DHARURA FASTA
+
IMPROVED CHF

A Home of innovative insurance solutions to address pressing risk management needs of the low-income households.

A Hub for development of social protection innovations, through micro-insurance models appropriate for Public Private Partnership (PPP)

Retreat Centre for mobilizing resources to aid in protecting those who cannot afford the premium for the micro insurance products that HIMSO offers or manages.

End of Project Evaluation for Promotion of Collaborative Emergency Transport System and improved Community Health Fund in the context of Universal Health Insurance in Tanzania

Proiect No: A – A-TZA-2021-0356

Evaluation Report

Final Report
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Disclaimer

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List of Abbreviations and Acronyms

BftW	Bread for the World
BSc	Bachelor of Science
C/DED	Council/District Executive Director
C/DMO	Council/District Medical Officer
CHF	Community Health Fund
CHMT	Council Health Management Team
CHuA	Community Health Users Associations
CIDR	Centre for International Development and Research
DC	District Council
DF	Dharura Fasta
DHIS	District Health Information System
ECD	Early Childhood Development
GoT	Government of Tanzania
HIMSO	Health and Insurance Management Services Organization
iCHF	improved Community Health Fund
ID	Identification Document
IDI	In-depth Interview
IEC	Information, Education, and Communication
IMIS	Insurance Management Information System
IR	Inception Report
KI	Key Informant
KII	Key Informant Interview
LGA	Local Government Authorities
M&E	Monitoring and Evaluation
MEAL	Monitoring, Evaluation, Accountability and Learning
MIS	Management Information System
MoH	Ministry of Health
MoU	Memorandum of Understanding
MPH	Masters of Public Health
NGO	Non-Governmental Organization
RAS	Regional Administrative Secretary
RHMT	Regional Health Management Team
SMHIS	Self-Managed Health Insurance Schemes
TECDEN	Tanzania Early Childhood Development Network
TOR	Terms of Reference
TZS	Tanzania Shillings
UHC	Universal Health Coverage
UHI	Universal Health Insurance
UNICEF	United Nations' Children Fund
VEO	Village Executive Officers
WEO	Ward Executive Officers

Glossary of Terms for Key Concepts Used in this Report

Concept	Definition
iCHF	Refers to a government lead health insurance scheme implemented to cater for low-income communities using low premium as a pro-poor strategy of improving health and financing mechanism
Evaluation	A process of determining level of implementation, successes, barriers and challenges as well as producing learning in order to inform a program, project, organization or country.
Dharura Fasta	Referred to as Emergency Transport System in English with the Words Dharura meaning Emergency and Fasta meaning quick derived from the English word "Fast". It is one of the health micro-insurance innovation designed by HIMSO to cover the transport part of the medical care milestone
Consultant	A professional leader and advisor with experience and knowledge of undertaking and leading an activity on behalf of a client
Client	An individual, institution, organization, firm or company that seeks consultancy service from the Consultant
Project progress	Change in project milestones, positively or negatively measured by achievement of objectives, set targets, goals and coverage of planned activities.
Evaluation Questions	Line of inquiry that provide generalized key issues and aspects to be explored during evaluation
Purchaser provider split	Distinction of the entity or firm that buys the services and the one that pays for.
Relevance	Alignment of the goals, objectives, rationale and expected outputs/outcomes with national policy, visions, missions and guidelines
Efficiency	A measure of how best resources (inputs) were utilized to establish the recorded outputs
Effectiveness	A measure of the way the objectives were translated to outcomes as the ultimate end results.
Impact	A measure of long term effects/outcomes from the project set goals and its contribution on the area of focus
Sustainability	A strategy and mechanism of ensuring that project activities, outputs, outcomes and effects are integrated and sustained in routine systems permanently after the project phase ceases.

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Executive Summary

The Health and Insurance Management Services Organization (HIMSO) is a Tanzania NGO dedicated to improving healthcare access and promoting sustainable insurance solutions. HIMSO's mission is to ensure equitable and affordable healthcare for all, while empowering individuals and communities to manage their health and insurance needs effectively. For more than a decade HIMSO has been implementing its own micro-health insurance product for emergency transport services (Dharura Fasta) and co-managing the improved Community Health Fund (iCHF) in 10 councils of Mbeya (Mbarali, Mbeya, Busokelo, Chunya and Rungwe) and Songwe regions (Momba, Songwe, Mbozi, Tunduma and Ileje).

From December 2021 HIMSO received financial support from Bread for the World to implement a project titled "promotion of collaborative Emergency Transport System and Community Health Fund in the context of Universal Health Insurance in Tanzania. The project is implemented by HIMSO in collaboration with Regional and District Councils in the same councils that HIMSO had been implementing its iCHF and Dharura Fasta initiatives. The project has maintained the two components of Emergency Transport (known as Dharura Fasta in Kiswahili) and the improved Community Health Fund (iCHF). The goal of the project is to contribute to the accessibility of quality health care services to the communities in the project area without financial hardship.

HIMSO is in the final stage of implementing the project. The organization commissioned an end-term evaluation to measure the project achievements, challenges and lessons learned. This evaluation was conducted in March 2024 by a team of Consultants. The evaluation team employed a mixed method approach in data collection all guided by the OECD-DAC Criteria. With the consideration of the evaluation objectives, data collection tools were developed with a focus of responding to the evaluation questions. The main data collection methods included document review, secondary data analysis, key informant interviews and household survey. Both primary and secondary data were used to answer the evaluation questions. While qualitative data was handled using a content analysis approach, quantitative data was analyzed using SPSS software.

Findings from the evaluation show that the project was coherently positioned within HIMSO functional areas and scope of work as well as in appropriate context of Mbeya and Songwe regions where HIMSO has implemented similar projects previously. In terms of relevancy, the project was found to be highly relevant.

To a large extent, the proposed interventions were able to respond to the project goal and objectives sufficiently effectively. The project indicators were found to have highly been achieved some of them by more than 100%. At the organizational level, HIMSO's team demonstrated sufficient capacities enough to bring about required project effectiveness suitable for offering financial and technical support to Regional and Districts iCHF teams and CHuA Offices. Similarly, the project interventions (Dharura Fasta and iCHF) were found to be well aligned to the national (short and long-term) plans and strategies especially with regards to social protection and pro-poor interventions that promote equitable access of quality health services through effective resource mobilization and health financing mechanisms.

On the other hand, the project was found to be sufficiently effective. With more than 9 months remaining, the project effectiveness was earmarked by increased project visibility, acceptability, increased utilization of Dharura Fasta services while maintain a balance of minimal spending of the collections as well as increased ownership of the project especially via co-management of iCHF and Dharura Fasta by CHuAs. Within the implementation period, the project goal, objectives and activities were sufficiently achieved and accomplished. Except for few indicators, targets for most of the project indicators at output and outcome level were met implying success in achieving project objectives. The evaluation determined factors contributing to the project effectiveness to include the project design, staff capacity and commitment, political support from regional and district authorities, project efforts in implementing participatory processes and activities that included all key stakeholders hence increasing project visibility, acceptability, awareness of micro-insurance concept and ultimately improved service delivery.

In terms of efficiency, the project was rated to be highly efficient accomplishing most of the planned activities and attain the set targets ahead of time for concluding the project. The project was found to have spent both financial resources and time very efficiently. In addition, the project was associated with improved quality of care, improved referral management, reduced maternal morbidity and maternal death as well as improved geographical and financial access of health services at impact level.
The nature of the project design, which included embedding the project activities within the existing regional and district health system provided an assurance for project sustainability. Similarly, since the two main interventions are the permanent HIMSO's core business, the likelihood of the project sustainability is high.

The good picture portrayed by the evaluation findings was slightly hiccupped by a few challenges both at the institutional up to the national level. The evaluation found that, there was a room for the HIMSO project team to further communicate the lessons learned from the project through publications which was not effectively conducted. Fixing such challenges and others as noted under the findings section could optimize the project impact. In order to sustain the project impact so far attained, a longer term phase of the project is recommended.

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1. Introduction and Background

This report is prepared by a team of two Consultants who complement each other to ensure an appropriate response to the terms of reference (TOR) for end term evaluation of Project no: A – A-TZA-2021-0356 issued by The Health and Insurance Management Services Organization (HIMSO).

HIMSO is a Tanzania NGO dedicated to improving healthcare access and promoting sustainable insurance solutions. HIMSO's mission is to ensure equitable and affordable healthcare for all, while empowering individuals and communities to manage their health and insurance needs effectively. HIMSO was established and registered in 2012 to complement the government's efforts in providing comprehensive quality healthcare coverage to low and middle-income households through innovative solutions, and with a vision of bridging the gap in healthcare services and creating a robust insurance framework. Over the 10 years, HIMSO has become a trusted partner in the healthcare sector, advocating for inclusive policies and innovative approaches to address the evolving healthcare challenges. HIMSO was formed with the support of CIDR (Centre for International Development and Research), a French based International NGO, which has promoted from 2002 to 2008 Self-Managed Health Insurance Schemes (SMHIS) in Mbozi and Kyela involving Community Health Users Associations (CHuA).

HIMSO is implementing its own micro-health insurance product for emergency transport services (Dharura Fasta) and co-managing the improved Community Health Fund (iCHF) in 10 councils of Mbeya (Mbarali, Mbeya, Busokelo, Chunya and Rungwe) and Songwe regions (Momba, Songwe, Mbozi, Tunduma and Ileje). Also is implementing Early Childhood Development (ECD) – Mtoto Kwanza Project in all councils of Songwe Region. HIMSO focuses on primary areas including healthcare access, insurance solution and health education. It has also successfully collaborated with various stakeholders, including government agencies, UNICEF, BftW, TECDEN and Dovetail Impact Foundation. These partnerships have allowed HIMSO to leverage resources, expertise, and networks, resulting in improved access to healthcare and expanded insurance coverage for vulnerable populations

The promotion of collaborative Emergency Transport System and Community Health Fund in the context of Universal Health Insurance in Tanzania, is the name of project implemented by HIMSO in Songwe and Mbeya regions (10 councils) since December 2021, with support from Bread for the World. The goal of the project is to contribute to the accessibility of quality health care services to the communities in the project area without financial hardship. It has two components, namely:

1) Improved CHF (iCHF) in Songwe and Mbeya Regions.
Under this component, HIMSO works across 10 councils in Songwe and Mbeya regions to enhance iCHF performance. The focus is on capacity building for district and regional officials through training and technical meetings.

2) Emergency Transport System (*Dharura Fasta*) in Mbeya and Songwe Regions.
This component is implemented in the same 10 councils, offering micro-health insurance for emergency evacuation during medical emergencies. This is an alternative means of emergency transport when public ambulances are not available are equally important.

As part of the project plan, HIMSO in collaboration with its funding agency - Bread for the World (BftW) and other collaborators, this evaluation was conducted at the end of project to determine how successful the project was and draw learning to inform future similar projects on how best such similar projects could successfully be implemented.

2. Goal, Objectives and Scope of Work

The goal of this evaluation was to determine the relevance and fulfillment of the project objective, efficiency, effectiveness, coherence, impact and sustainability. Results from this evaluation will enable the project team, HIMSO at large and its collaborating partners to reflect on the assessment of what has been achieved and learned during the period of the project implementation, and to provide important feedback and recommendation on the areas of project to be improved in the future.

2.1 Objectives of the project evaluation

The main objectives of the project evaluation were:

1. To determine the relevance and fulfillment of the project objectives, project efficiency, effectiveness, impact and sustainability.
2. To collect evidence using the evaluation findings so as to enable HIMSO and allies to reflect on the assessment of what has been achieved and learned during the period of the project implementation, and
3. To provide important feedback and recommendation on the areas of project to be improved in the future.

Specifically, the evaluation aimed to:

1. Determine the level to which the project goal, objectives and indicators are achieved.
2. Identify intended and unintended changes brought by the project.
3. Assess the sustainability of the project outcomes and impact
4. Assess how HIMSO is positioned to advocate for improvement of iCHF guideline.
5. Asses the capacity of CHuA Offices to manage Dharura Fasta and propose areas to improve.
6. Asses the improvement of iCHF (Regional and Councils) Offices to manage iCHF and propose areas to improve.
7. Draw lessons learned on the project design, implementation and management, and provide relevant recommendations for future projects, and
8. Inform the project holder (HIMSO) and BftW in relation to the future direction of the project.
9. Identify the main successes, challenges and opportunities existing for the project.

2.2 Scope of information and depth of evaluation covered

Based on the stated objectives, the evaluation focused at providing information in the following dimensions:

- Progress against objectives (with evidence) and reasons for lack of/no progress.
- Relevance as was the time of project set up and now as well as effectiveness, efficiency, impact and sustainability.
- Major challenges and if/how they have been overcome
- Deviations from objectives
- Significant new interventions (based on their results)
- Lessons and best practices to be applied for future projects
- Effectiveness of support from the corporate office on programs, operations and other aspects.

2.3 Evaluation Design

This was a cross-sectional assessment looking at the before and after situations of the project in relation to defined objectives, goals, and targets at one hand and established input, process and outcome indicators. Mixed methods approach were used to collect all relevant information. Both quantitative and qualitative data were collected and used to provide measures of the project implementation progress. Both primary and secondary data were also used.

2.4 Guiding framework

The team of Consultants employed two frameworks to guide the evaluation from which specific evaluation methods were drawn. These included:

1. Process Evaluation Framework
   This was used to assess whether the program was being implemented as originally intended, what services were being delivered, who is receiving those services, and perceptions of the program among stakeholders and implementers.
2. Performance Monitoring Framework
   This was used to assess baseline metrics compared to other data points at the time of evaluation since commencement of implementation of the strategy on a continuous basis throughout program implementation.

The two frameworks were combined into a composite framework (Figure 1 below) and used to guide the evaluation activity. This framework offered reflections on all important components of a standard evaluation process using the OECD-DAC criteria while maintaining specificity of a particular program or project. It concurred with the main objective of this assignment.

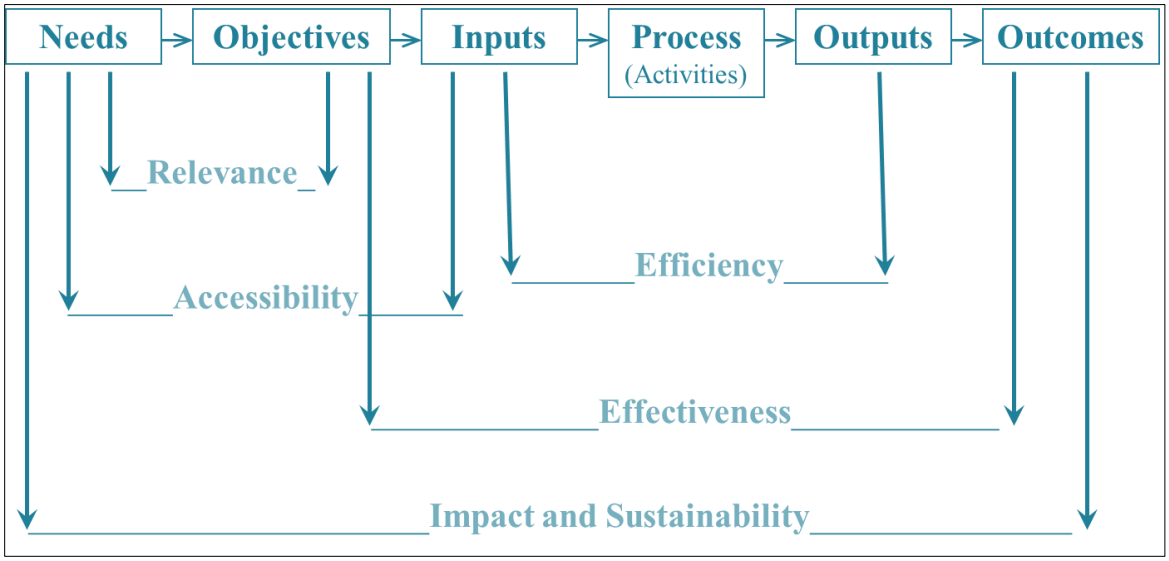

Figure 1: Composite Process and Performance Evaluation Framework

This framework guided the evaluation whereas, consideration of the original ideas and rationale of setting up the project (**Needs**) and how such needs were translated into specific project focus and activities (**objectives**) was key. The assessment of original concept and the set up objectives was used to measure **relevance** of the project. The evaluation further explored the actual inputs (**Inputs**) that were planned to be used to realize the project objectives against inputs that were made available and establish any gap. In many occasions, when comparing the intended needs of a program and the resources that were used to establish the project results one can be able to establish **accessibility** of the services or project outputs. In addition, the evaluation also looked at the activities (**Processes**) which the project implementation team applied to realize the intended project results (**Outputs**). Here, **efficiency** was measured by looking at how best resources (inputs) were utilized to establish the recorded outputs. Similarly, **effectiveness** was also measured by considering the way the objectives were translated to **Outcomes** which are the ultimate end results. Despite the fact that the project implementation has just been concluded and that **impact** might not be sufficiently registered, the evaluation used this framework to discuss with the client on specific impact indicators that could be used to trace and predict **sustainability** and scalability of the project with reference to context speculation. In this regard, impact and sustainability were measured by considering all program/project parameters namely needs, objectives, inputs, processes, outputs and outcomes.

2.5 Data Collection Methods

The evaluation team employed a participatory approach with mixed methods for data collection to execute the task. Data collection methods included:

- **Document review:** This involved undertaking a desk/document review of various project documents including project proposal to assess the original plans of the project, project activity and progress reports which offered and opportunity to assess progress against the targets and priorities set by the project.
- **Key Informant Interviews (KII):** These are interviews subjected to key informants at project, regional, council and community levels especially with participants who have leadership roles. Interviewees at this level were identified and selected based on virtue of their positions.
- **In-depth interviews** with project staff and HIMSO management, CHuA leaders as well as service providers at health facility levels. These interviews intended to gather information from front-line implementers of the project regarding how the project was translating the project plans into actions and results.
- **Household survey** using structured questionnaires was used with project beneficiaries at the community level. The idea was to capture perceptions and experiences of iCHF and Dharura Fasta members on the project implementation, perceived quality of project services, facilitating factors and barriers to accessing healthcare services as well as recommendations for improvements in co-management of Dharura Fasta and iCHF.

- **Round table discussion** and individual interviews with HIMSO staff. These data collection methods not only helped to collect quality data but also identify gaps where sufficient data is not available, or supporting explanations for existing data is lacking, or where information collected through various sources are contradictory.

2.6 Levels of engagement during the evaluation

At HIMSO level

At this level, the evaluation team interacted with HIMSO management and staff to assess all dimensions of assessment, specifically on advocacy, capacity building, and networking and collaboration. Also on the project design and its efficiency and effectiveness. Participants at this level were selected based on their role in the project under evaluation. The evaluation team accessed information from HIMSO management team and project team to draw their experience as frontline member of project implementation. HIMSO Staff and management were engaged through in-depth interviews (IDI) and round table discussion. The inception meeting was also used to collect initial data as well as clarifying some of the project plans that were not clearly stipulated in the TORs or project proposal. A total of 8 HIMSO staff and management members were involved in the round table discussions and three staff in IDI. During field work, HIMSO staff were involved in the evaluation with a coordination and logistical roles and the field coordinators from each district accompanied the evaluation team to support logistics and operational functions.

At Government level (Regional and District)

At the Government level the evaluation interacted with RAS Office, DED's Office, Office of the Regional Medical Doctors (RMOs) and the office of District Medical Officers (DMOs). Participants at this level were identified and selected on virtual of their position in regional and local governments. The evaluation assessed the existing engagements of these levels in facilitating and promoting iCHF and Dharura Fasta in the sampled Districts Councils and communities. Participants at these two levels were engaged through Key Informant Interviews (KII). At regional level, the evaluation was able to reach 5 out of 8 planned interviews while at district level the evaluation was able to reach 42 participants (88% of planned interviews)

Through the interaction with participants from these two levels, the evaluation aimed at establishing what the Government sees as an added value by participating in project interventions through HIMSO as compared to their own interventions. It also assessed how their interaction with HIMSO has helped enhance their capacity to manage iCHF in one hand and Dharura Fasta on the other hand as twin interventions and overall improvement of the quality of health services provided resulting from the co-management of iCHF and Dharura Fasta. In addition, the evaluation used the interactions with the evaluation participants from these levels to establish the effectiveness and the efficiency of the purchaser provider split, mode of claims payment as it is implemented in iCHF today. Key informant interviews were conducted to get in-depth information from selected respondents on their engagement in supporting, facilitating and promoting iCHF and Dharura Fasta.

At Community Level

At this level, the evaluation involved WEOs, VEOs, health service providers, leaders of the CHuA and, village leaders at one hand and members and beneficiaries of iCHF and Dharura Fasta on the other hand. Participants with leadership roles were selected based on their roles to the project while iCHF and Dharura Fasta were randomly selected using HIMSO membership database. The evaluation intended to assess the functionality of iCHF and Dharura Fasta, the capacity of CHuA Offices and, successes and challenges faced during sensitization and promotion of iCHF and Dharura Fasta, enrolment process and service delivery, including service satisfaction of the iCHF and Dharura Fasta members. It also assessed households' access to better essential health services. Respondents were drawn from CHuA Offices and among the members and beneficiaries of Dharura Fasta and iCHF. At this level, mixed methods, approaches and tools were applied to collect information on what have been the success of the project, expected and unexpected outcome, impact and challenges from both users and service providers. It included use of key informant interviews (KII) with community leaders, in-depth interviews (IDI) with service providers and questionnaires with iCHF and Dharura Fasta randomly selected members. **Appendix 1** provides a summary of evaluation participants and the coverage.

2.7 Evaluation Questions

The evaluation embarked at answering evaluation questions as set by the project. By answering these questions, the evaluation attempted to provide both information on the extent to which the evaluation objectives were attained but also the learning from the project implementation. Table 1 below provides the main evaluation questions used to guide the data collection activity.

Table 1: Questions to be answered by the Evaluation

Thematic Area	Key evaluation questions
Relevance of the project	1) To what extent are the project interventions (Dharura Fasta and iCHF) aligned with the needs of the people in regards to access to better essential health services as well as HIMSO's Mission? 2) To what extent are the project activities and outputs consistent with the intended goal, objectives, and indicators outcome and impacts? 3) How are the project interventions (Dharura Fasta and iCHF) aligned to the government's short and long-term plans and strategies in regards to health financing?
Effectiveness of the project	1) To what extent have the project goals, objectives, and indicators been achieved or are likely to be achieved by the project's conclusion? Explain the reasons behind the achievements or lack thereof. 2) To what extent has the project intervention (Dharura Fasta and iCHF) contributed to the health financing strategy in Tanzania? Provide insights into what could have been done differently for better results. 3) Are HIMSO's team capacities effective and suitable for offering financial and technical support to Regional and Districts iCHF teams, and CHuA Offices?
Efficiency	1) To what extent were the project funds utilized according to the agreed budget? 2) How did collaborations with iCHF managers at regional and district levels contribute to project efficiency?
Impact	1) How effectively have the implemented strategies (Dharura Fasta and iCHF) contributed to achieving healthcare accessibility and service utilization? 2) What is the discernible impact of HIMSO's advocacy efforts on influencing health financing policies at the national level? 3) How do regional and district administrations, health providers, and beneficiaries perceive the project's effectiveness and contribution towards achieving universal health care goals?
Sustainability	1) To what extent are the positive changes (see kind of change identified under impact) of the project likely to continue at beneficiaries' level beyond the end of the project period? 2) How likely will the project positive changes and impact continue at national level after end of donor funding? 3) How strong is HIMSO advocacy capacity to ensure continued policy engagement with relevant institutions at local, national, regional and international levels? 4) To what extent is HIMSO capable of supporting beneficiaries to continue positive project changes after end of donor funding? 5) Is there any structures /systems / processes and capacities at HIMSO (organizational set up and implementation processes) to assure sustainability? Is there need for improvement (details required) to continue – with or without external funding?
Coherence of the project	1) How well does the intervention fit in the overall internal and external context of HIMSO? 2) To what extent is there synergy and linkages between the project and other HIMSO projects and programs? 3) To what extent is there synergy and linkage between the project and national priorities? 4) Was there complementarity, harmonization, and coordination with others, and to what extent did the project interventions add value to other ongoing processes while avoiding duplication of effort.

The evaluation matrix that was used to map out the various evaluation questions with appropriate data collection methods and data source is includes as Appendix 2.

2.8 Data Management and Analysis.

Quantitative data was collected digitally using electronically programed questionnaires. This meant, data were made available on real time. All quantitative data were analyzed using SPPS software guided by an analytical plan which included indicators of interest. Management of qualitative data entailed transcription of interviews and summaries of field reports generated on daily basis. Analysis of qualitative data was conducted using thematic approach through a content analysis technique. The analysis was preceded by defining thematic areas based on the evaluation objectives and evaluation matrix. A complete and comprehensive methodological description is provided as **Appendix 3**

2.9 Limitations

The main limitation to this evaluation was time-consuming due to geographical distance from one village to the other. As a result, the sample size drawn for household survey was more for convenience than for statistical significance.

3. Evaluation Findings

3.1 Project Coherence

Coherence of this project was assessed from four dimensions. Within HIMSO, the **first dimension** was the reality that the project sustained, scaled up and addressed implementation challenges and gaps learnt from a previous project also implemented by HIMSO. Development of the current project under evaluation was a result of a completed phase of almost similar project implemented between 2018 and 2021 by HIMSO. The achievements and lessons learned lead to the development of the current project. Based on the recommendations of the end-term evaluation of the project, it was reasonable to mobilize resources for sustaining the attained achievements, addressing some of the challenges and scaling up lessons learned through the project to make the outcomes of the completed project worthwhile.

> "Access to emergency evacuation during a medical emergency from homes to health facilities and between health facilities is a basic need and requirement and a very important service for life saving during medical emergencies. Unfortunately, all of the public health insurance schemes do not cover this need. The synergy of Dharura Fasta and iCHF is the only unique scheme filling this gap in the country" [KI, CHuA Chairperson, Mbozi].

The **second dimension** was on the ***synergy*** of the project under evaluation with the overall scope of work by HIMSO as stipulated in HIMSO's five-year strategic plan. HIMSO identifies five strategic areas including **improving access to quality healthcare services**, which according to this evaluation is the largest priority area linked directly to the key message of the Health Sector Strategic Plan (HSSP V) with the motto *"No one should be left behind"*. Also HIMSO strategic plan identifies influencing social and behaviour change communication, improving community health management systems and scale up CHuA model to other regions as other priority areas of which all are well aligned with the project being evaluated.

The third dimension is the synergy and linkage of this project and other projects implemented by HIMSO. Through KII with HIMSO staff, the evaluation found that, the co-management of Dharura Fasta and iCHF is coherently linked to other projects including the Early Child Development (ECD) project. HIMSO utilized its extensive community based network developed over years of implementing iCHF and Dharura Fasta to create awareness and instigate community positive perception of the concept of ECD to the grassroots. The project was further strengthened when HIMSO joined the Tanzania Early Childhood Development Network (TECDEN). As a result, through the ECD project, HIMSO was able to reach over 500 local leaders who are now actively promoting ECD principles within their communities. Additionally, more than 120 health facilities are engaged in raising awareness about child nutrition and health, while also providing comprehensive ECD services. This collaborative effort has successfully sensitized 150 villages, resulting in increased knowledge on ECD among 7,500 community members, with a focus on parents and caregivers (65%). The three projects, Dharura Fasta, iCHF and the ECD have complemented each other quite well and optimize resource use.

In addition, the project has also a good synergy with the "Insuring the Destitute" project in which micro insurance is implemented to ensure accessible and affordable healthcare to all. Through the micro insurance, the low-income households are protected against perils that would have devastating impacts to their livelihoods, and in some extreme cases, their lives. Through this project, HIMSO creatively mobilize funds and other resources that aid in protecting those that cannot afford the premium for the micro insurance products that HIMSO offers or manages (i.e. iCHF and Dharura Fasta). This pro-poor initiative promotes not only access of healthcare to all but also ensures equity in health.

The fourth dimension is a measure of the project focus with the external (global and national) context. Beyond HIMSO self-strategic priorities, the project under evaluation was found to good synergy several global and national priorities and strategies. The emphasis in the HSSP – V is to promote the global call through the Sustainable Development Goals (SDG) of Universal Health Coverage (UHC). Based on the interviews with regional and Council health managers, HIMSO is perceived to have translated the concept of UHC quite well through the co-managed projects of Dharura Fasta and iCHF. The HSSP-V has defined two primary pathways to achieve UHC namely improved access to quality health care and ensuring affordability of the health services by every Tanzanian. While the Dharura Fasta is keen in promoting accessibility of healthcare, iCHF ensures that the project targeted population affords these services. As will be explained later in consecutive sections of this report, while Tanzania is under a critical review of its National Health Insurance

Scheme, the co-management of Dharura Fasta and iCHF under the CHuA model timely provides a learning that can inform and feed the current inconclusive discussion on the mandatory universal health insurance in the country.

Through previous and the current phases of Dharura Fasta and iCHF projects, HIMSO has conducted several advocacy engagements with the council, regional and national level to communicate learning from the two projects and how they can inform national health financing priorities especially on social protection strategies. During the project life, HIMSO participated in more than 11 meetings at national level and at least four routinely meetings at regional and council levels. It should be remembered that the first and largest public and national health insurance scheme was and is being implemented through the National Health Insurance Fund (NHIF). However, at its original design, NHIF was designated only for civil workers and hence excluding more than 80% of Tanzanians who are either in the Agriculture or informal sectors. iCHF was then introduced to cover for this 80% of the Tanzanians. Therefore, HIMSO's decision to invest and support on iCHF was meant to contribute to the Government's efforts in covering for the 80% of Tanzanians. Through these meetings, HIMSO was able to influence how iCHF could be implemented differently from the traditional way of its implementation and how the co-management of iCHF and Dharura Fasta could add value and impact of iCHF.

HIMSO's efforts are timely and relevant. Currently, Tanzania is at the final stages of launching "Universal Health Insurance" which aims at bringing together all different types of health insurance under one roof. The concept, approach and operationalization of UHC is still unclear to many. HIMSO's implementation of iCHF was and is still instrumental in creating awareness and imparting knowledge on at least the concept of "health insurance". For a country that had run its health system on the basis of free care for over 40 years after its independence, the change in mentality among its citizen, moving from "free care to cost sharing" was not an easy task. HIMSO has contributed significantly in creating this awareness and knowledge of health insurance and its benefits among Tanzanians through its iCHF project. This has laid down a good foundation for whatever improvement that will be done on the current design of iCHF.

Currently, Councils are being empowered and encouraged for more evidence based planning and allocation of resources using the burden of disease and cost-effectiveness of interventions as the basis. The CHMT is the lowest administrative unit that has responsibilities over public health. It has a decentralized budget and is responsible for paying salaries of health personnel at the district level. HIMSO works more closely with CHMTs while enjoying guidance of RHMTs. The assessed Dharura Fasta and iCHF schemes were implemented in the above described context. Designing the two projects with respect to this context was a plus in ensuring that acceptability, applicability and potential scalability being possible.

> "The work by HIMSO complements our work and plans at the council level. Everything they support and do was supposed to be our responsibility. They do what we ought to do and yet build our capacity. They are a set of five fingers of the left arm and complement our five fingers from the right arm". [CHMT Member, Mbeya DC].

HIMSO's programs of work is a gap filler in the above described organization of the health system at regional, council and community levels. Both Dharura Fasta and iCHF are pro-poor schemes that have sustained their operations in the two regions of Songwe and Mbeya for over a decade now. From the onset of the first phase of the project, HIMSO has focused on the health financing pillar and have been designed to fit within the existing nomenclature of the Tanzanian health system without disrupting the modus operandi and routine operations. Operating from Mbeya and Songwe regions, HIMSO takes advantage of its strategic position in the Regional and Local Government Authorities in which it identifies system gaps and opportunities and intervenes innovatively to address various public health issues. It extends its linkages across different levels of the health system and strategically positioning its program of work within national priorities. This approach has made HIMSO an important key stakeholder and partner at both national and sub-national levels. An additional unique feature is its connectivity to the community in which it operates: The organization an the project is well known and well-integrated.

General section reflections

- Generally, the current evaluated project is well aligned to both internal and external contexts of HIMSO. It is a result of the appreciative results of previous phases of the two interventions carrying more defined activities, a wider geographical coverage and of beneficiaries and involving a wider network of partners than was the case in the previous phases.

- Within HIMSO, the evaluated project is exemplary in providing of how different projects/programs within the same organization can find synergies. IT has a good link with other projects implemented by HIMSO including the ECD and Insuring Destitute projects.
- Externally, the project focus matches and complements quite well the regional and council health management efforts in ensuring availability, accessibility and affordability of quality health care in the regions and districts being implemented.
- At global and national levels, the project aligns quite well with the SDG on UHC and the national priority of ensuring accessible and affordable health services for every Tanzania as advocated by HSSP-V.
- At the national, regional and council level, the project activities were found to be in harmonization with similar activities by other key stakeholders. In addition, the project innovative CHuA adds and offers an exceptional unique value to the various related activities focusing on promoting accessible and affordable health services

3.2 Project Relevance

3.2.1 Alignment of the project interventions with the government's short and long-term plans in health financing Overall Relevance

HIMSO's choice of interventions (Dharura Fasta and iCHF) was found to align with the Tanzanian Health Policy (of 2007 and the draft of 2020), the Vision 2020-2025, HSSP V, Five Year Development Plans as well as Health Financing Strategy (2016 -2026) for the country. The National health policy advocates for cost sharing where the Government takes the larger responsibility of financing the health sector but directs other sector partners (including communities) to take part in mobilizing resources for health. The policy identifies user fees, community health fund (CHF) and various other health insurance schemes (including the NHIF) as part of the mechanisms through which health sector resources would be mobilized from. Similarly, the HSSP-V translates these policy directives by putting forward sector strategies to describe how these directives should be implemented. The Directorate of the Health Financing further defined these strategies into action points including **mandatory health insurance for all**, **creating one national financial and risk pool for health**, and **guarantying health insurance coverage for the poor and vulnerable** among others. These are the focus areas that HIMSO's general scope of work targets but also being interventional areas for the Dharura Fasta and iCHF co-managed project – making the project relevant to national priorities. Although HIMSO is not implementing mandatory health insurance, it promotes behavioural change in how communities should get used to health financing hence preparing a good ground for the mandatory health insurances when commences. Similarly, HIMSO's interventions promotes pro-poor health financing strategies hence finding a good match with the national health financing strategy on protecting the poor and the vulnerable populations.

"To the best of my knowledge, the project is implementing something that I know the Government has always wanted to implement but with less knowledge, little experience and limited resources they couldn't do it. As a result, the project is helping the country as a learning hub to demonstrate possible ways of implementing national plans on iCHF". [KI, CHMT Member, Ileje].

As indicated earlier. the Tanzanian's fifth Health Sector Strategic Plan (HSSP V) is built on the motto of "Leaving No One Behind" engineered by the urge to match with the global move of attaining Universal Health Coverage (UHC). The HSSP-V prioritizes health systems strengthening (HSS) as the main course of action to improve the performance of the health sector while maintaining a balance of Public –Private Partnership (PPP). These efforts are used by the Government of Tanzania (GoT) to attain its Development Vision (2020 -2025) as well as its five-year development plans. System strengthening is also key in achieving the Sustainable Development Goals (SDG) within the Tanzanian context.

HIMSO's program of work fits and align with one of the health system strengthening strategies of resource mobilization for service delivery and improvement of quality of care. The project activities address the essentials of Health Financing strategies while at the same time improving other health system components (Governance and leadership, Health Information System, Service delivery and quality of care).

3.2.2 Project Relevance with respect to the needs of the people.

a) Relevance related to iCHF

HIMSO's decision to support strengthening of iCHF activities in Mbeya and Songwe regions was found to be liked and appreciated by the majority of the evaluation participants. More than two thirds of the evaluation participants interviewed at community level perceived the project as a solution to their long wish of being able to access and afford health services at any time. *"When the Government introduced cost sharing, paying out of pocket was a common practice amongst most of us. Later on and with the education we received from HIMSO, we understood and found the benefit of pre-paid schemes such as iCHF and Dharura Fasta, especially during medical emergencies",* said a community leader from Mbozi district. The other one third of the community members interviewed were sceptical about iCHF, some influenced by the current Government move where it is unclear to them how iCHF is going to be merged with the National Health Insurance Scheme while a few others lamented on recurrent challenges of finding stock-out of medicines when they seek health services from health facilities using their iCHF membership cards.

The main focus of the project under evaluation is to improve both quality and access of health services while ensuring that people are able to afford the services regardless of their socio-economic status. The evaluation found that, at community level, affordable access to healthcare was also the need of the project targeted population. This match of common interest between the project and the needs of the people was made possible from the project approach of working with the people during the project design. Based on the previous phases of the project, the project design, plans and interventions were anchored from community perceptions, perspectives, needs and expectation as far as iCHF implementation is concerned. Similarly, the matched relevance was further supported by addressing barriers and challenges of implementing the same during the previous phases of iCHF project in the two regions. Previous phases of the project identified dissatisfaction among iCHF members related to stock-out of medicines and unfriendly attitude of service providers when visiting health facilities. Similarly, the previous phases had also identified delays and long bureaucracy in the iCHF member registration and issuance of membership card. The current project has taken into consideration these concerns and provided tailor-made solutions (e.g. ICT-based solutions in registration of iCHF members) which constitutes some of the project activities in the current phase of the project. This makes the project relevant to the needs of people being targeted.

At regional and council levels, past experience of implementing iCHF documented challenges such as shortage of human resources to manage and oversee iCHF activities in councils, limited knowledge in health financing matters, limited capacity in conducting follow-up and revenue collections, problematic record keeping, drop out iCHF enrolment officers (EOs), failure of district health systems and facility managements to translate reimbursable funds to health facilities into improved health services as well as challenging iCHF data system. Other issues of concerns included weak iCHF community based coordination mechanisms and lack of ownership of iCHF at District level which impact the support to local support to run iCHF. These and more other concerns constituted part of the project design and interventions in the current phase of the project. Some of the evaluation participants at regional and district level provided examples such as improved quality of health services especially on availability of medicines and medical supplies particularly after the project was introduced. Reduced stock outs, increased base of iCHF members (which in turns improves revenues from iCHF collections), and increased demand of service utilization were part of the cited improvements perceived to be contributed by the project. Similarly, participants perceived that there were similar improvements in districts that implemented iCHF under the support of HIMSO compared to districts that were not covered by the project.

The relevance of the project on iCHF was also associated with the project approach during the designing and introduction phases. By making the project design and implementation

Side Bar 1

Mbeya and Songwe regions present a typical rural Tanzanian scenario where the Government efforts to improve health services by increasing the network of its health facilities (with the aim of ensuring that every citizen accesses health services in not more than five kilometers from their residence) is far from being fully realized. Even if this goal will be met, a five kilometer walking is still a long distance for a sick person especially, during emergency or severe illness episodes. In most of the rural Tanzania parts, local transportation within villages (as is the case in cities where town buses, coaches and taxi services are available), is missing. Within the official referral system for health care delivery across different levels of care, ambulatory services are one of the biggest challenges in the country.

Functioning of effective referral systems is impaired by lack of ambulatory vehicles, funds to sustain the vehicles through sustained maintenance and replacement of the vehicles once need to and high cost of running the services against very limited facility budgets. On top of this, the ambulatory service protocol does not include linking the facility and home of the patient but rather assumes supporting the client who has sought services at one level and need to be ferried to another level within the Public health service arrangement. Worse enough, availability of specialized care within the Public health system is limited to district and regional level and in most cases, these are points located far away from the majority of the district residents. Lastly, functioning of the ambulatory services within the public referral system is limited to "one way only"; this means, a patient will be helped with ambulance services from lower to higher facility but not way back to home after recovery or death.

Source: HIMSO Evaluation Report, 2021.

participatory, the project was perceived relevant because it encompassed the beneficiaries thinking and needs from the onset. The evaluation team was made to understand by one of the CHuA leaders that HIMSO engaged almost all key stakeholders in many of its project planning, implementation and monitoring. *"All CHuA management have become permanent partners in all key decisions made by HIMSO regarding implementation of the two projects"* said a CHuA Chairperson in Rungwe District.

b) **Relevance of Dharura Fasta Component**

The relevance of the innovation around the Emergency Transport System (ETS), branded as Dharura Fasta was clear and highly appreciated. Comparatively, the evaluators feel that there was more liking of Dharura Fasta than iCHF. Most of the evaluation participants spoke highly, appreciatively and positively about Dharura Fasta.

> . "Dharura Fasta is the best ever! One of the very creative and intelligently thought innovation. Just imagine the geographical challenges we have even with normal means of transport. What would we be doing during emergencies if it wasn't for Dharura Fasta? the ambulances cannot go everywhere. Even more, ambulances cannot pick people from their homes but Dharura Fasta vehicles do". [KI, CHW, Momba].

Through all phases of implementing Dharura Fasta in the two regions, the positive perceived relevance of the project has never changed (Side Bar 1). HIMSO's Dharura Fasta innovation comes in to respond to all of the gaps described under side bar 1. Dharura Fasta members uphold a sincere positive attitude and reflection of the intervention such as reduced chances of loss of life among pregnant women and new-born as a result of timely evacuation of those experiencing medical emergencies and the benefit package Dharura Fasta offers in terms of transport support back home after receiving medical care in a referred facility. .

Of recent, HIMSO has redefined the concept of emergency to include medical emergencies beyond reproductive health related services. Similarly, addition of other products such as support to transport dead bodies if a member passes by when receiving medical treatment in hospital, have increased the perceived high value of Dharura Fasta.

> "I am one of those who benefitted from Dharura Fasta. As they say, the day you are naked is the day your in-law comes. My wife had a threatened miscarriage. Our village is more than 80 kilometres from the health centre. I was completely broken and didn't know what to do. Then my wife reminded me of contacting our CHW in the village and ask if we qualify to make use of the Dharura Fasta for my wife's ailment. When she came and examined her she said yes and immediately arranged means of transport to the health centre. I did not believe if that little money I contributed was saving my wife's life [Member of Dharura Fasta, Rungwe].

The sense of ownership of the project is also increasing. Some of the political, administrative and regional health managers perceive the project being public property but managed by HIMSO on behalf of the Regional and Council Management.

> "I don't like it when you refer to the project as HIMSO project. HIMSO had piloted it many years ago, we gave them every kind of support to generate the needed evidence that the interventions work. They handled the project and the interventions back to the regional government. It is our project now. That's why we strive in making CHuA very strong. CHuAs are ours, they are led by us [KI, Regional level, Mbeya Region].

3.2.3 Alignment of project activities and outputs with respect to the intended goal, objectives, out-come and impacts

According to the project documents, the goal of the project under evaluation is to contribute to the accessibility of quality health care services to the communities in the project areas without financial hardship. Specifically, the project aim to enhance iCHF performance in 10 councils drawn from the two regions while at the same time offering micro-health in-surance for emergency evacuation during medical emergencies to complement availability and accessibility of healthcare services. To achieve the goal and these two main objectives, HIMSO embarked on implementing two main interventions namely Dharura Fasta and iCHF as described in earlier sections of this report.

The evaluation assessed the activities which were developed under each intervention whether they were relevant enough to produce the expected project outcomes and answer the project goal and objectives. To do so, the evaluation team held a roundtable discussion with project staff from HIMSO to draw rationale for the proposed activities. Three criteria were used to justify the relevance of each project activity developed. First, if the proposed activity has ever been tried before either by the previous phase of the project or by other projects within HIMSO or outside HIMSO. This was intended to measure the validity of such activity. Second was to establish the effectiveness of the activity based on the past experience and if the activity was a scale-up effort or a new trial. This assessment intended to ascertain if the proposed activity has a potential to bring about the expected project outcome. Third was to identify synergy and linkage of the activity with one or several of the project objectives. A total of 14 main project activities were mapped, some of them with sub-activities within. All activities fell under four main categories namely project introduction, sensitization and stakeholder engagement, designing, management and operationalization of the main interventions (iCHF and Dharura Fasta), capacity building and institutional strengthening and advocacy and lobbying. At least one third of the project activities were a scale-up efforts, and the rest were either activities sustained from the previous phases of the project or new activities. Each activity was linked to a particular output and collectively linked to expected outcomes.

The evaluation team found that there was a very keen selection of activities which contributed to the project achievements as will be narrated in the consecutive sections of this report.

General Reflections

- This evaluation finds the project to have, for a large extent, met the project goal and objectives sufficiently effectively. The project indicators were found to be have highly been achieved some of them for more than 100%.
- At the organizational level, HIMSO's team demonstrated sufficient capacities enough to bring about required project effectiveness suitable for offering financial and technical support to Regional and Districts iCHF teams and CHuA Offices.
- Over years, and within the implementation period of the evaluated project, the two interventions have sustained a highly perceived perception of being an invaluable project and relevant from policy perspectives as well as from the perspectives of service users.
- The project interventions (Dharura Fasta and iCHF) are well aligned to the national (short and long-term) plans and strategies especially with regards to social protection and pro-poor interventions that promote equitable access of quality health services through effective resource mobilization and health financing mechanisms.
- Due to being well aligned with the national health financing priorities and through the advocacy and lobbying strategy by the project team, the project interventions (Dharura Fasta and iCHF) contributed significantly to the health financing strategy in Tanzania.
- Beyond alignment to policy and national health priorities, the choice of the project interventions (Dharura Fasta and iCHF) was such considerate to the needs of the people in regards to accessing quality and equitable health services. These needs include affordable and reliable availability of basic health services that ensures reliable availability of medicines, improved provider attitude, limited bureaucracy in accessing iCHF membership etc. Such needs have remained and matched with the main focus of HIMSO's mission and scope of work.
- Experience and learning from the previous phases of the project was a god drive for selection of a good set of project activities which had sufficient validity and reliability of bringing about the desired change and outcomes as planned by the project. Both new and adapted activities were found to be consistent with the intended goal and objectives of the project.
- The co-management approach of the two main project interventions and integrated activities has added value of each through optimization of project resource use, complementarity of the activities and outputs, and improved community positive attitude to iCHF based on the highly accepted Dharura Fasta intervention.
- As a result of the project relevance across all levels of the health system, there is an increasing ownership of the projects by the Government, more so at District and Regional level with a slight improvement of the same at national level. The increased advocacy by Mbeya and Songwe regional authorities to the Ministry of Health and PORALG have resulted to the two regions being granted permission to implement the current phase of the project using the co-management of Dharura Fasta and iCHF with all blessings of the two ministries.

3.3 Effectiveness

3.3.1 Overall effectiveness

The phase of the project evaluation focuses at a continuation of previous phases of the two interventions (also referred to as projects). While the overall goal and objective of iCHF and Dharura Fasta projects during the previous phases were

to improve access to health services of the rural populations in the Mbeya and Songwe regions, the current project aimed at increasing share of the population in the project areas that uses insurance products of iCHF and Dharura Fasta for health care.

Objectively, the projects intended to ensure that, at the end of implementing the project:

1) At least 8 of 10 established CHuAs manage the insurance scheme- Dharura Fasta and iCHF (co-managed) as agreed in the MoUs
2) iCHF membership in the project regions Mbeya and Songwe is increased by at least 20% and at least 80% of Dharura Fasta users are satisfied with the service (based on the baseline data)
3) Regular documentation of iCHF in the project region, including the observed challenges and difficulties as well as possible solutions are transmitted to the Ministry

3.3.2 Completion of Project Activities

The evaluation found that, the project was able to achieve 93% completeness of planned activities. Most of the activities were achieved at about 100%. This evaluation was conducted 9 months prior to project closure date and therefore the likelihood of completing the remaining activities to 100% rate is very high. There were four planned activities which were yet to be accomplished at 100%. These included:

1) **Networking**: One networking activity was not implemented. The plan to establish networking with PharmAccess was not accomplished. The reason behind this is the closure of the project at PharmAccess end that was supposed to be linked to the co-managed iCHF and Dharura Fasta from HIMSO's end.
2) **Knowledge generation**: While most of the sub-activities under this activity were conducted as planned, organizing webinars was not conducted. The evaluation found that the project staff had limited experience in organizing such events.
3) **Trainings**: Despite the completion of all planned training, the evaluation team noted several other rooms for optimizing trainings especially for capacity building of HIMSO project staff. Capacity building could have been organized on areas such as in organization of webinars, scientific writing and publication in peer review journals where staff admitted limited knowledge and experience.
4) **Institutional and programming capacity strengthening**: Part of sub-activities under this activity was to produce several publications based on the lessons learned from the project. This sub-activity was not conducted for reasons explained in item 3 above.

Appendix 4 provides a summary of state of completion of planned activities and rating.

3.3.3 Project Achievements

HIMSO and its partners have always used Networking, collaborations, knowledge generation, social and behavioural change communication, media houses, social marketing, reflective approach (participatory and consultative meetings) and trainings as key strategies and interventions to achieve the respective phase objectives for Dharura Fasta and iCHF. During the implementation period of the phase under evaluation, additional innovations were made in some areas which, based on the perception of the evaluation team, contributed to remarkable outcomes of the project. These include:

1.0 Strategic Interventions to improve Management of Dharura Fasta and iCHF

The co-management of iCHF and Dharura Fasta were the two main project interventions. In addition, the project implemented a set of other strategic interventions and activities that promoted improvement in how Dharura Fast and iCHF could be co-managed. These included:

- **Introduction of the concept of co-management of Dharura Fasta and iCHF**: This strategic innovation helped to bring in insightful valuing of Dharura Fasta as opposed to iCHF. It helped to showcase the complementarity nature of the two interventions at a layperson's perspective especially so by entrusting its management in the hand of CHuAs.
- **Mapping of CHW, Enrolment Agents and Transport Providers**: The project took initiative to develop a more defined database of Community Health Workers, Enrolment Agents and Transport Providers in order to improve monitoring mechanism and ascertain their performance and contribution to the project
- **Strengthen CHuA and establish three more in new councils:** CHuA have been a strong base of the two interventions but particularly so for iCHF. This model which is only found in HIMSO project areas alone across the whole country promotes trust, ensures transparency and help to timely resolve issues which would otherwise not be easily picked and dealt with. The project invested in CHuA training to co-manage Dharura Fasta and iCHF enrollment

- **Training of Community Health Workers to manage emergency cases:** Using the past experience, training content of CHW was more emphasized and tailor made responding to reported past experiences. CHW had better answers to users' questions and needs with additional capacity in managing project activities at grassroots level.
- **Develop and implement reward system to Enrolment Agents, Community Health Workers and Transport Providers**: This was a highly thought creativity which boosted the project performance contributing to notable positive outcome especially utilization of Dharura Fasta services.

These interventions were expected to lead to the attainment of the project goal which was to contribute to the accessibility of quality health care services to the communities in the project area without financial hardship. To measure these changes, the project developed several indicators at output and outcome levels. The evaluation used these indicators to assess the collective effect of implementation of the above activities which resulted into several changes as desired and envisioned by the project (Table 2). There were a total of 25 indicators altogether at output level with defined targets. The project was able to reach the target of 13 indicators at 100%, 11 indicators at more than 60% and one at 50%. Two indicators (networking forums attended by HIMSO for lobbying and advocacy purposes at district level by the end of project term and number of people involved during project introduction activities) exceeded the targets (Table 2).

Table 2: Project achievements at output level

Activity Code	Output Definition	Target	Achievement	%
1	**Project introduction meetings:**			
1.1	A project implementation approval is guaranteed by the ministry	1	1	100%
1.2	An introduction meeting is conducted at both regions with involvement of 8 RMT and 8 RHMT	32	28	88%
1.3	A project introduction meeting is conducted in all ten councils involving 210 participants			
	Number of Councils	10	10	100%
	Number of Participants involved	210	170	81%
1.4	The project is introduced in all 211 wards of Mbeya and Songwe regions involving a total of 2,134 participants.			
	Number of wards	211	211	100%
	Number of people involved	2,136	2,150	101%
2	**Management of Dharura Fasta Insurance (ETS) and iCHF**			
2.1	CHWs, EA and TP mapped in each village of Songwe and Mbeya region and their payment (incentive) mechanism is developed.			
	CHWs	856	856	100%
	EAs	856	856	100%
	Transport Providers (TP)	2,568	1,586	62%
2.2	CHuAs is set-up in three new Councils (Momba, Songwe and Tunduma) and is functioning in collaboration with iCHF and key government departments i.e community development	3	3	100%
2.3	CHuA and iCHF teams at district level in both regions received a training on co-managing Dharura Fasta and iCHF and have demonstrate capacity to deliver intended project results.	30	29	97%
2.4	856 CHWs and 10CHuA Coordinators received training on the management of emergency cases.			
	CHWS	856	820	96%
	CHuA Coordinators	10	10	100%
2.5	The capacity building training for 10 CHuA Coordinators in both regions is conducted in addressing skills gap identified.	10	10	100%
2.6	Demand creation activities have been conducted and increase Dharura Fasta and iCHF enrollment in all 211 wards of Mbeya and Songwe regions.	211	192	91%
2.7	The reward system is developed and used to remunerate CHWs, EAs and TPs in all 10 councils of Mbeya and Songwe regions.	1	1	100%
3	**Institutional and programming capacity strengthening:**			
3.1	The Management Information System (MIS) is upgraded for co-managing Dharura Fasta and iCHF data in all councils and generate information for advocacy purposes.	1	1	100%
3.2	HIMSO staff and CHuA team in all ten councils are trained on proper utilization of the upgraded MIS and use generated data/information for lobbying and advocacy purposes	38	36	95%
3.3	Reflective meeting on organization level (HIMSO Staff, CHuA team, Board)			
3.3.1	*A total of three project-focuses reflective meetings have been conducted involving HIMSO management and CHuA team by the end of the project term.*	3	2	67%
3.3.2	*A total of three organizational meetings have been conducted by the end of the project term involving HIMSO management team and board members*	3	2	67%
4	**Advocacy, Lobby and Networking**			
4.1.1	A total of 2 project progressive meetings at regional level conduced in both regions and offer solutions for suitable approaches for project progress!	2	1	50%
4.1.2	*A total of 40 stakeholders progressive meeting conducted at council level* in all ten councils and used as a platform for sharing project learning and impacts.	40	15	38%
4.2	**HIMSO participating in strategic networking forums**			
4.2.1	*A total of six national level networking forums attended by HIMSO by the end of project for lobbying and advocacy purposes.*	6	6	100%
4.2.2	*6 regional level networking forums attended by HIMSO by the end of project for lobbying and advocating project results/impact.*	6	6	100%

4.2.3	*30 networking forums attended by HIMSO for lobbying and advocacy purposes at district level by the end of project term*	30	14	47%

At an outcome level, the project was able to meet all the targets except for one indicator (engagement meetings with different stakeholders). The targets for three indicators were exceeded and the rest of the indicators were met as desired (Table 3).

Table 3: Project achievements at outcome level

	Baseline value	Cumulative Target	Cumulative Actual	Achievements in %	Remarks
Number of CHuA who signed MoU	0	10	10	100%	
Number of CHuA fulfilling co-management criteria	0	10	8	80%	
Number of CHuA fulfilled mandatory criteria (5 and 6)	0	8	8	100%	
Number of new HH enrolled in iCHF	33,615	38,103	50,191	49%	Exceeded target by 29%. Target was an increase by 20% from the baseline value
Number of DF members	26,903	104,000	57,232	55%	Exceeded national target. National target is 30%.
Number of DF member used the service	1700	3,894	3,401	87%	
Percentage satisfaction of Dharura Fasta	85%	80%	80%	100%	
Number of periodic reports submitted to Regional and Council Authorities[1]	4	77	78	101%	
Number of engagement meetings conducted	12	83	40	48%	
Percentage of actions/ resolutions acted upon	25%	100%	82%	82%	

Although not defined in the project monitoring and evaluation framework, the evaluation team included several other proxy indicators as included in assessment tools to assess the project effectiveness as related to the project goal and objectives. Some of these proxy indicators included:

a) **Increased trust and satisfaction of project beneficiaries to the project interventions**

According to household survey data, all Dharura Fasta clients (72 participants) and more than a half of iCHF members (46) interviewed in the course of this evaluation were found to be positive on the interventions particularly on Dharura Fasta which they perceive as a success. There were zero complain from Transport agents on receiving their reimbursement from the project via CHuA. None of the Dharura Fasta members reported to have missed the service when she/he called for help via the established channels of communication. Except for two people who had reservations on the state of the vehicles used by Transport Agents being old, Dharura Fasta was generally perceived to perform efficiently (Table 4). These findings correspond very closely with the percentage satisfaction of Dharura Fasta recorded by the project using routine M&E data (Table 3 above).

[1] A total of 13 reports were submitted in each quarter of the year to the Regional and Council Governments to update them about project progress, challenges and recommendations for mitigating the challenges.

Table 4: Percentage of Dharura Fasta Members Reporting perceived experience of using the service (at any time during their membership)

Item	Time	% by District						
		Busokelo	Rungwe	Mbeya DC	Momba	Mbozi	Ileje	% Total
		(n=12)	(n=12)	(n=12)	(n=12)	(n=12)	(n=12)	(n=72)
Time between requesting for evacuation and departure	<30min	67%	83%	67%	50%	83%	100%	**75%**
	30 min -1hr	33%	17%	33%	50%	17%	0%	**25%**
	>1 hr	0%	0%	0%	0%	0%	0%	**0%**
Time between departure and arrival to receiving facility	<30min	50%	67%	83%	33%	17%	0%	**42%**
	30 min -1hr	33%	33%	0%	33%	50%	100%	**42%**
	>1 hr	17%	0%	17%	33%	33%	0%	**17%**
Time between arrival to initiation of medical care	<30min	83%	100%	50%	100%	50%	67%	**75%**
	30 min -1hr	17%	0%	50%	0%	33%	0%	**17%**
	>1 hr	0%	0%	0%	0%	17%	33%	**8%**
Time spent under medical care in receiving facility before discharge or death	<30min	0%	0%	0%	0%	0%	0%	**0%**
	30 min -1hr	0%	17%	0%	0%	17%	0%	**6%**
	>1 hr	100%	83%	100%	100%	83%	100%	**94%**

Source: Evaluation survey data.

The project had set a target of 80% satisfaction level of Dharura Fasta (DF) and iCHF. According to project monitoring data, this target was attained at exactly 80%. Primary data from the evaluation support this monitoring data as it records 91% satisfaction level for Dharura Fasta and 74% for iCHF (Table 5).

Table 5: Percentage of iCHF and DF members reporting their satisfaction levels

Satisfaction Rating	Intervention	% by District						
		Busokelo	Rungwe	Mbeya DC	Momba	Mbozi	Ileje	% Total
		(n=12)	(n=12)	(n=12)	(n=12)	(n=12)	(n=12)	(n=72)
Extremely satisfied	Dharura Fasta	89%	90%	92%	88%	89%	95%	91%
	iCHF	67%	72%	66%	80%	81%	75%	74%
Very Satisfied	Dharura Fasta	11%	8%	6%	10%	9%	4%	8%
	iCHF	15%	20%	24%	10%	8%	10%	15%
Moderately Satisfied	Dharura Fasta	0%	2%	2%	2%	2%	1%	1%
	iCHF	13%	2%	8%	2%	7%	13%	8%
Not Satisfied	Dharura Fasta	0%	0%	0%	0%	0%	0%	0%
	iCHF	5%	6%	2%	0%	4%	2%	3%

On the other hand, some of the challenges reported in the previous evaluation were still prevailing during this evaluation. While HIMSO's support to make the iCHF scheme functional are paramount and obvious, the national guidelines for managing iCHF which do not allow much flexibility and adaptability by the district councils were observed to still impair the expected outcome from HIMSO's investment. At the project level, effectiveness was marked by ensuring timely training of key players of the scheme (against government delays in granting project approval), deployment of enrollment officers, procurement of working tools and equipment (including motorcycles, ID Cards etc.), supporting the iCHF information system (IMIS) and regular supportive supervision. HIMSO was highly appreciated in its role of providing coordination and supervision of enrolment officers in collaboration with the District iCHF Coordinator. HIMSO has also encouraged and promoted transparency on running of the iCHF activities including displaying and communicating back to communities' monthly collection and display that in public notes boards. However, as explained earlier, iCHF is challenged by a lot of rumors of its future survival amid establishment of the Universal Health Insurance Scheme hence creating hesitance of new members to join, making the resource based from collection of premium minimal and as a result little contribution to improving quality of care.

b) Improved referral systems in the implementation districts:

HIMSO's routine data indicate that, a total of 2117 referrals were made in the period of project implementation (Table 6). With a total of 57,232 active members of Dharura Fasta across the two regions, the referral beneficiaries constitute 4% of all members. This proportion is very encouraging as it ensures sustainability of the micro-financing strategy where the expenditure is very minimal but with very high client satisfaction.

Table 6: Number of referrals by district supported by Dharura Fasta

District	Mbeya DC	Rungwe	Mbarali	Chunya	Busokelo	Mbozi	Songwe DC	Ileje	Tunduma	Momba
Number of Referrals	735	304	125	225	279	146	26	212	51	14

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2.0 Achievements through Advocacy, Lobbying and Networking Initiatives

Although networking and advocacy had remained to be permanent agenda for HIMSO advocating for Dharura Fasta and iCHF, more efforts were directed at making this activity more scientific, targeting and fruitful. This was possible through:

- **Development of an internal advocacy strategy with support from CSS-interFINi:** With extensive experience and resourceful support from interFINi, HIMSO was able to develop its advocacy strategy which was used to guide all networking, lobbying and advocacy activities.
- **More frequent engagement with decision makers of regional and district authorities:** Based on the experience gained through capacity building from interFINi , the project staff were more aggressive and made more frequent interactions with Government officials at the two levels resulting to quick and easy buy-in of ideas and joint planning. This was further strengthened by conducting annual project progressive meetings at regional level as well as by conducting bi-annual stakeholders progressive meeting at council level
- **Increased frequency of participating in strategic networking forums.** This included participating in two national level networking forums at regional and district networking forums.

Among the achievements brought by these efforts include **increased visibility** of the project across all key stakeholders. Findings from KII with community leaders and CHW revealed that, there is an **increased understanding of the concept of Dharura Fasta** among community members to the extent that CHWs are registering new members who are coming to them than going out to households to sensitize and convince new members to join the micro-insurance. Some of the District health managers indicated that the multiple project initiatives have also contributed to **increased project acceptability**, Similarly, the co-management of the two interventions by CHuAs (innovated by HIMSO) have **increased project ownership** both by the CHuAs and by the District Health authorities. For example, in Momba District, CHuA leaders have become coopted member of the Council Health Management Team (CHMT) implying a high recognition and integration of CHuA functions in district health system. In other districts, the iCHF district coordinators work closely with CHuA leader and on daily basis.

3.0 Effectiveness of HIMSO in Managing and Implementing the Project

HIMSO learned from the past and acknowledged their functional gaps. The project included in its plans broad perspectives of strengthening both the institutional capability and staff capacity both within HIMSO and other institutions with roles to support the project. Efforts for this included:

- **Upgrading Management Information System (MIS) for co-managing Dharura Fasta and ICHF**: The institution, through the project revisited its Monitoring, Evaluation, Administration and Leaning (MEAL) system in order to ensure integration of information emanating from different dimensions of the project. The upgraded MIS helped the institution to facilitate co-management of Dharura Fasta and iCHF, not only at HIMSO but also with CHuA offices.
- **Orientation on the proper utilization of upgraded MIS to HIMSO and CHuA**: The project did not end at upgrading the system alone but also oriented all key stakeholders and users of the system on how to use and benefit from its use.
- **Scheduled reflective meetings at organization level (involving** HIMSO Staff, CHuA teams and Board members in reviewing institutional and project plans, finding collective solutions to identified implementation challenges etc.)
- **Keen attitude of documentation of best practices and lesson learnt on DF and iCHF** and use of the lessons immediately and timely during the project implementation rather than extracting such lessons at the end of the project trough standard evaluations:
- **Enhancing HIMSO staff with relevant skill development package:** The project conducted training need assessment for HIMSO staff to identify skills gap and applied the findings to design and conduct capacity strengthening sessions for the project staff.

- **Filling in all important positions for project implementation staff at the NGO level:** The project did not experience shortage of required staff. Although some of the staff had mixed roles, they were able to complement each other to carry out project activities effectively.

More output based results that support a strong project effectiveness are include in Table 2 above.

3.3.4 Project contributed to the health financing strategy in Tanzania

This phase of the project was implemented at the heart of national discussion and consultation regarding a shift from the voluntary public health insurance scheme to the obligatory universal health insurance within the context of UHC. The project under evaluation was among the few practical projects that informed the processes regarding how the new health financing strategy through the universal health insurance could be implemented. According to the project reports, HIMSO participated in six national level networking forums where the project conducted lobbying and advocacy of the project experience. In these engagements, HIMSO shared the project experience which together with experiences and models from other organizations, lead the Government to have the following clauses in the new Health Financing Strategies:

Pillar 3: Pooling of Funds

- The Government is committed to create one **National Financial and Risk Pool f**or Health in order to improve financial and risk pooling mechanisms within the health sector. This will imply merging, over time, existing finance pools such as NHIF, NSSF-SHIB, iCHF, GoT subsidies for the poor, general revenue budget, parallel funding flows and other funds into the NHIF pool, in order to purchase a standard Minimum Benefit Package for the whole population.
- The government guarantees Health Insurance **Coverage for the Poor and Vulnerable,** through ensuring effective identification and inclusion mechanisms based on experience as shared by various implementing partners, in order to create a health financing system which is responsive to the needs of the poor and vulnerable, and which leaves no person behind.

Pillar 4: Health Care Purchasing

- The Government will establish a Standard Minimum Benefit Package as legal entitlement to the whole population. This package would evolve over time as available funding increases, and the health system is strengthened.

As a national strategy, there was no a direct acknowledgement of the project in these Government commitments but HIMSO, through this project was part of the processes resulting to such resolutions. There was more contribution to the new financing strategy through iCHF experience than Dharura Fasta. The informal communication between the evaluators and national level officials revealed that, the Government would prefer to consider the Dharura Fasta model later on after the first few years of implementing the Universal Health Insurance and solve the operational huddle before adapting and scaling up of Dharura Fasta. However, the Government indicated no objections for regions and district councils that would prefer to adept and customize the model into their regions and districts.

3.3.5 Overall Factors Contributing to Project Effectiveness

This evaluation found similar factors with what was found in the previous evaluation regarding factors that facilitated the project effectiveness. These include:

- **Project set up**: The project design during this phase has a lot of improvements with several innovations adapted as a result of lessons learned from previous phases. The Co-management of iCHF and Dharura Fasta has been instrumental to improving the effectiveness of the project.
- **HIMSO Staff and Management capacity to support CHuA, Districts and Regions**: A huge investment has been employed to strengthen the capacity of HIMSO's management and project staff to enable them to have sufficient capacity to oversee the project in all dimensions (designing, planning, implementation, monitoring and networking) while influencing Government commitment through Regional and District level authorities.
- **Sustained Resource Mobilization Efforts**: In the whole of the implementation period, HIMSO's management never rested in pursuit of resources. HIMSO had been on watch for funding opportunities particularly through partnership hence receiving in kind support (through training, demand creation etc.) and optimize the use of the available resources.

- **Staff Motivation**: HIMSO staff are highly motivated. This evaluation found that their motivated is not linked to financial incentives but rather the project outcomes and impact across the levels of the health system they support.
- **Good working relationships and team work among Staff**: HIMSO staff have maintained and sustained a team work spirit, little observation of job description between the project staff where everyone is able to support everyone else.
- **Management and leadership**: HIMSO Board of trustees is further strengthened through training and accumulated experience. Most of the Board members have remained the same for several years which is helpful to ensures existence of institutional memories, continuity of the agenda and focused direction.

3.3.6 Implementation challenges

- **iCHF vs Dharura Fasta information system challenge**: The investment in co-management of iCHF and Dharura Fasta is challenged with lack of interoperability between the Dharura Fasta Information System (MIS) and that for iCHF (IMIS). Despite several efforts, HIMSO haven't been able to synchronize the two systems since the Government (at national level) hasn't taken equal efforts to initiate the synchronization.
- **Failure to translate reimbursable funds to health facilities into improved health services**: This challenge was found during the previous evaluation and was still found during this evaluation. The evaluation noted that despite having facility accounts fully operational, few health facilities were getting their reimbursement from serving iCHF members on time. Extreme delays were reported and hence these facilities were made incapable to fill in the gap of medical supplies as was intended using the iCHF revenues.
- As a result of delays in reimbursement which in turn failed health facilities to fill in gaps on medical supplies and medicines, **community members perceived iCHF being not helpful to them** as they failed to get the desired services (quality health care).
- A notable stagnant (and in some communities a deceleration) state of households enrolling in iCHF. Several factors are linked to this situation including:
    - The Government announcement of introducing the Universal Health Insurance which implies merging of iCHF with other schemes into one health insurance scheme hence making the fate of iCHF unclear and uncertain
    - Perceived poor quality of health service in health facilities hence unmet client expectations
- **Limited ability of village government to make agreed village contribution**s that would be used to pay for village premium on Dharura Fasta leading to limited access of healthcare services by pregnant women, infants and children under five due to lack of transport during their medical emergencies.

General Section Reflections

- This project is very effective. With more than 9 months remaining, the project effectiveness was earmarked by increased project visibility, acceptability, increased utilization of Dharura Fasta services while maintain a balance of minimal spending of the collections as well as increased ownership of the project especially via co-management of iCHF and Dharura Fasta by CHuAs.
- The project goal, objectives and activities were sufficiently achieved and accomplished. Except for few indicators, targets for most of the project indicators at output and outcome level were met implying success in achieving project objectives.
- Factors contributing to the project effectiveness include the project design (such as the co-management of iCHF and Dharura Fasta), staff capacity and commitment, political support from regional and district authorities, project efforts in implementing participatory processes and activities that included all key stakeholders hence increasing project visibility, acceptability, awareness of micro-insurance concept and ultimately improved service delivery.
- The accumulated project experience and lessons learned through various project phases enabled the advocacy and lobbying activities during the current project phase to have more effect across all levels of the health system. The advocacy and lobbying efforts lead to the project contribution in the national health financing strategy as in the context of UHC.
- HIMSO's team capacities remains to be an asset at regional and district level health system in Songwe and Mbeya regions. The team's participation at national level engagements also adds value to the project usefulness making the team, the project and the interventions effective and suitable for offering financial and technical support to Regional and Districts iCHF teams, and CHuA Offices and contributing to national dialogues.
- Generally, there were more successes than challenges or hindrances. Most of the recorded challenges were beyond the project ability and capacity.
- The project under evaluation has remarkably been innovated in project design contributing to its high effectiveness.
- Despite the fact that most of the iCHF planned activities were implemented as planned (contributing to high project

effectiveness), there are still systematic challenges facing the intervention

- At project level, interoperability of the two information systems (MIS for Dharura Fasta and IMIS for iCHF) are not talking to each other yet. This challenge requires a lot of lobbying and advocacy.
- While the project was successful in creating its visibility via community gathering, social marketing, social media, mass media and website, HIMSO lacked capacity in scientific writing and publication in peer review journals. A recommendation is provided as part of this report to address this incapacity, possibly within the remaining period of time before a complete project closure.

3.4 Efficiency

3.4.1 Financial efficiency

The project was able to accomplish almost 93% of all the deliberated outputs as per described activities on Tables 2 above. Within this period, the project spent 68% to accomplish 93% of the planned activities. The project still has about 32% of the total financial resources to accomplish the remaining project activities (Table 7). The evaluation noted the following:

- The project spending adhered to the agreed budget and with little flexibility over years observing compliance when measured as totals.
- Each budget line was kept as planned and there was no need of funds from one budget line be moved to another.
- Personnel and administration budgets were the least spent budget lines. However, quick calculations of the spending plan in the remaining period of the project before its closure offers a precise picture of this status and that all funds will be exhausted by then.
- None of the miscellaneous (reserve) funds were spent. This is a positive attribute showing both financial reputation of the organization as well as readiness of the project at the remaining period of time to mitigate any unexpected need for additional funds.

This evaluation was unable to measure any variance because all budget lines were within the spending limits and none of the budgeted activities spent more than planned.

Table 7: HIMSO financial efficiency for Co-Managed iCHF and Dharura Fasta Projects

Expenditure items		Budget	Expenditure	Balance	Balance in %
1.0	Project activities	1,180,400,000	938,442,007	241,957,993.21	20%
2.0	Personnel	644,800,000	414,374,823	230,425,176.93	36%
3.0	Administration	469,300,000	216,569,047	252,730,953.46	54%
4.0	Procurement	55,380,000	47,270,000	8,110,000.00	15%
5.0	Evaluations	100,100,000	92,416,500	7,683,500.00	8%
6.0	Reserve	46,020,000	0	46,020,000.00	100%
Total		**2,496,000,000**	**1,709,072,376**	**786,927,623.60**	**32%**

3.4.2 Technical efficiency

Technical efficiency is measured by looking at the timeliness of achieving project goals, objectives and outputs. To this, the **project attained most of the planned activities ahead of the projected timelines and or milestones** making the project's technical efficiency very high.

The evaluation team believes that, HIMSO's good technical efficiency is due to its strong **check and balance mechanisms** built on its newly developed MEAL system which not only improves real-time tracking of project activities and expenditure but also accountability. At the time of conducting this evaluation, the MEAL system was fully operational. HIMSO Board, project management and staff had all received training and orientation on how to utilize the Management Information System (MIS). This makes the HIMSO community upload data and generate reports easily. HIMSO has a long term memorandum of understanding with Bridging Technologies, a company which developed and support managing the MEAL platform. In addition, HIMSO has a strong and effective Board with members whose

experience in health systems, health financing and management is paramount. The management and staff reported to receive **sufficient support from HIMSO Board** including technical directives and resource mobilization on behalf of HIMSO.

3.5 Impact

Impact is a long term outcome of the project. In its design, the Monitoring and Evaluation Matrix did not indicate which indicators would be used to measure impact. In responding to the evaluation questions under impact sub-component, the evaluation team opted to use some of indicators included in the previous phase of the project implementation. Using various sources of data (including HMIS, HIMSO routine database, household survey and KII with various project stakeholders), the impact level evaluation questions intended to assess the extent to which the project contributed to improved healthcare accessibility and service utilization. To this, the evaluation found that, Mbeya and Songwe regions are generally recording improved performance in several nationally defined indicators including improved Antenatal care (ANC) attendance, improved facility delivery improved access of basic quality care (Table 10). All proxy indicators used, Mbeya and Songwe regions were either better or equal to the national score. More interestingly is the percentage of people who were unable to access healthcare and services where percentages from Mbeya (17%) and from Songwe (22%) were far less than of many other regions in the country as well as that of the national level (Table 8).

Table 8: Proxy indicators for Dharura Fasta and iCHF in Mbeya and Songwe regions

Impact Indicator	Regions		
	Mbeya	Songwe	National
ANC Attendance	91%	99%	90%
Facility Delivery	81%	86%	81%
Difficulty in accessing health care due to Distance	26%	39%	29%
Difficulty in accessing health care due to lack of money to pay for healtcare	17%	22%	36%
Difficulty in accessing health care due to any other problem	34%	40%	50%

Source: Tanzania DHS report, 2022.

While the evaluation understands that, HIMSO cannot claim credit for the reported performance above, KII with regional and District health managers also inferred to HIMSO project contribution especially through **RHMT and CHMT capacity building**, effective **Dharura Fasta intervention which ensures geographical accessibility** to health facilities during medical emergencies and slightly **improving iCHF membership base which also improves financial accessibility** to health services in the two regions.

Using the household survey data, the project impact could also be expressed in terms of accessibility of emergency transport. The household survey data showed that 35% of Dharura Fasta members interviewed at household level reported to have once used the service. This is by far higher than what was found using HIMSO routine data but can be explained by the small sample size of Dharura Fasta members used for the evaluation. This percentage still indicates a good project effectiveness by making use of the funds from the micro-insurance intervention minimal. Also, the findings reflect ease of access of the emergency transport for referrals. These are referrals cases in which either public or Dharura Fasta organized means of transport were also used to transfer patients from one point to another. Similarly, these findings show that health centers are managing sufficient referral cases from dispensaries and reduce unnecessary referrals to district hospitals implying good quality of care at that level (Table 9).

Table 9: Reported referrals by district and by level of care

Category	Level	Item	Mbeya Region				Songwe Region			
			Busokelo	Rungwe	Mbeya Dc	Total	Momba	Mbozi	Ileje	Total
By level of Care	Home to Dispensary/ HC	Total referrals	4	5	2	11	6	2	6	14
		By Public Transport	0	0	0	0	0	1	0	1
		By DharuraFasta	4	5	2	11	6	1	6	13
	Dispensary/HC to District Hospital	Total referrals	2	0	0	2	0	1	2	3
		By Public Transport	2	0	0	2	0	1	0	1
		By DharuraFasta	0	0	0	0	0	0	2	2
	District Hosp to Regional Hosp	Total referrals	0	0	0	0	0	0	0	0
		By Public Transport	0	0	0	0	0	0	0	0

		By DharuraFasta	0	0	0	0	0	0	0	0

Through Dharura Fasta, the primary target beneficiaries are pregnant women and children and especially so during medical emergencies. Data from the household survey conducted as part of this evaluation revealed that, most of the reported referrals (60%, n=15) involved clients in the age range of 15 to 45 years old of which majority were women and under-five children (Table 10). Infants constituted 24% while under-five children constituted 16% of all referrals among the sampled evaluation participants. Although the sample size is too small to draw conclusion, these findings (which were used to validate project routine data) are in line with what could be found from the large project routine data set.

Table 10: Total referrals by district and by age category of patients

Item	Mbeya Region				Songwe Region			
	Busokelo	Rungwe	Mbeya Dc	Total	Momba	Mbozi	Ileje	Total
Infant	0	3	0	3	1	1	1	3
< 5	0	0	0	0	2	0	2	4
5 to 9	0	0	0	0	0	0	0	0
10 to 14	0	0	0	0	0	0	0	0
15 to 45	4	2	2	8	3	1	3	7
> 45	0	0	0	0	0	0	0	0

All of the 15 referral cases that involved Dharura Fasta members aged 15 to 45 were found to be pregnancy related. Different types of medical reasons were associated with these referrals (Table 11). Having 60% of all referrals attributable to pregnancy related reasons makes the project rationale being relevant and hence contributing to the desired impact of reducing pregnancy related morbidity and mortality.

According to the DHIS-2 data, the 10 districts that implement Dharura Fasta in Mbeya and Songwe regions recorded a total of 6012. With 2117 (35%) of all the referrals supported by means of transport under Dharura Fasta makes the Dharura Fasta an impactful intervention. If the pattern of having about 60% of such referrals related to pregnancy related complications, the contribution to reducing maternal morbidity and maternal deaths as well as saving the lives of the newborn is presumably high.

Table 11: Nature/type of Emergency by district

Type of emergency	Mbeya Region				Songwe Region			
	Busokelo	Rungwe	Mbeya Dc	Total	Momba	Mbozi	Ileje	Total
Pregnancy related	4	2	2	8	3	1	3	7
Dog bite	0	0	0	0	0	0	0	0
Burn	0	0	0	0	0	0	0	0
Malaria	0	1	0	1	0	0	3	5
Accident	0	0	0	0	0	0	0	0
Hypertension	0	0	0	0	0	0	0	0
Premature baby	0	2	0	2	1	1	0	2
Other	0	0	0	0	0	0	0	0

3.5.1 Project contribution towards achieving universal health care goals from stakeholders' perceptions

The second evaluation question under impact intended to assess the project contribution towards achieving universal health coverage from the perspectives of regional, district, health facility and community levels. The evaluation found that, at community level iCHF as one of the national health financing strategy towards a universal health coverage is still facing systemic challenges that affect users' perceptions. Most of the iCHF challenges are beyond the control of the project under HIMSO. The laypersons' perception of quality of care is tied to three types of factors namely able to receive consultation (regardless of the level of qualification of the service provider conducting the consultation), able to receive medical examinations and tests and able to receive medicines. If one or all of these are unreliably not available, service users perceive the services to be of poor quality. It is unfortunate that majority of iCHF members interviewed during the course of this

> " The Government is not keeping its word after collecting our money on the name of iCHF membership" [iCHF Member, Mbozi].

evaluation resented on stock out of medicines and shortage of staff in health facilities. This in turn tarnish a bad image on iCHF as a pre-paid scheme where users feel to be cheated.

On the contrary, Dharura Fasta is positively perceived especially after the expansion of benefits and products associated with the scheme to include transporting dead bodies from health facilities to home. Eight out of every 10 members of Dharura Fasta find the intervention a good pro-poor strategy which fits quite well with the concept and notion of UHC. This leads to their high level of satisfaction of the scheme.

> *"a*t first, when I was told that by just contributing 1000 shillings each month I will qualify to become a member of Dharura Fasta and benefit from it, such as assisted with transport during a medical emergency, I thought it was just a joke. I did not believe that, a place where one would need to pay as much as 150,000 shillings, I could use my annual subscription to receive the service". [Female member of Dharura Fasta, Ileje].

According to some of the health managers at regional and council level indicated that, implementation of UHC require a lot of preparations especially in capacitating the key implementers and laying down the required systems and infrastructure such as financial health information system, accountability tools and reporting platforms. At district level, evaluation participants acknowledged HIMSO's technical and financial support which helped to strengthen and promote functionality of iCHF and Dharura Fasta which are exemplary to UHC strategies. Acknowledgement of capacity building training, support to conduct supportive supervision, material support such as motorcycles and bicycles for iCHF, CHuA and Enrollment officers was also reported. The mass campaigns that were jointly conducted with District councils and lead by HIMSO were frequently cited as among the most successful interventions to promote awareness of iCHF and Dharura Fasta.

The innovative formation and use of CHuA, use of community based groups, aligning interventions and activities for promoting iCHF in the regions within the existing infrastructure and routine systems, as well as using Council human resources whenever possible and making local governments take lead in running the project were among the factors pointed out to contribute to project effectiveness. District iCHF Coordinators were of the opinion that their districts were performing slightly better than most of other districts in the country.

On the other hand, some of the evaluation participants pointed out to some perceived dimensions of ineffectiveness.

- At least half of community leaders and almost all members of iCHF and Dharura Fasta would prefer to increase financial transparency on the Dharura Fasta and iCHF accounts where HIMSO and or CHuA could be issuing out financial reports showing collections and expenditure at least twice a year as public notice.
- About forty household members (56%) of respondents interviewed at household level were not happy with the unmatched pace between being taken from home (through Dharura Fasta service package) but delayed in receiving care on arrival in health facilities (delay to see the doctor and long waiting times for medical examinations and dispensing
- Lack of alert mechanisms to remind iCHF members when their membership is about to expire. Some of them find out that their membership has expired when they are at the service delivery point accessing healthcare.

3.5.2 Project Impact on Health Financing Policy

The third evaluation question under the impact sub-component intended to assess and measure the extent to which the project has contributed and impacted on policy processes as far as health financing strategies are concerning. At policy level, project efforts to influence policy were concerted in the advocacy, lobbying and networking to which the project was well engaged. The achievement of the advocacy and lobbying for influencing health financing policy in the context of UHC was also explained under the Project Effectiveness section sub-section 3.3.4.

3.6 Sustainability

3.6.1 Sustainability strategies

One of the strongest sustainability strategy for this project is the decision to use the composite of the innovative co-management of Dharura Fasta and iCHF as its unique brand and identity of continuous core business of HIMSO. This decision has each phase of the project to have a better design and a more effective implementation strategy than the

previous phase while expanding its scope and impact. Like the previous phase of the project, HIMSO has maintained four sustainability strategies that it used before but added a fifth strategy as follows:

1) **Transfer of knowledge to CHuA and iCHF players** to ensure that they can professionally manage Dharura Fasta and iCHF on their own.
2) **Continuous resource mobilization for financial sustainability of Dharura Fasta through CHuA**: HIMSO works with CHuA to ensure sustainability of Dharura Fasta.
3) **Financial sustainability for iCHF.** This was made possible by design of lobbying for 10% of all collected premium from iCHF to be allocated to administration costs (i.e. on iCHF administration costs to cover costs directly to iCHF management such as printing of member forms, IDs, claim forms etc.).
4) **Managing Dharura Fasta risks as per the insurance principles**: HIMSO manages Dharura Fasta as per the insurance principles which include proper pricing for the risks carried. Frequent pricing studies have been carried out to fulfill this requirement.
5) **Co-management of iCHF and Dharura Fasta:** This innovative strategy has helped to add value to the role of CHuA, which initially was more biased to iCHF alone, to take equal role and responsibility to support implementation an operationalization of Dharura Fasta. This is one of the strongest sustainability strategies as it ensures a gradual uptake of Dharura Fasta into public hands.

In addition, the project sustainability is further assured from the fact that:

- Health financing and resource mobilization is a government priority agenda and is still growing hence requiring innovative ideas and strategies as delivered by HIMSO
- The composite innovations offer ground for learning and improvement of the national health insurance schemes
- Dharura Fasta and the mode of operation of iCHF using CHuA is a unique model appropriate administrative and political fit in the regions of Songwe and Mbeya
- The two composite project has received high acceptability of and satisfaction by the wide spectrum of stakeholder in the two regions especially within and among primary beneficiaries.
- The innovative pricing of Dharura Fasta ensures affordability and accessibility of its insurance products hence increasing its acceptability and allowing many households to join.
- The availability of basic infrastructure and systems to support implementation of project activities such as using Government systems, CHuA offices and strong support from ward and village governments (including the village contributions) ensures local ownership and sustainability
- There is an improved capacity of CHuA Offices over years to manage Dharura Fasta and iCHF

The one main challenge towards sustainability is the fact that, as the Dharura Fasta and iCHF grow, there hasn't been a reliable means of source of funding so far to ensure sustainability beyond resources mobilized by HIMSO.

4. Conclusions and Recommendations

4.1 Conclusions

In conclusion, the evaluation findings suggest that,

- **The project is potentially on track:** According to the available data and based on this evaluation, the project has achieved most of its planned activities ahead of time. It still has about nine months to wind up any pending activities especially those related to ensuring a smooth exit and preparation of sustainability ground.
- **The project is coherent, valid and relevant**: In all dimensions, be it policy based or context and timeliness, the project was found to be coherent to the existing country and regional efforts in strengthening the health system through a strong health financing mechanism. It is also very relevant for promoting the health system in delivering sustainable and quality health services to its population by ensuring that peoples' needs and expectations are met. Social protection is key in any population especially the rural, hard to reach and vulnerable populations being addressed by the project.
- **Dharura Fasta remains to be an exceptional social protection intervention. The intervention is exceptionally acceptable by its members and** has proved beyond doubt that it is a working and delivering initiative. There is a very high level satisfaction of the innovation among the primary beneficiaries of the project.
- **The project effectiveness through iCHF still faces systemic challenges:** iCHF was found to experience a number of challenges which impaired its effectiveness. It is a known fact that collections from iCHF are not to ensure readily available quality care in health facilities. However, this knowledge does not matter to its members who expect quality care whenever they seek health care from the facilities. Stock out of medicines, provider attitude and long waiting times are some of the poor quality attribute that discourage iCHF members.
- **The project efficiency is high**: With almost 9 months before the end date of the project implementation, the available financial data suggest high efficiency in utilizing financial resources to attain and achieve the planned outputs. This happens while completion of the project activities is estimated at about 93%. The Organizational discipline in managing the project resources is highly commendable.
- **Proxy indicators suggest a significant contribution of the project impact on several national and regional indicators.** Comparatively, the two regions of Mbeya and Songwe achieved higher scores of several indicators than many other regions or national level score suggesting that the regional initiatives, including Dharura Fasta and iCHF are making a difference.
- **The embedment of Dharura Fasta and iCHF in regional and Council health systems and structures offers a promise for sustainability: Several** factors indicate chances for a high project sustainability. The project should, however, not relax but strive for additional sustainability strategies.
- **The Co-management of Dharura Fasta and iCHF uniquely offers a learning platform:** The two arms of the project have generated massive data for leaning, both locally and internationally. The project has made its best to communicate this learning but there is still room for a wider communication of the lessons learned from this project.

4.2 Recommendations

The following recommendations are made based on the evaluation findings

4.2.1 Recommendations for HIMSO

1. The project effectiveness and efficiency has been impressive. The effectiveness and efficiency has left the project with both time and resources that could be used to further prepare a better ground for project sustainability. This could be through developing the pathways to make CHuA self-sustained through working with the CHuA economic model, conducting capacity assessment for CHuA and ascertaining their different levels but also by lobbying and advocating for a total integration of CHuA in District Health System and supporting CHuA to have full control of iCHF in the same way it manages Dharura Fasta.
2. This evaluation has demonstrated that, the functioning of iCHF and Dharura Fasta has a direct effect to quality of services in health facilities. Hiccupped enrolment of iCHF members is an example of a perceived negative effect of members' expectations not being met. HIMSO's strengthened efforts to support and advocate the integration of CHuAs in district health system and hence provide CHuAs with full control in managing iCHF may be used to improve effectiveness and efficiency of iCHF and ultimately improve quality of services.
3. Some facilities still report delays in receiving reimbursements from iCHF management after having served iCHF members. The evaluation recommends an active engagement of regional authorities, possibly involving RASs to assess and determine the root causes of the delays and collectively draw interventions to solve the problem.
4. In order to bring about linkage between the grassroots and the national level in the context of UHI, HIMSO should consider community-based feedback mechanisms building lobbying and advocacy capacity of CHuAs and involve them when HIMSO is engaging the national level during advocacy and lobbying activities.
5. The evaluation found that, a total of 78 periodic reports were prepared and shared with the regional and Council authorities. This is massive efforts. However, this level of efforts was not equally implemented in producing scientific writing and publication. The evaluation team suggest to use some of the reserve resources to organize capacity building activity for this area. In addition, HIMSO staff should allocate time during the remaining project period to conduct a retreat for publication with the aim of producing at least three publications using the rich project data.
6. As part of the investment in building the capacity of HIMSO staff in scientific writing and publication, the project should in future consider inclusion of a specific budget line and activity plans for dissemination of project results that shall incorporate budget for retreat to develop manuscripts for publications. Based on experience, publications are hard to be in office settings.
7. In the remaining period of the project implementation, strive to conduct a stronger lobbying activity for synchronization and interoperability of Dharura Fasta Web-based Portal and IMIS. Formulate a team comprising of political leaders such as Regional Administrative Secretaries and District Executive Directors to build an agenda and be the project spokespersons during lobbying interactions with the national level decision makers.
8. Sustain your current network of partners and expand. Plan to enter partnership with partners stronger than yourself so as to harness what you don't have. In order to do this in a better way, development your criteria for who to partner with and conduct a small assessment to develop an inventory of potential partners both locally and internationally.
9. Strengthen research component. Consider of having a research scientist on board beyond the M&E Officer. This will increase your ability to develop research agenda as part of your project implementation plan and hence improve the weight of your project evidence based communication.
10. HIMSO should improve its feedback mechanisms to the community to unravel some of the described challenges such as dissatisfaction on iCHF. Use of strategic feedback approaches such as "socializing evidence for participatory action – SEPA" ((https://www.ciet.org/wp-content/blogs.dir/20/files/2019/10/Poster-SEPA.pdf) can help to provide both simplified ways of providing feedback but also developing participatory solutions to the challenges.
11. HIMSO has continued to implement its project with short term grants of not more than three years. In future, plan to sustain and implement the co-management of Dharura Fasta and iCHF in at least five-year project period. This is important to influence community behaviours while producing stronger evidence to support policy influence especially in the forthcoming period of implementing the Universal Health Insurance.

4.2.2 Recommendations to Donors and Collaborating Funding Agencies

1. Support the culture change within HIMSO in relation to project results dissemination especially in the international forum. Consider providing HIMSO management and selected project staff fellowship linked to an internship with strong publication history abroad or within your own Foundation.
2. The forthcoming period of launching the Universal Health Insurance is a revolutionary period where the Government is trying something that isn't sure of its efficiency and effectiveness. Consider supporting HIMSO to use its infrastructure in Mbeya and Songwe to pilot the Universal Health Insurance using the available Dharura Fasta and iCHF schematic platform to make the area a learning hub for the Government.

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Appendices

Appendix 1: Coverage of Evaluation Participants

Evaluation Participants	Songwe			Total	Mbeya			Total	Grand
	Mbozi	Momba	Ileje	Songwe	Mbeya DC	Busokelo	Rungwe	Mbeya	Total
RAS	0	na	na	0	0	na	na	0	0
RMO	1	na	na	1	0	na	na	0	1
RRCHCO	1	na	na	1	1	na	na	1	2
Regional ICT Officer	0	na	na	0	0	na	na	0	0
Regional Social Development Officer	1	na	na	1	1	na	na	1	2
HIMSO Staff and Management	8	na	na	8	0	na	na	0	8
DMO	1	1	1	3	1	1	1	3	6
DRCHCO	1	1	1	3	1	1	0	2	5
iCHF Coordinator	1	1	1	3	1	1	1	3	6
District ICT Officer	0	1	1	2	0	1	0	1	3
District Social Development Officer	0	0	1	1	1	1	1	3	4
CHuA	1	1	1	3	1	1	1	3	6
HIMSO Coordinator	1	1	1	3	1	1	1	3	6
Facility Incharge	1	1	1	3	1	1	1	3	6
Members/Beneficiaries (ICHF)	6	6	6	18	6	6	6	18	36
Members/Beneficiaries (ETS)	6	6	6	18	6	6	6	18	36
CHW	1	1	2	4	2	2	2	6	10
Transport Agent ETS	1	1	1	3	1	1	1	3	6
VEO	1	1	1	3	1	2	2	5	8
WEO	0	1	2	3	1	2	1	4	7
Health Provider (Impact Assess-ment)	1	1	1	3	1	1	1	3	6
Village chairperson	1	1	2	4	2	1	2	5	9
	23	25	29	88	29	29	27	85	173

Appendix 2: Evaluation Matrix

Question/Theme	Sub-Questions	Data Collection Method	Data Source	Baseline (if Applicable)
Relevance of the project	1. To what extent are the project interventions (Dharura Fasta and iCHF) aligned with the needs of the people in regards to access to better essential health services as well as HIMSO's Mission?	Document Review Interviews	Project Documents Primary Data	
	2. To what extent are the project activities and outputs consistent with the intended goal, objectives, and indicators outcome and impacts?	Document review	Project Activity Reports	
	3. How are the project interventions (Dharura Fasta and iCHF) aligned to the government's short and long-term plans and strategies in regards to health financing?	Document Review Interviews with Regional and District Levels	Project Proposal Primary Data	
Effectiveness of the project	1. To what extent have the project goals, objectives, and indicators been achieved or are likely to be achieved by the project's conclusion? Explain the reasons behind the achievements or lack thereof.	Secondary Data review Interviews Document Review	Routine project data Household survey Project reports	Baseline data available for some indicators
	2. To what extent has the project intervention (Dharura Fasta and iCHF) contributed to the health financing strategy in Tanzania? Provide insights into what could have been done differently for better results.	Document Review Interviews	Project reports/publications Primary data	
	3. Are HIMSO's team capacities effective and suitable for offering financial and technical support to Regional and Districts iCHF teams, and CHuA Offices?	Interviews with HIMSO staff Interviews with Regional and District levels	Primary data	
Efficiency	1. To what extent were the project funds utilized according to the agreed budget?	Document review	Project accounting reports	Original Project Budget Available
	2. How did collaborations with iCHF managers at regional and district levels contribute to project efficiency?	Interviews with RHMT&CHMT	Primary data	
Impact	1. How effectively have the implemented strategies (Dharura Fasta and iCHF) contributed to achieving healthcare accessibility and service utilization?	Interviews Household survey Document review	Primary data Project reports	Utilization data available
	2. What is the discernible impact of HIMSO's advocacy efforts on influencing health financing policies at the national level?	Interviews Document review	Primary data Advocacy reports meetings	
	3. How do regional and district administrations, health providers, and beneficiaries perceive the project's effectiveness and contribution towards achieving universal health care goals?	Interviews with Regional, District and Community level participants	Primary data	
Sustainability	1. To what extent are the positive changes (see kind of change identified under impact) of the project likely to continue at beneficiaries' level beyond the end of the project period?	Interviews Critical analysis of collected data	Primary data Justifiable evaluation findings	
	2. How likely will the project positive changes and impact continue at national level after end of donor funding?	Interviews Critical analysis of collected data	Primary data Justifiable evaluation findings	

	3. How strong is HIMSO advocacy capacity to ensure continued policy engagement with relevant institutions at local, national, regional and international levels?	Interviews Critical analysis of collected data	Primary data Justifiable evaluation findings	
	4. To what extent is HIMSO capable of supporting beneficiaries to continue positive project changes after end of donor funding?	Interviews Critical analysis of collected data	Primary data Justifiable evaluation findings	
	5. Is there any structures /systems / processes and capacities at HIMSO (organizational set up and implementation processes) to assure sustainability? Is there need for improvement (details required) to continue – with or without external funding?	Interviews Critical analysis of collected data	Primary data Justifiable evaluation findings	
Coherence of the project	1. How well does the intervention fit in the overall internal and external context of HIMSO?	Interviews Critical analysis of collected data	Primary data Justifiable evaluation findings	
	2. To what extent is there synergy and linkages between the project and other HIMSO projects and programs?	Interviews Critical analysis of collected data	Primary data Justifiable evaluation findings	
	3. To what extent is there synergy and linkage between the project and national priorities?	Interviews Critical analysis of collected data	Primary data Justifiable evaluation findings	
	4. Was there complementarity, harmonization, and coordination with others, and to what extent did the project interventions add value to other ongoing processes while avoiding duplication of effort.	Interviews Critical analysis of collected data	Primary data Justifiable evaluation findings	

Appendix 3: Detailed methodological description and Time frame

1. Evaluation approach

1.1 Guiding framework

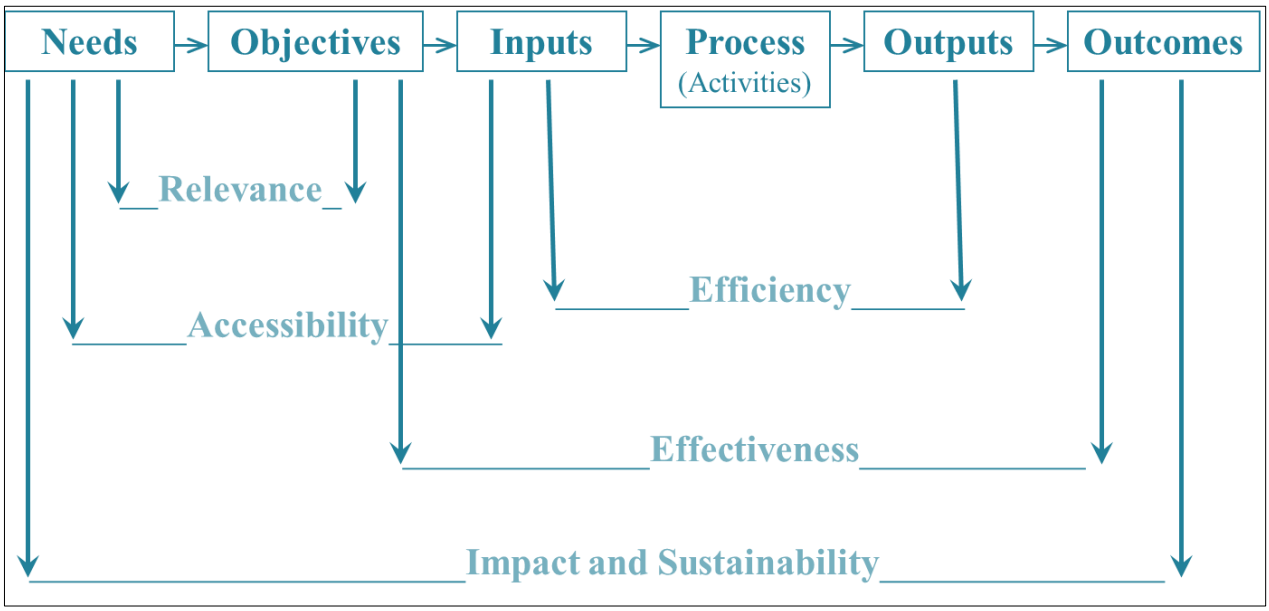
Based on our understanding of the TOR and the needs of the client, the Consultant proposes to use a combination of two frameworks to guide the evaluation from which specific evaluation methods will be drawn. These include

3. Process Evaluation Framework
   This will be used to assesses whether the program is being implemented as originally intended, what services are being delivered, who is receiving those services, and perceptions of the program among stakeholders and implementers.

4. Performance Monitoring Framework
   This will be used to assesses baseline metrics compared to other data points at the time of evaluation since commencement of implementation of the strategy on a continuous basis throughout program implementation.

The two frameworks are combined into our proposed guiding framework

The two frameworks are combined into a composite framework blow that will be used to guide the evaluation activity. This framework offers reflections on all important components of a standard evaluation process while maintaining specificity of a particular program or project. It concurs with the main objective of this assignment.



This framework will guide the evaluation whereas, evaluation will consider the original ideas and rationale of setting up the project (**Needs**) and how such needs were translated into specific project focus and activities (**objectives**). The assessment of original concept and the set up objectives will be used to measure **relevance** of the project. The evaluation will further explore the actual inputs (**Inputs**) that were planned to be used to realize the project objectives against inputs that were made available and establish any gap. In many occasions, when comparing the intended needs of a program and the resources that were used to establish the project results one can be able to establish **accessibility** of the services or project outputs. In addition, the evaluation will also look at the activities (**Processes**) which the project implementation team applied to realize the intended project results (**Outputs**). Here, **efficiency** will be measured by looking at how best resources (inputs) were utilized to establish the recorded outputs. Similarly, **effectiveness** will also be measured by considering the way the objectives were translated to **Outcomes** which are the ultimate end results.. While our team understands that the project implementation has just been concluded and that **impact** might not be sufficiently registered, we intend to use this framework to discuss with the client

on specific impact indicators that can be traced which will help to predict **sustainability** and scalability of the project with reference to context speculation. In this regard, impact and sustainability will be measured by considering all program/project parameters namely needs, objectives, inputs, processes, outputs and outcomes

1.2 Evaluation Design

This will be a cross-sectional assessment looking at the before and after situations of the project in relation to defined objectives, goals, and targets at one hand and established input, process and outcome indicators. Mixed methods approach is hereby proposed. We intend to use both quantitative and qualitative data to provide measures of the project implementation progress. Both primary and secondary data will be used where document review particularly of the project documentation will be employed. Our evaluation team will conduct review of relevant documents pertaining to the broader environment of the project and the various programmes and projects implemented under the strategy. Key to this, the evaluation will include all relevant key programme documents emanating from and influenced by the project, including the proposals and other monitoring missions, implementation reports, project documents produced with messages, media publications as well as illustrative case studies with photographs.

Primary data will be derived from key informant interviews (KII), in-depth interviews (IDI) and structured questions/surveys. Similarly, round table discussion and consultation with the project Staff, project management and Board authorities to HIMSO will constitute part of the primary data to be collected.

2. Data Collection Methods

2.1 Methods

As described at the Design section, both primary and secondary data will be used to answer the evaluation objectives. A triangulation of methods will thus be used to collect both types of data. The following methods will be used.

2.1.1 Document Review

The evaluators will review different programme and project documents in order to establish progress of the project implementation against objectives, major challenges and how they have been overcome, deviations from objectives, new interventions if any, lessons learned and best practices to be applied for future projects. Key documents to be reviewed will include Baseline Survey Report, Economic model, mutually binding document (organization documents), Agreement of cooperation, Progress reports, audited financial accounts and any other documents deemed important at the time of conducting the evaluation.

2.1.2 In-depth interviews (IDI) and Key Informant Interviews (KII)

In-depth interviews (IDI) and KII are proposed to be used as a follow up method after document review. The intention is to fill in gaps of information, to solicit clarification and get interpretations of data and findings obtained through document review. Similarly, the two methods will help to unleash undocumented information which sometimes is a case for some implementers who assume the information to be less important or biased due to familiarity of subject or context. IDI will be conducted with service providers from facilities linked with the two interventions while KII will be specific with Government officials and leaders at regional, council and community level.

2.1.3 Surveys

The implementation of the project is best translated by the effect and impacts it leaves behind to the primary and secondary beneficiaries in regions, councils and communities in which programmes and projects implemented under the objectivity of the project are located. Communities at household level in which the project was implemented will be visited and through them measure other aspects of the project including satisfaction, willingness to pay, personal experiences on utilization of services under the two schemes and others.

2.1.4 Round Table Discussion

Round table discussion will also be employed as an additional evaluation method where the evaluation team will meet with members of HIMSO staff to discuss their experience on development and implementing the project through their various programmes of work. similarly, round table discussion will be used to complement information gathered through document review, KII and IDI and where gaps or contradictions were observed. Round table discussions are usually very important learning sessions for both the Consultant and Client.

2.1.5 Gender responsiveness examination.

Inclusive in the bold steps will be examining the project to learn the extent to which it was (is) gender responsive. The Consultants are also gender specialists and will include a gender analysis to examine how men and women, adolescent boys and girls, people with disabilities and other disadvantaged and vulnerable sub-populations were factored in the project.

2.1.6 Validation meetings

There shall be several meetings with HIMSO to ensure that a common understanding of the assignment and a comprehension of the TOR is clear for both the Client and the consultant. Prior to commencing the evaluation, the Consultant will develop an inception report that will be presented in an inception meeting with HIMSO. Similarly, before finalizing the report, the evaluation team will share the draft re[port with the client and later integrate comments and feedback received. Later on there shall be a validation meeting with client to present preliminary findings and use the session as an additional evaluation method to polish, validate and consolidate the evaluation findings.

2.2 Sampling

For the qualitative part, a multi-stage sampling strategy will be employed whereby at the first stage, a purposeful sampling will be used to identify types of respondents to be interviewed and areas and or departments, units and partners where these respondents will be drawn. Where there are several persons who qualify for the IDI, a random sampling approach will be used based on "who is readily available" to participate in the interviews.

A complete random sampling will be employed for the quantitative part. A complete description of sampling approach and sample size calculations will be provided during the inception phase. The Consulting team proposes to conduct the evaluation using a representative sample of at least half of the implementing districts (rather than involving all 10 participating districts) in order to reduce the cost of the evaluation.

2.3 Evaluation sites

All 10 districts that HIMSO is implementing its micro-health insurance product for emergency transport services (Dharura Fasta) and co-managing the improved Community Health Fund (iCHF) namely Mbarali, Mbeya, Busokelo, Chunya and Rungwe) in Mbeya and Momba, Songwe, Mbozi, Tunduma and Ileje in Songwe Region will constitute a sampling frame. The consulting team proposes to include at least three districts from each region in efforts to minimize cost of the evaluation. A complete selection approach will be provided during the inception phase.

2.4 Evaluation Participants

Appendix 2 provide a suggestive list of potential candidates/persons/institutions that will be interviewed or consulted during the course of the evaluation.

2.5 Quality Assurance

We place high priority on the quality of our output, and thus, quality assurance is an integral part of this assignment. Quality will be assured through four basic exertions. First, the high profile interviews for the evaluation will be conducted by the three Consultants themselves.

Second, we propose to establish a technical team constituting members of the HIMSO that will act as a steering committee, supporting the direction of the evaluation. Apart from participating in the IDI, the steering committee will also engage in the following roles:

- Advise on approaches or methods to be taken and interviewees
- Review the final report
- Lead the planning of incorporation of recommendations to ensure gaps are addressed by the final evaluation of the strategic period.

Third, effective recruitment, training of supervisors and research assistants will be conducted. Post training assessment will be conducted to ensure detailed understanding of objectives, process, and output requirements for consistency and completeness.

Fourth, close supervision of fieldwork by the consultants and field supervisors will ensure that interviewers collect data coherently and in a manner that maintain data integrity and completeness. Each data set completed by interviewers must be checked and approved by supervisors on a daily basis. Similarly, supervision will be embedded throughout the data entry, cleaning, and validation process.

Continuous monitoring through telephone communication between field supervisors and senior researchers will ensure that obstacles are quickly resolved and fieldwork progresses within the expected time frame. The Led consultant, supported by Assistant Consultant will ensure a well written report captures at technical finding and presents in summarized but very informative manner

3. Ethical Considerations

3.1 Ethical Approval

It is assumed that this is an internal organization activity involving people with roles and responsibilities to implement project activities. As thus, approval will only be sought from the office of RAS.

3.2 Informed consent

However, although no formal ethical approval will be sought, at the point of data collection, all interviewees will be asked for their verbal consent. An information sheet about the evaluation will be drawn up in Swahili and English, explaining why it is being carried out, by whom, and what it will involve. Respondents will then be asked if they have any questions and whether they agree to take part in the evaluation. Only those who will consent will be interviewed. Confidentiality of all evaluation participants will be assured.

4. Personnel and Validity of the Inception Report

4.1 Personnel

We have assembled a highly experienced team to meet the requirements of the assignment. The team brings together experts who have core competencies in project implementation, project management, evaluation designs, statistical data processing and analysis, report writing and consultative skills. It consists of two consultants, one supervisor and six assistant evaluators (interviewers). The two consultants include;

1. **Mr. Selemani Mbuyita** who will be the Lead Consultant: Mr. Mbuyita is a public health specialist with more than 25 years of experience in program/project management. M&E Framework Design, Gap Analysis, Data Management, Analysis and Use, Formative/Baseline Evaluations, Mid Term Reviews, along with End Term Reviews both for projects and organizational strategies and is also conversant with program and project implementation and operational research. He posses strong quantitative and qualitative research methodology knowledge and skills and is charac-

terized with timely deliverance of his commitments. Mr Mbuyita is very conversant with HIMSO's scope of work and has previously worked with HIMSO through more than three similar assignments with an outstanding and quality outputs.

Mr. Mbuyita will be the Lead Consultant and the contact person in this assignment.

2. **Ms. Neema Boniface Massawe:** who is an experienced researcher and evaluator with more than 10 years of working as a consultant. Ms Neema is a Professional program management and insurance expert in life and non-life insurance with 10 years of experience in Insurance, Banking, and not-for-profit organizations managing digital projects focused on improving quality and access to healthcare, empowering women, and youth, underwriting, managing claims, and marketing. Ms. Neema will be a Co-Consultant deputing the Lead Consultant.

   The detailed Curriculum Vitae of the two Consultants are appended with this proposal.

The two consultants have identified and assembled well experienced Assistant Evaluators who have worked on similar assignments previously. They are also very conversant with the context and culture of the people of Mbeya and Songwe regions hence making them well positioned for this assignment. The table below provides a list of these assistant evaluators and the supervisors identified to support this assignment.

Table 12: List of Assistant evaluators

S#	Name	Sex	Title	Years of Experience	Contact
1	Mussa Joseph Mlingwa	M	Research Assistant & Admin	8	0718943835
2	Khalid Kiloko	M	Research Assistant	15	0717962000
3	Samwel Mnyota	M	Research Assistant	18	0787431225
4	Upendo Lugendo	F	Research Assistant	6	0654561260
5	Beatrice Shayo	F	Research Assistant	17	0743490954
6	Iddajovana Kinyonge	F	Research Assistant &Supervisor	18	0784802577
7	Raifa A. Ally	F	Research Assistant	5	0764778708
8	Irene Mashasi	F	Research Assistant & Supervisor	20	0716846439
9	Fatma Laddah	F	Research Assistant	15	0678662828
10	Mohammed Mohamed	M	Research Assistant	7	0743107600
11	Jolly Hussein	F	Research Assistant	20	0713882273
12	Tonny Joseph Kitumbo	M	Research Assistant	5	0683935494

4.2 Validity of the Inception Report

This evaluation protocol together with the proposed staff will be valid for 90 days from the day of signing the contract

4.3 Timeline

We understand that this work must take place between 25th January and 28th February 2024, covering a total of 21 professional days. Table 3 provides a work plan that will guide the execution of the assignment.

Table 13: Work plan

	Work Plan for HIMSO - End Project Evaluation												
SN	**Activity**	**Jan-24**					**Feb-24**				**Responsible**	**Deliverables**
	Week	1	2	3	4	5	1	2	3	4		
1	Signing agreement with HIMSO										HIMSO & Consultant	Signed agreement
2	Submission of Inception report (IR)										Consultant	Evaluation protocol and tools (IR)
	Presentation of the IR										Consultant	Final comments on evaluation protocol and tools
3	Finalization of final protocol and tools incldung programming in Tablets										Consultant	Finalized survey protocol and tools
4	Approval from local authrities										HIMSO	Approval and clearance from local authorities
7	Communication with study districts and logistics										HIMSO	Logistcs completed
8	Training of Assistant evaluators										Consultant	Trained Assistant evaluators
11	Travel to study districts										Consultant and Team	Team deployd to evaluation sites
6	Field Data collection										Consultant and Team	Evaluation Data
12	Review of projec documents										Consultant	
13	Key informant interviews										Consultant and Team	Quantitative and qualitative data sets
16	Data analysis										Consultant	Data analysis outputs
17	Report writing										Consultant	Draft report
18	Feedback meeting										Consultant	Power point presentation of the Draft report
	Final report										Consultant	Final report

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Appendix 4: State of Completion of project activities

Scoring Key	
	All activities conducted as planned
	Almost all activities conducted with a slight gap or deviation from original plan
	A half or more of the interventions were implemented
	Less than a half of the interventions were implemented

SN	Planned Activity	Description	Implementation Status	Reason for incompletion (if applicable)	Total Expected Score	Score Attained	Score Card
A: Broad Activities							
A1	**Networking**	1. Intended to network with o PharmAccess, o Health Promotion and System Strengthening – Tanzania (HPSS) and interFINi consultants limited 2. Participate in o health stakeholder's meetings, o advocacy meeting and o strategic networking forums at district level, regional and national level	All completed except networking with PharmAcess	The project at PharmAccess that would have linked the two projects ceased operations	6	5	83%
A2	**Collaborations**	Planned to work in collaborations with Local Government Authorities (LGAs) for approval of 1. the intended project to take place in their respective area and 2. access to government infrastructures such as health facilities, public ambulances in case of emergency and 3. the use of Enrolment Agents for enrolling Dharura Fasta Member and iCHF member.	Implemented as planned without any gaps		3	3	100%
A3	**Knowledge generation**	Planned to generate knowledge that will enable to showcase HIMSO's contribution on the agenda of health financing during networking and advocacy meetings in the following forms 1. Social media 2. HIMSO website content 3. Scientific publications 4. Presentation in scientific conferences and webinars.	Except for webinars all of the rest initiatives were implemented as planned	Limited experience in organizing webinars	4	3.5	88%
A4	**Social and behavior change communication :**	Planned to develop a communication strategy on social and behavior change communication strategy that would detail 1. Key behaviors to be addressed 2. Communication campaigns through community troops 3. Communication campaigns through radio 4. Development of IEC materials	All of these activities were conducted as planned.	Opportunities for improvement in conducting social and behavioral studies could have been used to further enrich determination of key behaviors	4	4	100%
A5	**Media houses and cultural**	Planned to engage media for community awareness and sensitization on Dharura	These sessions were successfully		4	4	100%

	troops engagement:	Fasta and iCHF through and by sustaining interactive radio programs with radio stations in 1. Rungwe, 2. Mbeya, 3. Mbozi and 4. Ileje.	implemented				
A6	**Reflective approach**	Initiate communication with EASUN in order to learn and apply reflective methodologies in planning and implementation of the project.	This activity was implemented, sustained and continues				100%
A7	**Trainings**	1. Training Project Field Staff 2. Training LGAs 3. Training of CHuA 4. Training of Transport providers 5. Training of CHWs 6. Training of Community Leaders 7. Training of Health facility in-charges 8. Any other Training	All of these trainings were successfully conducted	There was a room for identifying other areas for HIMSO staff capacity building such as organization of webinars and scientific writing and publication in peer review journals	7	6	86%
B: Specific Activities							
B1	**Project introduction meetings**	1. Visit at NGO register Office in Dodoma to introduce the project and submitted the document for approval 2. Conduct one-day project introduction meeting at regional level 3. Conduct one-day introduction meeting with all District/Councils reaching 210 participants in ten councils of Mbeya and Songwe 4. Conduct one-day on-site introduction meeting with 211 ward development committee members at each of the 10 project councils/districts with a total of 2,134 (864 females and 1,270 males).	All of these activities/interventions were implemented as planned		4	4	100%
B2	**Management of Dharura Fasta Insurance (ETS) and iCHF**	1. Mapping of CHW, Enrolment Agents and Transport Providers: 2. Establish CHuA in three new councils 3. CHuA training to co-manage Dharura Fasta and iCHF enrollment 4. Training of Community Health Workers to manage emergency cases 5. Capacity building for 10 CHuA to sustainably co-manage DF and iCHF 6. Conducting demand creation for Dharura Fasta and iCHF enrollment 7. Develop and implement reward system to Enrolment Agents, Community Health Workers and Transport Providers:	All of these activities were implemented as planned and successfully		7	7	100%

B3	**Institutional and programming capacity strengthening**	1. Upgrade Management Information System (MIS) for co-managing DF and ICHF: 2. Orientation on the proper utilization of upgraded MIS to HIMSO and CHuA: 3. Reflective meeting on organization level (HIMSO Staff, CHuA team, Board) 4. Documentation of best practices and lesson learnt on DF and iCHF: a. Documenting processes, successes and lesson learnt on co-managing Dharura Fasta and iCHF – annually b. Publication of the best practices and lesson learnt- annually 5. Enhancing HIMSO staff with relevant skill development package: a. Conducting a training need assessment for HIMSO staff to identify skills gap b. Conducting at least two needs based capacity strengthening for staff	Most of these activities were conducted as planned except publication of best practices	Limited capacity of scientific writing and publication in peer review journals exist among Project staff	7	6	86%
B4	**Advocacy, Lobbying and Networking**	1. Develop an internal advocacy strategy with support from CSS-INTERFNi 2. Engagement with decision makers of regional and district authorities a. Conducting -annual project progressive meetings at regional level b. Conducting bi-annual stakeholders progressive meeting at council level 3. HIMSO participating in strategic networking forums a. Participate in two national level networking forums per year b. Participate in at least one regional networking forums/platform per year c. Participate in at least one district strategic networking forum/platform per year	All of these activities were successfully conducted and as planned		6	6	100%
	TOTAL SCORES				**52**	**48.5**	**93 %**

Appendix 5: Evaluation tools

Enclosed as a separate file

Appendix 5: Terms of Reference for the evaluation

Enclosed as a separate file