] In Dar es Salaam, CHMT secures budget for holding a session for CCHP creation hosted by RHMT.

<table>
<tr><td></td><td></td><td>Source: FY 2011/12 to 2014/15: MOH, Completion Report , FY 2015/16 to 2016/17: Questionnaire (MOH)</td><td></td></tr>
<tr><td></td><td>70 % or more of CHOPs are submitted to MOHand PMORALG by FY 2016/2017. (Overall Goal Indicator 2)</td><td>・ The rate in FY 2013/14 during Project implementation was 78%, in FY 2015/16 after Project completion was 48%, and in FY 2016/17 was 60%, which did not reach the target of 70%.
・ Negative factors that affect the submission of CHOPs:
- Low motivation towards plan development[28]
- Irregular SS by RHMTs to RRHs[29]
・ Positive factors that affect the submission of CHOPs:
- “Guideline for Developing Comprehensive Hospital Operational Plans (CHOPs) for Regional Referral Hospitals”[30] prepared by JICA technical cooperation “Project for Strengthening Hospital Management of Regional Referral Hospitals” (2015-2020) in August 2016
CHOP submission rate<table><tr><td colspan="2">During Phase 2</td><td colspan="2">After Project Completion</td></tr><tr><td>2013/14</td><td>2014/15</td><td>2015/16</td><td>2016/17</td></tr><tr><td>78%
(18/23)</td><td>NA</td><td>48%
(11/23)</td><td>60%
(14/23)</td></tr></table>Source: Questionnaire (MOH)</td><td>Not achieved</td></tr>
<tr><td></td><td>Good managerial practices initiated by RHMTs, RRHMTs and CHMTs are shared and accumulated. (Overall Goal Indicator 3)</td><td>(Country level)
・ According to the hearing survey in PORALG and RHMTs, good practices have not been collected or shared effectively. The RHMT conference, which had been held during the Project for sharing good practices and promoting learning among RHMTs, has not been held since Project completion due to budget shortfall.
・ The conference between RMO and DMO, which had been held during Project implementation, has been continuously held since Project completion, but it has not placed emphasis on good practices.
・ The format for RHMT quarterly reports has a column for describing good practices, but not all the regions filled in the column.
(Regional level)
・ In Pwani, a CHMT performance evaluation system was established. In Tabora, case examples in which RHMTs shared cases of other districts and contributed to problem resolution could be found.</td><td>Not achieved</td></tr>
</table>

Source: Materials provided by JICA

As for the Indicators of the Overall Goal, the CCHP approval rate improved after Project completion, as described above. However, the improvement of the submission rate of CHOPs and the establishment of an effective structure to collect and share good practices are future challenges. In light of the above, the Project achieved its Overall Goal “RRHs and CHMTs having responsibility for health service delivery carry out activities in an appropriate time frame according to an appropriate plan developed based on their roles” at a limited level.

[28] This is because budget (Basket Fund) is not allocated to CHOPs, unlike CCHP, even if it is submitted.

[29] There is an opinion that it is difficult to make self-evaluation as many of the members of RHMTs work at RRHs and some of them are members of RRHMTs. As stated in this opinion, efficient, regular support has not been provided by RHMTs to RRHMTs.

[30] As with the Project, JICA technical cooperation “Project for Strengthening Hospital Management of Regional Referral Hospitals” aims to improve hospital management of RRHs. According to the hearing survey, all the RRHMTs in the five regions used this guideline for creating CHOPs. Therefore, the submission rate of CHOPs and the quality of CHOPs are expected to improve through the Project.

3.2.2.2 Other Positive and Negative Impacts

None in particular

As described above, a certain level of effects expressed through the implementation of the Project. The effectiveness and impacts of the Project are fair.

By Project completion, the roles of RHMTs had been clarified, RHMT members had obtained knowledge and skills to support CHMTs and RRHMTs, and a support structure had been largely established. After Project completion, it was expected that RHMTs would promote the independent development of CHMTs and RRHs, with the progress in decentralization, and would improve health services in cooperation with CHMTs and RRHs. However, RHMT's contribution to improvement of the managerial performance of CHMTs and RRHs was limited. In addition, as all the RHMTs subject to the hearing survey conducted only perfunctory SS, it was not considered that SS reached the expected level.

3.3 Efficiency (Rating: ③)

3.3.1 Inputs

Table 6: Project Inputs

Inputs	Phase 1		Phase 2	
	Plan	Actual (At the time of Project completion)	Plan	Actual (At the time of Project completion)
(1) Expert dispatch	Not specified	Long-term: 3 people Short-term: 2 people (Total: 70.33 MM)	Not specified	Short-term: 9 people (98.1MM, including expenses covered by the consulting firm where Japanese experts belonged)
(2) Participants received	Not specified	9 people	Not specified	10 people
(3) Equipment	Vehicles, office equipment, etc.	Vehicles and office equipment including personal computers, printers and projectors, that cost equivalent to a total of approx. 4.815 million yen	Vehicles, IT equipment for internet connection (modem, etc.)	Vehicles and office equipment, etc.
(4) Total project cost (Japanese side)	350 million yen	351 million yen	360 million yen	354 million yen

(5) Total project cost (Tanzanian Side)	Personnel expenses for Tanzanian counterparts, expenses related to the preparation of facilities and land, etc.	Tsh. 178,524,500 (partial expenses for the implementation of monitoring and evaluation and CMSS activities), (Others including expenses for operation and utilities of the Project office, and vehicle fuel and maintenance to carry out CMSS activities, etc.)	Personnel expenses including salaries and allowances for Tanzanian counterparts, and expenses related to the operation of the Project office, etc.	Expenses for the operation of the Project office including utilities, personnel expenses for Tanzanian counterparts, etc.

Source: Phase 1 and Phase 2 Completion Reports and Terminal Evaluation Reports

3.3.1.1 Elements of Inputs

[Dispatch of experts]

During Phase 1, a total of five long- and short-term experts were dispatched under the titles of "Health System Management/Governance," Human Resource Development Specialist," "Monitoring & Evaluation" and "Administrative Coordinator." The total MM was 70.33 and was carried out mostly as planned.

During Phase 2, which was implemented between November 2011 and March 31, 2014, a total of nine short-term experts were assigned. Their areas of expertise were "Chief Advisor/Health System 1/Finance Management 1," "Health Management/Health System 2/Finance Management 2," "Capacity Development 1/Training Development 1," "Capacity Development 2/Training Development 2," "Health Planning 1," "Health Planning 2" and "Administrative Coordinator/Training Management."

[Training in Japan and Provision of equipment]

As indicated in Table 6, they were implemented mostly as planned.

3.3.1.2 Project Cost

With regard to the project cost, 100% of the planned budget was expended in Phase 1, and 97% of the planned budget was expended in Phase 2[31].

3.3.1.3 Project Period

Both Phase 1 and 2 were implemented as planned (100%).

As explained above, both the project cost and project period were within the plan. Therefore,

[31] The planned budget for Phase 1 was 350 million yen, and the actual expenditure was 351 million yen (100% of the budget), and the project cost was as planned. On the other hand, the planned budget for Phase 2 was 360 million yen, and the actual expenditure was 354 million, and the project cost was within the plan (98% of the budget.) Contrary to this finding, the Phase 1 contract was signed between JICA and the consulting firm with a contract value which was more than the planned budget. No written record was found to explain reasons for this discrepancy. Further, no relevant information was obtained through hearing surveys.

efficiency of the Project is high.

3.4 Sustainability (Rating: ①)

3.4.1 Policy and Political Commitment for the Sustainability of Project Effects

Sustainability in policy aspects is assessed as low at the time of the ex-post evaluation. The capacity development of RHMTs is not given priority in either the *Health Sector Strategic Plan Four* (HSSP IV, 2015–2020; developed in 2015) or the policy of the new fiscal year (FY 2018/19). Besides, while the Presidential statement of November 2017 confirmed the change in government offices responsible for the operation and management of RRHs, no policy or statement had been released by the time of the ex-post evaluation. During the hearing surveys with PORALG and MOH officers in June 2018, they stated that a task team in MOH was preparing documents about RRHs, but these documents would not include issues related to RHMT roles and future directions of RHMT and CHMT.

The information collected by July 4 indicated that MOH and PORALG had not reached a consensus on the implementation of the assessment and appraisal system of CHOP and SS visits to RRHs as well as the future relationship between RHMTs and RRHs. In addition, according to the basket funders, within five years, the central government will deposit budgets directly in bank accounts of all local health facilities operating under CHMTs. Provided that it is realized, health facilities will be required to prepare their budgets and expend accordingly although their current capacity for budget preparation is considered insufficient. Given this situation, MOH and PORALG are required to clarify the type of support to be provided by RHMTs and CHMTs to local health facilities, and roles and the position of RHMTs in the new structure. Both agencies, however, were taking no substantive action to rectify the situation at the time of the ex-post evaluation.

As new policies had not been shared with RHMTs, the RHMTs in Dar es Salaam and Dodoma were undertaking usual assignments including SS visits to RRHs when the second study team returned (July 4, 2018).

3.4.2 Institutional/Organizational Aspect for the Sustainability of Policy Effects

As of July 4, 2018, the sustainability of project effects in terms of institutional/organizational aspect is assessed as low. As described above, MOH is going to release a policy about RRHs. Conversely, it is unlikely that MOH is going to develop and issue any policy related to a new RHMT structure anytime soon because MOH and PORALG have reached no consensus about the future relationship between RHMTs and RRHs. In 2015, the Division of Health, Social Welfare and Nutrition was established in PORALG, leading to more involvement of PORALG in the management and operation of RHMTs. In spite of this, any official coordination meeting has not been organized between PORALG and MOH for the last two years. It is necessary to

promote cooperation and coordination between the two agencies in order to ensure the sustainability of the project effects.

When the Project was planned, it was aimed to ensure thorough dissemination of policy information from RHMTs to CHMTs and RRHs. However, the hearing surveys with the CHMTs and RRHs during this ex-post evaluation study revealed that while CHMTs and RRHs receive relevant information directly from MOH, RHMTs are unaware of such information at times. It is necessary to review the position and expected roles of RHMTs in order to use them strategically.

In many regions, RHMT core members[32] are assigned to RRHs concurrently. As both PORALG and MOH plan to assign the members exclusively to RHMTs, if this is put into practice, RHMTs will be able to perform their functions more efficiently.

3.4.3 Technical Aspect for the Sustainability of Project Effects

With regard to the technical sustainability of project effects, there are issues to address with priority. At the time of the ex-post evaluation, RHMTs continuously used SS tools and provided feedback to CHMTs and RRHs in reference to the tools. This should be highly commended. However, as described above, PORALG and MOH had not reached consensus on the future relationship between RHMTs and RRHs. It was not clear to which organization the SS tools and skills to assess the CHOPs that were developed under the Project should be transferred. Despite a high percentage of resignations, transfers[33] and turnover of staff members at RHMTs and CHMTs, no mechanism has been in place to ensure the proper handover and transfer of duties by a member leaving an office to another taking over his/her position. Systematic training has not been carried out for new recruits. Unless these situations are rectified, the number of members who were trained by the Project will be continuously decreasing from RHMTs, and thereby RHMTs will not be able to sustain the technical capacity enhanced by the Project. Table 7 below shows the number of staff members in the eleven regions who were trained by the Project and are still working in the RHMTs at the time of the ex-post evaluation. It also indicates the percentage of resignations, transfers and turnover of RHMT staff members, which is around 25–50%. Among the five regions visited by the ex-post evaluation study team, the RHMTs situated either in the urban areas or their peripheral areas (Dar es Salaam, Mwanza and Pwani Regions) have a lower staff turnover. According to the information collected through hearing surveys at two CHMTs from each region, the staff turnover is higher in CHMTs than RHMTs.

[32] One RHMT is composed of nine core members and nearly two dozen quasi-members.
[33] It does not mean that officers are transferred from RHMT to CHMT or the other RHMT.

Table 7: The Number of Staff Members Trained in the Eleven Regions and Rate of Staff Members who Left RHMTs

	Morogoro	Tabora	Katavi	Mbeya	Rukwa	Mwanza	Iringa	Mara	Arusha	Pwani	DSM[34]
Number of RHMT staff members trained during the Project	8	8	4	8	3	8	8	8	8	9	9
Number of RHMT staff members trained during the Project and still working at RHMTs	4	4	2	8	3	5	5	6	5	6	6
Percentage of resignations transfers and turnover	50%	50%	50%	0%	0%	38%	38%	25%	38%	33%	33%

Source: The Questionnaire Survey (RHMTs)

3.4.4 Financial Aspect for the Sustainability of Project Effects

The financial sustainability was recognized as an issue even from the implementation period and is still concerned at the time of the ex-post evaluation. RHMTs' three financial sources are from the basket fund, donors, and block grants (recurrent budget). However, they are mostly dependent on the basket fund and donors just as they were in the past.

According to the Phase 2 Terminal Evaluation Report, a total of 3.7 million USD was allocated to RHMTs from the Basket Fund. However, according to PORALG, the RHMT budget has decreased significantly; the FY 2018/19 budget allocated to RHMTs from the basket fund is limited as approximately 4.5 billion Tanzanian shillings (Tsh.) (equivalent to approx. 1.98 million USD[35]). For FY 2018/19, the RHMTs in the Dar es Salaam region, the biggest region in Tanzania, and the Mwanza region, the second biggest region, are allocated not more than 277 million Tsh. (approx. 120,000 USD) and 211 million Tsh. (approx. 90,000 USD) respectively. The Katavi region is allocated not more than 130 million Tsh. (approx. 57,000 USD), which is the lowest in all the regions. The basket funders stated that approximately 3% of the Basket Fund is currently allocated to RHMTs, and there is no plan to increase this amount because the government does not have a clear policy on RHMT functions.

While there are budgets allocated by donors to RHMTs, they are generally earmarked to particular projects implemented by donors, which target specific areas such as Malaria and HIV/AIDS. Therefore, RHMTs are not given authority in most cases. A large portion of the block grants is allocated to personnel expenses; other than that, it is spent on utilities and other miscellaneous items that are necessary to maintain and operate RHMTs. The proportion of the block grant excluding personnel expenses in the RHMT budget is insignificant.

Because the government failed to announce its policy on RRHs before RHMTs completed the

[34] DSM (Dar es Salaam): Abbreviation of Dar es Salaam, which is the biggest city in Tanzania

[35] Exchange rate: 1 Tanzanian Shilling = 0.04792 yen and 1 USD = 108.812 yen. (Exchange rate of June 2018 in JICA's Exchange Rate Table 2018)

FY 2018/19 plans and budgets, the budget to conduct SS visits to RRHs is still included in the plans of RHMTs. Provided that the government decides to remove SS visits to RRHs from the responsibility of RHMTs, PORALG will review the RHMTs' budget plans in December and cancel its budget for SS activities from RHMTs to RRHs. In this case, the RHMTs' budget will shrink further and it can be more difficult for them to have any influence on the regional health management system. Conversely, if the government decides to continuously assign RHMTs to SS visits to RRHs, RHMTs will be able to keep the budget with them.

In light of the above, it is determined that there are problems related to financial aspects.

In conclusion, major problems have been observed with regard to the policy background, organizational, technical and financial aspects. Therefore, the sustainability of the project effects is low.

4. Conclusion, Lessons Learned and Recommendations

4.1 Conclusion

The aim of this Project was to develop the capacity and functions of Regional Health Management Teams (RHMTs) in all 21 regions (increased to 25 regions during the Project) of Tanzania, by developing training programs on managerial practices including Supportive Supervision (SS), for MOH conducting SS to RHMTs, and for RHMTs conducting SS to Council Health Management Teams (CHMTs) and Regional Referral Hospitals (RRHs), while also clarifying the institutional framework, thereby contributing to the capacity development of RRHs and CHMTs as well as the improvement of health management at the regional level.

The Project had challenges in its design for Phase 1. The Project was launched when the structure of MOH for RHMTs had not been established, and a wide range of plans, such as the strengthening of cooperation among the central, regions, and districts and the development of the capacity of RHMTs, were to be developed in three years, a limited period. However, the Project is highly relevant as its purpose is consistent with the policy and development needs of Tanzania and Japan's ODA policy in terms of "Development of administrative managerial capacity for providing public services with the progress in decentralization."

The roles of RHMTs are to inform CHMTs and RRHs about policies, have them develop appropriate plans, and carry out activities according to the plans through SS. The Project clarified the roles and largely established a structure to enable RHMTs to function. The supervision capacity of RHMTs also improved. However, one of the Indicators to determine the effectiveness of the Project "The annual average number of opportunities that RHMTs conduct SS to CHMTs and RRHs", which is one of the most important indicators, was not achieved. As a result, although the Overall Goal Indicator "CCHP approval rate" was achieved, the "CHOP submission rate" was not achieved. According to a hearing survey of CHMTs and RRHs in five

regions, the importance of RHMTs had been partly recognized but limited. Considering all the matters above, the effectiveness and impacts of the Project are fair.

The efficiency of the Project is high as its cost and period are within the plan.

As for sustainability, the Project does not have a new regional health system or a mechanism to strengthen the roles and functions of RHMTs because of a structural change after Project completion and a high percentage of resignations, turnover, and transfers. Problems have been observed with regard to the policy background, organizational, technical, and financial aspects. Therefore, sustainability of the Project effects is low.

In light of the above, this Project is evaluated to be partially satisfactory.

4.2 Recommendations

4.2.1 Recommendations to the Implementing Agency

4.2.1.1 Recommendations to both MOH and PORALG

Regular organization of official coordination meetings with participation of both MOH and PORALG

The ex-post evaluation study team confirmed that although meetings have been appropriately organized between MOH and PORALG at a practitioner level, no official coordination meeting between both agencies has been organized for the past two years. The evaluation study team found at the second field survey in July 2018 that these agencies have different views on future systems of both SS visits to RRHs and CHOP appraisals. It is important for both agencies to regularly hold coordination meetings in a friendly manner to discuss and decide on a variety of issues. They include the review of the system of SS visits by MOH and PORALG to RHMTs, revision of tools for SS visits to CHMTs and RRHs, and implementation of continuous SS visits to RRHs that were established and developed under the project. Based on mutual agreement, they should work together for improvement of the health management system and heath service delivery.

Strengthening of the RHMTs' Operational Mechanism in a New Structure

At the time of the ex-post evaluation study, MOH is responsible for the development of a "Policy" and a "Strategy" on RHMTs, while PORALG is assigned to the preparation of a "Plan" on RHMTs. However, none of the Policy, the Strategy and the Plan describes a future operational mechanism of RHMTs.

Since the devolution of authority and responsibility for public functions to council administrative offices, capacity development of CHMTs has been given higher priority than that of RHMTs. In some regions, CHMTs have knowledge about CCHPs and capacity to develop documents at a level equal to, or even better than, RHMT. Besides, most RHMT staff members are assigned to RRHs concurrently and have little time to work for RHMT activities. Under

these circumstances, the government announced that RRHs will be placed under the responsibility of MOH instead of RHMTs (that is administratively under the PORALG) from FY 2018/19. All health facilities including health posts will eventually receive basket fund directly from the central government based on the budget plan developed by themselves and be required to carry out activities in accordance with the prepared plan. In light of this, strategies on capacity development and human resource allocation of RHMTs should be implemented taking into account the roles and the position of RHMTs in the new regional health management system. An operational system of RHMTs should be strengthened in accordance with these strategies.

Capacity Development of RHMT Members

No institutional system has been in place for capacity development of RHMT members since project completion. As indicated above, in some regions, the capacity of RHMTs is not better than that of CHMTs, although RHMTs are in position to supervise the operation of CHMTs. In some regions, nearly 50% of the core members in RHMTs left their job, compared with the time of project completion. Nevertheless, RHMTs has no system to train new RHMT members on knowledge and skills gained under this project. It is recommended that the capacity of RHMT members be strengthened through regular training organized within the operational mechanism of RHMT that is to be strategically developed as discussed above.

Development and update of SS Tools

All RHMTs in the five regions visited indicated that it is necessary to update the tools for SS visits to CHMTs and RRHs that were developed by this project. Some RHMTs have revised the checklist, which is one of the SS tools, upon instruction from RMOs. However, the RHMTs in the other regions have been using the tools without any revisions or modifications because they were thinking that only MOH was authorized to do so. It is recommended that contents of the checklist be thoroughly reviewed taking into account points to be checked when RHMTs carry out SS visits to CHMTs, and be revised promptly.

Appointment of RHMT Core Members as Full-time PORALG Officers

During the project planning stage, the project was concerned that RMO is the only one regional health officer under PORALG. This situation has remained the same at the time of the ex-post evaluation. Most of the other eight core members of RHMTs are concurrently assigned to RRHs as medical personnel. While they are assigned to RHMTs to carry out administrative tasks, they are concurrently posted as medical personnel, who are under the supervision of an RRH director. In addition, they tend to give higher priority to RRH duties, thereby hardly spending sufficient time at RHMTs. As a result, it is difficult for RHMTs to implement SS visits

to RRHs in an effective and efficient manner. During the hearing survey, MOH and PORALG shared a plan that the eight core members of RHMTs will be appointed as independent full-time PORALG officers in the future (RMOs have already been PORALG officers.) Regardless of this plan of the two agencies, many core members whom the evaluation study team interviewed expressed their desire to be assigned to RRHs, instead of RHMTs. Hence, it may take time before this arrangement is introduced. However, it is highly recommended that RHMT core members be assigned only to RHMTs in order to operate them more efficiently and effectively.

Establishment of a Planning Support System for RHMTs and CHMTs with the Progress in Decentralization

Among the five regions where the ex-post evaluation study team conducted the hearing survey, there is one region where both the RHMTs and CHMTs consider the preparation of annual plans one of their high priority assignments. The CHMTs are aware of the importance to develop CCHPs, thereby allocating budgets to related activities, including expenses to participate in an annual five-day CCHP preparation workshop organized by the RHMT. At the workshop, they are able to work with the other CHMTs by referring to each other's document, resulting in better quality CCHPs. As a result, they are able to submit a CCHP before a deadline. Therefore, MOH and PORALG should encourage RHMTs and CHMTs to allocate appropriate budgets to organize and participate in meetings and workshops for CCHP development by fully explaining its importance.

4.2.2 Recommendations to JICA

None.

4.3 Lessons Learned

Commencing a project after an implementation system is in place.

It is important to carefully assess the timing of project commencement for technical cooperation projects to produce expected effects. As decentralization processes progress, essential roles, which can be played by regions, were gradually recognized. Nevertheless, a department or officers responsible for RHMTs in MOH was/were not appointed in a timely manner. The project was forced to operate without any implementation system for one year and four months after its commencement. During this period, the project organized the training for RHMTs and developed a draft policy dissemination package, but it took one year and four months to be able to carry out project activities in effective way. As a result, the effects of Phase 1 were not as much as expected. To avoid such a situation, it may be necessary to postpone the project commencement until an implementation system in MOH had been properly in place. It is recommended that JICA assists a recipient country in putting an implementation system in

place by providing small inputs including the dispatch of an expert, if the responsibility system and implementation system were not confirmed. Successful implementation of technical cooperation projects requires strong commitment of an implementing agency (a recipient country) to a project. It is important for JICA to assess the most appropriate timing of project commencement at the project planning stage.

Deciding on the project size based on planned inputs

Phase 1 was designed to carry out a variety of activities all across the nation within the short project period of three years. They included capacity development of all of the newly approved RHMTs, institutionalization of CMSS, strengthening of a coordination and support system between central and regional health agencies, and establishing and operationalizing SS visits by RHMTs to CHMTs. As a consequence, the effect of SS from RHMTs to CHMTs was limited. In the future, at the project formation stage, JICA should develop a well-focused project plan that can be realized within the expected project period of three years.

However, when the project focuses whole health management system, not only RHMTs, higher project effect would be expected if you plan pilot project which include "enhance cooperation between RHMTs and CHMTs, and develop their capacity" such as SS and regular meetings of RMO and DMO. In other words, the cooperation between relevant organizations is the key point for project effect and it's quite important to set the activity and indicator which shows the relevant organization's cooperation. Nevertheless, it is difficult to realize them for RHMTs, which had just been approved, in a period of three years.

Further, if the project is designed to support an organization that is newly created, in order to make steady project implementation and project effect, it is recommended that project sets the center project scope for cooperation between the project and the organization (in this project it refers to CHMTs), which is responsible for budget allocation and health service delivery.

When targeting a whole regional health management system as described above or when forming and planning a project to support a newly established organization, it is important to consider the activity plan and objective setting corresponding to the input scale after considering the focus of the project and the key point of realization of project effects.

Clarification of roles and functions of MOH and PORALG in JICA projects

In the future, it is recommended that role and functions as well as Outputs anticipated by respective agencies (RORALG and MOH in Tanzania) be elaborated in a Record of Discussions (R/D), when the projects are formed and planned in other country that has multiple administrative agencies with jurisdiction over a series of health systems such as administrative organizations, hospitals, health offices as in this project. It is difficult for donors to coordinate activities across line ministries. Therefore, if roles and functions of respective agencies as well

as their anticipated Outputs during the project implementation period are clarified, it is more likely that the project will be provided with cooperation smoothly by both agencies in the course of its implementation. This will contribute to continuing the project effects even after the termination.

Assessment System of Plans of subordinate offices under the Decentralized Governance

RHMTs are responsible for appraisal of the quality of CCHPs and CHOPs prior to their submission to PORALG and MOH. This procedure was established by this project and the JICA expert who was dispatched in 2017, and relevant activities for capacity development of RHMTs have also been implemented by both. After the appraisal of CCHPs, RHMTs inform CHMTs of their CCHP scores and request them to revise the document accordingly to improve quality. It would be almost impossible for the central government to carry out detailed appraisals of CCHPs, which are submitted by more than 180 CHMTs. Thus, to assign RHMTs to the first appraisal of CCHPs and CHOPs can be a good example of an approach to efficiently improve quality of the document. Because the capacity of RHMTs to appraise documents still had room for improvement in Tanzania at the time of the ex-post evaluation, relevant training should be continuously organized. It will also contribute to enhancement of project sustainability. Many of the other African countries also have a similar system to Tanzania in which health offices submit their plans to their superior offices. Few of these countries, however, have a mechanism to appraise submitted plans by scoring them objectively in order to ensure quality of plans. The appraisal mechanism introduced in Tanzania can be shared with other African countries that are under decentralized governance.

Appendix 1: Achievement of Output Indicators (At the Times of Project Completion and the Ex-Post Evaluation)

[Phase 1]

	Output/Indicator	At the time of Project Completion	At the time of Ex-Post Evaluation
Output 1	**Management skills of RHMTs to respond to changing environments and new technologies are strengthened.[36]**	○	–
	1-1. Knowledge level of participants on training topics is improved.	○	–
	1-2. Number of RHMT members trained under the TC-RRHM is increased.	○	–
Output 2	**RHMT Supportive Supervision from RHMTs to CHMTs is integrated and functions.**	△	△
	2-1. Proportion of CHMTs supervised quarterly according to the Supportive Supervision Guideline is increased.	×	–
	2-2. Policy dissemination package is prepared and distributed.	○	×
	2-3. Policy dissemination guideline is developed.	×	–
Output 3	**Central Management Supportive Supervision from the central to RHMTs is institutionalized in MOH & PMORALG.[37]**	△	×
	3-1. Standardized procedure for Central Management Supportive Supervision from the central to RHMTs is developed.	○	–
	3-2. Proportion of RHMTs supervised according to the standardized procedure/guideline is increased.	○	×
	3-3. Office in charge of Central Management Supportive Supervision is identified and functions in both MOH and PMORALG.	△	–
Output 4	**A coordinated system[38] in responding to local issues among central and regional levels is strengthened.**	○	–
	4-1. RHMT composition, rules and functions are clearly defined and understood among Regional Secretariats and Ministries.	△	–
	4-2. Opportunities for RHMT meetings at the zonal level are increased.	○	–
	4-3. RRHM sub-committee of the TC-SWAP is held when necessary.	○	–
	4-4. RRHM Newsletter is published biannually.	○	–

(○: Achieved, △: Partially achieved, ×: Not achieved, –: Not assessed at the time of the ex-post evaluation because they are related to activity performance)

[36] Changes in the knowledge level of participants were assessed not by an examination objectively but by self-evaluation after the training using the five-point grading scale. Although it was not objectively assessed, many participants indicated that training increased their knowledge. The training materials were developed in accordance with topics for each training session. A total of six management trainings were organized on "Leadership & Management," "Strategic Thinking and Planning," "Supportive Supervision and Coaching," "Policy Dissemination" and "Annual Planning and reporting" with the participation of a total of 962 participants (out of which 742 were RHMT staff members.)

[37] Although the engagement of PMORALG in activities was not adequate, a CMSS mechanism was established, and during Phase 1, a total of six CMSSs were organized, visiting 16 – 22 regions every year. In light of this, it was concluded that the Output was sufficiently produced.

[38] It was mostly achieved by the end of Phase 1. Stakeholders, except RRHs, gained adequate understanding on roles and functions of RHMTs. The mechanism to promote coordination between central and regional agencies was strengthened through publication of newsletters and meetings in zones.

[Phase 2]

	Output/Indicator	At the time of Project completion	At the time of Ex-Post Evaluation
Output 1	**Management skills of RHMTs in supporting CHMTs and RRHMTs are improved.**	○	×
	1-1. Training package for the agreed six topics is developed and utilized.	○	×
	1-2. 80% or more of the RHMTs start making follow-up based on the training contents within a month after the training.	○	–
Output 2	**Roles and functions of RHMT to support CHMTs and RRHMTs are institutionalized and consolidated.**	○	○
	2-1. A final draft of the revised document "Functions of Regional Health Management System" is completed by September 2013 and approved officially by June 2014.	○	–
	2-2. All RHMTs adopt the revised organizational structure per the revised document by October 2014.	△	○
	2-3. Newsletters and promotion materials are distributed widely.	○	–
Output 3	**Guidelines and tools for RHMTs to perform their functions are developed.**	○	○
	3-1. Supportive supervision tools for RHMTs to CHMTs and RRHMTs are developed by February 2013 and by October 2013, respectively.	×	–
	3-2. RMSS tools are disseminated to all RHMTs by February 2013 (RHMTs to CHMTs) and by November 2013 (RHMTs to RRHMTs) respectively.	○	–
	3-3. 90% or more of RHMT members satisfy the quality of the RMSS-C tools and are willing to utilize to support CHMTs.	○	○
	Proposed Indicators) 3-4. RHMT members satisfy the quality of the RMSS-H tools and are willing to utilize to support RRHs.	–	○

(○: Achieved, △: Partially achieved, ×: Not achieved,–: Not assessed at the time of the ex-post evaluation because they are related to activity performance)

Appendix 2: State of Supportive Supervision Implemented in the Five Regions

Region A: Although there seem to have been some positive effects of SS on the capacity of CHMTs, the CHMTs have good capacity to begin with, and the effects of SS visits may be limited. With an initiative of the RHMT, a seven-day workshop was organized for the CHMTs in preparation of CCHPs. Among the five regions visited by the ex-post evaluation study team, RHMT members in only Region A are independent from RRHMT. This arrangement has helped the RHMT to establish a system to carry out SS visits to RRHs effectively.

Region B: SS seems to have some positive effects. The RHMT carries out SS visits to all CHMTs at every quarter. Compared to the other RHMTs visited, this RHMT demonstrates the strongest leadership. (For example, the RHMT requires RRHs for the submission of weekly reports and has effectively cooperated with RRHs. The RMO in person has been in charge of specific CHMTs and conducts SS visits to these CHMTs.) The RHMT is aware of its own constraints and has sufficient capacity to execute its duties. While the system has been in place whereby RRHs submit weekly reports to the RHMT, the frequency of SS visits by the RHMT to RRHs is not as high as it should be.

Region C: There are some positive effects of SS on the capacity of CHMTs. The RHMT files results of every SS visit by village, which are kept in a good condition compared with the other four RHMTs visited. It also uses the SS tools appropriately as intended by the project. However, CHMT members rarely share information with each other. In this regard, further capacity development of CHMTs is required. Since the RHMT gives higher priority to CHMTs than RRHs and the capacity of RRHMT is low, it can be concluded that the effects of SS on the capacity of RRHs have been limited.

Region D: This RHMT has revised the SS tools on its own, reflecting regional conditions. It indicates the positive engagement of the staff members in the supportive supervision. However, they are not able to conduct quarterly SS visits due to other assignments including political activities. They themselves admitted that they had failed to conduct SS visits to CHMTs and RRHs in an effective manner.

Region E: It seems that there are some positive effects of SS. While the RHMT stated that they conduct quarterly SS visits, the two CHMTs, which the ex-post evaluation study team visited, informed the team that the RHMT was not involved in the process to develop the FY 2018/19 CCHPs. Thus, there is a possibility that the RHMT has not carried out SS visits effectively. Although RRHs confirmed that the quality of SS visits by the RHMT has been improved, they seemed not to value the RHMT. Therefore, it can be concluded that SS visits by the RHMT to RRHs have not been effective. This RHMT demonstrated the best teamwork among the five RHMTs visited.

Appendix 3: Effects of Supportive Supervision by RHMTs

This ex-post evaluation study was implemented with an aim to assess the effects of supportive supervision. Under this study objective, the study team carried out hearing surveys[39] with PORALG, MOH, RHMTs in the five regions, two CHMTs and one RRH each from the five regions and basket funders. Based on the information collected, the study team analyzed the effects of SS from the following points of view; (1) Importance of RHMTs, (2) Capacity of RHMTs, and (3) Capacity/performance of CHMTs and RRHs, and, subsequently, concluded that SS visits by RHMTs to CHMTs and RRHs have only partially contributed to improvement of the managerial performance of CHMTs and RRHs.

(1) Perceptions towards the importance of RHMTs

The study team carried out hearing surveys with the CHMTs and RRHs in the five regions with regard to guidance provided by the RHMTs to them during the last SS visit before the ex-post evaluation study, and the level of importance that they attach to the RHMTs. The CHMTs and RRHs regard RHMTs as an organization to coordinate issues with the central government agencies. The CHMTs stated that they can function adequately without any involvement of the RHMTs in their activities although the RHMTs may assist them in some way or another when necessary. In other words, they do not have much regard for the RHMTs. Concerning the RRHs, they tend to overlook roles of the RHMTs. This is probably because some RHMTs are not able to conduct quarterly SS visits, as instructed, because of delays in budget disbursement or another assignment, and regarding the development of CCHP, CHMT members have knowledge about CCHPs at a level equal to, or even better than, RHMT members.

(2) Capacity of RHMTs

Although RHMTs have partially managed to maintain the capacity which they had built under the project, there is no assurance that they will be able to maintain such capacity in the future. Prior to the project, roles of RHMTs were not elaborated at all and no SS tools or reports were available. Thus, at the time of the ex-post evaluation, the interviewees from the five regions asserted that the capacity of RHMTs is "good" compared to the past. Further, the study team confirmed capacity of RHMTs to some extent; the strong leadership of the Mwanza RHMT, the capacity of the Dar es Salaam RHMT to coach CHMTs in the CCHP preparation, the good teamwork in the Pwani RHMT, and the capacity of Tabora RMHT to use the SS tools and file the results of SS visits. However, some CHMTs indicated that the capacity of RHMTs is not

[39] Because the number of interviewees was limited, there is a possibility that views of the interviewees do not represent those of project beneficiaries. In addition, there is concern indicated in "2.3 Constraints during the Evaluation Study."

better than those of CHMTs. Further, not all of the five RHMTs carry out SS visits to RRHs in an effective manner. Some of the possible reasons why RHMTs are not able to execute their assignment appropriately are as follows. RHMTs are often assigned to tasks which are not within the scope of their assignment. Many RHMT members are not independent from RRHs. Because of the high staff turnover,[40] the RHMTs in nine out of the eleven regions from which the study team collected information have now few members who were directly trained by the project. Nevertheless, no system has been in place to transfer knowledge and skills from the trained members to newly assigned members, or to develop the capacity of current members. Consequently, RHMTs are not able to maintain their developed capacity.

The ultimate objective of the project was to improve health service delivery in regions under the decentralized system. It was anticipated that through the project, RHMTs promote the independent development of CHMTs and RRHs with the progress in decentralization, and improve health services in cooperation with CHMTs and RRHs. In spite of this project objective, what RHMTs are engaged in now is to carry out SS visits simply, and some RHMTs are not able to execute even quarterly SS visits. The capacity of RHMTs is too inadequate to achieve this project objective.

(3) Capacity/Performance of CHMTs and RRHs

The five regions were visited during the ex-post evaluation study and two CHMTs were selected from each region for the interview. Upon request from the study team, each RHMT selected one CHMT with good performance. One of the reasons why the capacity and performance of these CHMTs and RRHs is good is because competent members are collected at RHMTs in urban areas such as the Temeke RHMT in the Dar es Salaam region. On the other hand, the Dodoma RHMT and the Bahi CHMT and the Mwanza RHMT and RRH attributed their good performance to good "teamwork" and "leadership," as well as their participation in the JICA technical cooperation project, "Project for Strengthening Hospital Management of Regional Referral Hospitals," which started in 2015. None of them indicated SS visits by RHMTs as a main reason for their good performance and capacity.

[40] Please refer to Table 7 in "3.4 Sustainability."