Fixing Health Systems



# Team Players

## Building the skills of local health care planners

*Training and innovative tools were key to the success of the Tanzania Essential Health Interventions Project, along with small funding increases. The tools and strategies allowed the districts of Rufiji and Morogoro to target their new resources on the largest contributors to the burden of disease and on health care delivery. The most dramatic result, among many, has been an average decline in child mortality of more than 40%.*

The World Health Organization (WHO) estimates that US $35 to $40 per capita is the "bare minimum" needed to provide basic health services. The Tanzania Essential Health Interventions Project (TEHIP) settled on a more modest amount. It boosted the health budgets of two rural districts by $2 per capita, bringing total per capita spending close to $12. Surprisingly, the districts could only spend a small portion of the extra money. It was not until they introduced new practices — backed up by significant training — that they could absorb more funds.

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The lesson? You need more than money to improve health care.

"Our simple message is that you can put as much money as you want into a district but unless you put in capacity building at the same time, it is unlikely that the district will be able to utilize that money," says Dr Graham Reid, TEHIP's Project Manager.

But once you get the health care system functioning well, a little money can go a long way.

## A collaborative approach

This "simple message" has emerged after 6 years of research and development activities in the large rural districts of Rufiji and Morogoro. TEHIP, a collaborative project between Canada's International Development Research Centre (IDRC) and the Tanzanian Ministry of Health, provided local health-planning teams with small funding increases, along with tools and strategies that allowed the districts to target their new resources on the largest



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TEHIP grew out of a proposal in the World Bank's *World Development Report 1993: Investing in Health* — that mortality in the developing world could be significantly lowered by adopting a minimum package of health interventions to respond directly, and cost-effectively, to evidence about the local burden of disease. Tanzania, then undergoing health sector reform, was in a good position to test such a hypothesis.

Under the reforms, responsibility for health care planning was devolved to District Health Management Teams (DHMTs). TEHIP staff and Ministry of Health officials initially thought the teams would need only two planning tools: one to measure burden of disease and the other to help select cost-effective interventions. But in 1997, the first year the districts had access to $2 extra per capita through TEHIP, they could only spend 57 cents. To channel more money into health services, the district health teams first had to improve their ability to plan, to manage, to administer, and to implement.

"That's how it started," says Dr Harun Kasale, TEHIP's Project Coordinator.

## First steps

It began with team building. Although decentralization had thrust the task of health care planning onto the DHMTs, the teams lacked the skills to develop and implement the plans. As a collection of specialists, they also needed to learn to work together.

To address these shortcomings, TEHIP introduced the DHMTs to a modular training course, called *Strengthening Health Management in Districts and Provinces*. The course was developed by WHO to fill the gap between what is taught in formal management training courses and what actually happens in the field.

By following the processes outlined in the WHO course, which was translated into Kiswahili, the teams began to work together to assess problems and propose solutions. In doing so, the teams "found that almost 60% of the problems — ranging from low immunization rates to poor vehicle maintenance — were within their capacity to solve," says Dr Kasale. They also learned that problem solving involved delegating and sharing responsibilities, essential elements of team building.

"It consolidated teamwork," says Dr Harun Machibya, the District Medical Officer for Morogoro of the *Strengthening Health Management* process. "It was a real eye-opener."

Another key strategy to improve management skills came from *Ten Steps to a District Health Plan*. This "reader-friendly" manual guides teams carefully through each stage of the planning process, even including a sample planning workshop agenda with scheduled tea breaks. The Primary Health Care Institute/Iringa, (PHCI), in collaboration with the Nijmegen Institute for International Health of the Netherlands, synthesized *Ten Steps* from the Ministry of Health's "National District Health Planning Guidelines."

## New tools

TEHIP also worked to develop a set of tools that the DHMTs could use to allocate resources more effectively. For example, the "burden of disease profile tool" simplifies the local burden of disease by transforming it into easy-to-read graphs, tables, and charts. Another tool shows how individual spending commitments coalesce as an overall plan. By combining their new planning skills with these tools, the DHMTs were able to reorient their budgets to place greater emphasis on major causes of mortality, namely malaria and a cluster of childhood illnesses.

The DHMTs also tackled other problems that emerged during the planning process. Staff had to learn to draw up contracts, hold structured meetings, issue cheques, procure supplies, and interact with accountants — all the little things that are crucial to the functioning of a health system but often overlooked.

By way of example, Dr Kasale recalls his first appointment as a District Medical Officer. He wanted to order supplies and was told he needed to fill out an LPO (local purchase order). "What was an LPO? You don't learn this in medical school."

On behalf of TEHIP, Tanzanian institutions developed training programs for staff on administrative and financial

procedures. The teams broadened their membership to include accountants to help with budgeting and financial reporting. Computers were brought in to replace the thick ledgers dating from the colonial years. Office management improved, thanks to training in filing, email correspondence, and meeting organization. The DHMTs also addressed the ongoing maintenance of health care facilities and equipment, including vehicles. Since 1998, official drivers of district vehicles and motorcycles have been attending driving and maintenance courses — all funded through the district health plans.

## Communication problems

One of the biggest challenges facing the DHMTs, however, was the personal supervision of district health facilities. Morogoro, for example, had 96 widely dispersed facilities, making regular visits physically impossible.

The concept of developing a "management cascade" responded to this need. In the cascade system, selected "mother" health centres are responsible for supervising groups of "daughter" dispensaries with the aid of two-way radios and reliable transportation. Supervisors use motorbikes — and a boat in the case of coastal Rufiji district — to cover their territories, while dispensaries are supplied with bicycles. (Jokes Dr Machibya of Morogoro: "I could use a helicopter."). The cascade system is also used for delivering drug kits and bednets, collecting reports, and implementing national campaigns, such as immunization programs.

The benefits of the cascade system have spread to sectors outside of health. For example, it is used to distribute examinations to remote schools. The Rufiji DHMT has also installed a satellite connection that links all members of the district authority — not just the health team — to the Internet.

Tanzania's Ministry of Health has adopted the management cascade and introduced it to other districts. The system has been praised for its effectiveness in devolving responsibility to lower levels within the health system, thereby having a positive impact on morale by providing new challenges and increased job satisfaction for workers in the communities. In addition, the cascade's ability to provide local communities with greater access to diagnostic labs is seen as increasingly important as the country gears up for new responses to HIV/AIDS. (For more information on the cascade system, see box: "A Cascade of Benefits.")

Indeed, as countries throughout the world struggle to deal with the AIDS pandemic, it is critical to have a robust health infrastructure in place to support the introduction of new therapies and treatments. As Ms M.J. Mwaffisi, Permanent Secretary of Tanzania's Ministry of Health, points out in the foreword to *Fixing Health Systems*, published by IDRC: "It is obvious that good management, motivated health workers, and functional networks of communication and transportation are required for such

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## A Cascade of Benefits

The cascade system vastly improved communication between health care workers and further strengthened the concepts of teamwork and shared responsibilities. Notes Dr Graham Reid: "The cascade is not simply a radio, it is a state of mind."

In the report *The TEHIP Spark: Planning and Managing Health Resources at the District Level* produced by IDRC's Evaluation Unit (www.idrc.ca/evaluation/policy), a District Medical Officer (DMO) and his health management team described situations in which they were able to provide treatment to people by radio through "communication between the DMO and dispensaries, [and that] it only took 12 hours to mobilize drugs and information." Previously, communication would have taken several days due to poor roads and periodic flooding throughout the Rufiji district. Faster response times are especially important during floods that are often accompanied by malaria and cholera outbreaks.

Positive uses of the managament cascade in Morogoro and Rufiji districts include

- actual supervision of peripheral facilities with time for supervisors to directly observe patient care;
- more coherent laboratory specimen collection and diagnostic laboratory reporting functions;
- timely delivery of drugs, equipment, and supplies;
- coordination of referrals of patients to the district hospital;
- emergency epidemic support;
- routine collection of health information and data;
- notification of arrival of staff salaries, leading to less closure of health facilities as health workers travel to collect their salaries too soon and have to wait before returning;
- improved maintenance of facilities and equipment and replenishment of stationary and other supplies;
- improved linkages and communication with communities;
- local organization of capacity building workshops, technical training, and refresher courses; and
- posting of replacement health staff when regular personnel are ill or have died.

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**Health workers use bicycles, motorbikes — and a boat in the case of coastal Rufiji district — to cover their territories.**

new treatments to reach the people who need them, and for those treatments to be used effectively."

Just as WHO identified the minimum amount of money per capita needed for basic health care, TEHIP is helping to define the minimal essential elements of capacity building needed to deliver that care. Once that care is provided, the results are remarkable. In Rufiji and Morogoro, child mortality fell by more than 40% in the 5 years following the introduction of new tools and strategies. In the same period, the death rate for Rufiji adolescents and adults between 15 and 60 years old declined by 18%.

Many of the lessons and experiences associated with these statistics are beginning to move beyond Rufiji and Morogoro to other districts in Tanzania, with training courses on selected planning tools, on strengthening health management, on building a health care plan, and on the management cascade. DHMTs in other districts are learning — in the words of former Tanzanian President Julius Nyerere — that to plan is to choose.

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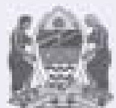
## Fixing Health Systems

More information on the capacity building of District Health Management Teams in Morogoro and Rufiji can be found in *Fixing Health Systems*, by Don de Savigny, Harun Kasale, Conrad Mbuya, and Graham Reid. The book describes the Tanzania Essential Health Interventions Project — its origins, impact, important lessons, observations, and recommendations for decision-makers and policy analysts. The full text of the book is available on a thematic Web dossier, which leads the reader into a virtual web of resources that explores the TEHIP story: **www.idrc.ca/tehip**.

*Fixing Health Systems* is part of IDRC's *In_Focus* Collection, which tackles current and pressing issues in sustainable international development.

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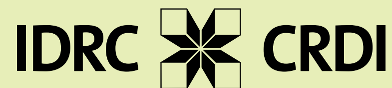


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