Essential Health Interventions Project (EHIP)

Tanzania Essential Health Interventions Project (TEHIP)

EVALUATION REPORT

to IDRC and the MOH

May 1999

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FIRST EHIP/TEHIP EVALUATION

EVALUATION REPORT

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ACKNOWLEDGEMENTS

To paraphrase one of the key informants during the exercise being reported here, an evaluation is a mirror which assists the project being evaluated to take a good look at itself....

If an evaluation is a mirror, then evaluators are mere mirror-handlers turning the device this way and that in order to give the project or person being evaluated an opportunity to view itself or himself from as many angles as possible.

We can only hope that as evaluators we chose the right mirror: plain and with a good reflective surface; not concave or convex and capable of giving distortions. We also hope that we held the mirror at all the required angles, creating opportunities to view blemishes as well as the overwhelming number of beauty spots....

As we prepared for and executed this evaluation we received a lot of assistance from many persons but if we were to name each and everyone we would have to spare a special chapter. However, a few names stand out either because their position thrust them into greater contact with us or the nature of our enquiry required that we interact with them more. If there are some names that we do not record here it is not because their contribution is any less significant but because we had to end the list somewhere and to all those we wish to record our gratitude.

The EHIP Office in Nairobi --the Executive Director, the Project Officer, the Research Officer and the Financial Controller-- all gave very useful input into the preparation of the framework and, particularly the Project Officer, unequalled administrative support.

The Project Management in Dar es Salaam -- the Project Manager and Project Coordinator; Research Manager and Research Coordinator as well as the Financial Manager, Administrator and Project Secretary gave us much constructive criticism during the preparation of the framework and facilitated many of the activities relating to data collection and report writing.

The DHMTs and DMO Morogoro, the DED Morogoro and TEHIP researchers went out of their way to assist us and so did the staff at the CIDA Programme Support Unit in Dar es Salaam which became home to us for a few weeks..

To all of them I would like, on behalf of the whole Evaluation Team, to express our profound gratitude.

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May 14 1999

EXECUTIVE SUMMARY

The first EHIP/TEHIP evaluation was carried out from February to April 1999. As part of the evaluation, wide-ranging but intensive interviews with key persons associated with the project and extensive desk review of important project documents were made.

It is the opinion of the Evaluation team that although the project is quite complex, it is very well designed. The TEHIP Project Team works well together, the support structures are in place and functioning and the "beneficiaries" of the project are satisfied with the project's output so far.

The Evaluation found highly motivated staff appreciative of an opportunity to work in a climate where supplies are available. District Administrators and regional health authorities understand the project and are supportive.

The project effectively contributes to the government's health sector and social sector reforms. It is widely accepted and appreciated by the Ministry of Health with which it has a very close working relationship.

The Project's organisational structure is good; the counterpart system works. The Project's Operations Committee (POC) and the Scientific Advisory Committee (SAC) are considered to be highly productive and to be providing needed project direction. The Project Steering Committee (PSC), however, which is almost equivalent of a Board of Governors, is said to be a bit on the complacent side and not given to critical examination of issues .

The project is well integrated into the district health delivery system but at the national and regional levels some more integration especially related to sustainability needs to be done. Also the Ministry of Local Government, whose "ownership" of the project is rated low, needs to expand and upgrade its participation beyond its membership in the PSC.

While the communities are happy about the highly noticeable improvement in service delivery and supplies, their "involvement" has stagnated at the labour-donation level. Neither at the beginning nor during the two years of project implementation has the community been centrally involved. When something had to be dropped from the research budget it was community participation which had to go. Although this type of involvement was never intended as part of the project, the Evaluation Team wishes to point out its importance in sustainability of the EHIP idea and functions beyond project life.

DHMTs are overstretched almost to the limit. Health facility workers also report a dramatic increase in the number of patients requiring care. Their ability to cope, if this trend continues, needs attention.

A concern over the standard of health workers especially in Rufiji was expressed. While it is true that TEHIP/WHO managed to train these workers through adapting the learning materials and extending the time frame of the courses, it is also true that a better solution would be to deploy appropriate staff to the facilities.

Another concern raised by some of the key informants regards what has been called the "absorptive capacity" of resources --ostensibly referring to the apparent failure of districts to utilise funds earmarked for them. The Evaluation found out that this low "absorption capacity"of districts is a result of delay in purchasing ordered supplies, and partly a reflection of still- existing management anomalies at the district level.

The Evaluators feel that four years of project life are not enough to do justice to the goals and objectives of TEHIP whose lessons may have wide-ranging implications to health systems in third world countries. The Team recommends an extension of the project for one to two years and to use this time for handing over and phasing out. It also recommends an ex-post evaluation to be certain of long term sustainability of the project.

Thinking and action geared towards the issue of replicability in other districts and other countries should start now. The responsibility for this should lie with EHIP which should intensify its information, promotion and marketing activities. EHIP should also intensify its fundraising for current budgetary shortfalls and for future replication in other countries especially since the stakeholder base has narrowed somewhat with the withdrawal of some and low level financial support by others.

CHAPTER 1

BACKGROUND

1.1 History of the EHIP Project

The project now known as the **Tanzania Essential Health Interventions Project (TEHIP)** and its progenitor, the **Essential Health Interventions Project (EHIP)**, owe their beginnings to the World Development Report, 1993 (WDR 93) titled **Investing in Health**. Reviewing the state of the world's health, the report noted that although health, as measured by mortality rates and life expectancy, had improved across the world in general terms, the situation was far from satisfactory and was in some parts of the world declining. New infections, the so-called emerging diseases such as AIDS, were threatening to reverse gains in mortality and survival rates achieved over the past three or so decades in developing countries even as old infections which had been brought under control, such as Tuberculosis and malaria (malaria deaths have doubled), make dramatic re-entry onto the world health stage. Resistance of disease organisms to hitherto effective and affordable drugs and vectors to cheap and safe insecticides is increasingly robbing the world of two effective tools that contributed significantly to the reduction of mortality from some of the most serious diseases in the history of mankind. In Africa particularly, massive population displacements brought about by unending civil strife and natural disasters complicate the picture even further.

At the same time diseases associated with affluence and the established democracies of the West such as diabetes, hypertension and heart disorders (so-called man-made diseases) exist side by side with diseases of poverty contributing to disability and therefore to a high burden of disease (BOD).

Besides the epidemiological reasons cited above, the report notes that serious cuts in social spending dictated by macroeconomic reforms combined with donor fatigue and deficiencies in the national health systems have contributed to the dismal health sector performance in developing countries. It identified the following factors:

Misallocation of Resources:

Resources are allocated to interventions with low cost-effectiveness at the expense of known highly cost-effective ones. Examples of such low cost interventions are: expensive surgery, investment in high-tech equipment and disproportional allocation of resources to tertiary care facilities that benefit a few and to expensive and specialised training instead of low cost training of personnel that are capable of handling the most common health problems of the society. Tanzania, for example spends 25% [1] of its health sector allocation on its three tertiary care facilities.

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[1] Source: Ministry of Health, Tanzania, Budget 1999

Inequity:

The poor, who in any society carry the greatest disease burden, suffer from poor access to health care while the rich who may have more influence on the health system enjoy disproportional benefit from the national health investment. Since the poor comprise the majority in developing countries, this lack of access translates into high average burden of disease.

Inefficiency:

Often the health system is wasteful, for example in purchasing costly brand name drugs instead of generics and in inappropriate deployment and bad utilisation of equipment and bed space.

Escalating Costs

Both at the household and the national levels costs are very high due to reasons cited earlier but also due to unregulated physician charges and insurance, unnecessary specialist care, and expensive technology.

Excessive Centralisation and Poor Planning

In many developing countries the bad health situation is made worse by poor planning, low morale and motivation of health workers, excessive centralisation of resources and decision-making, and wide fluctuations in budgetary allocations. The health service delivery is therefore characterised by low quality of care, inadequate supplies, congestion at facilities, short consultations, misdiagnoses and inappropriate treatment.

The report sees and justifies a role for the government in financing health care. Three reasons for this are given:

1. Many health related services are what it calls **public goods**. The report defines public goods as those health services which are best provided to whole communities rather than to individuals. For example with regard to the control of most communicable diseases a health authority stands a better chance of success if it invests in a public intervention such as mass vaccination.

2. Wide access to health services by the poor is an accepted approach to **poverty reduction** because the government lifts the burden of health care off poor families' shoulders.

3. **Regulation** of private health care providers and insurance ensures quality and equitable access to health care.

The report proposes/recommends three policy directions to governments:

1. Foster an environment that enables households to improve health including mostly non-health interventions such as education (especially for girls), economic growth policies that benefit the poor, and promoting the rights and status of women.

2. Promote diversity and competition and provide incentives for cost containment. This could be achieved by privatization of insurance for nonessential clinical services and the delivery of clinical services by the private sector even when they are publicly financed.

3. Improve spending on health by rationalizing health care expenditures through reduced spending for tertiary care facilities, emphasizing the financing and delivery of cost effective interventions, ensuring the delivery of a package of clinical service tailored to local needs and improving service management through decentralisation.

The Report continues to argue that if a government in a developing country were to redirect its resources from interventions with high cost per DALY (Disability-Adjusted Life Year) to those with highest cost-effectiveness, the burden of disease could be reduced dramatically. The report categorises public health and essential clinical health service interventions with high cost-effectiveness potential:

Public Health Interventions:

Immunization
School-based health services
Information and selected services for family planning and nutrition
Programmes to reduce tobacco and alcohol consumption
Regulatory action, information and limited public investments to improve the household environment
AIDS prevention.

Essential Clinical Services

Pre-natal and maternal services
Tuberculosis control
Control of sexually transmitted diseases (STD's)
Care for serious childhood illnesses such as diarrhoeal diseases, acute respiratory infection, measles, malaria and acute malnutrition
Selective emergency and trauma services

The report actually posits that if 80% of the population in a developing country were reached by the essential interventions a 32% reduction in the burden of disease would be achieved at a total cost of USD 12 per capita. Acknowledging that USD 12 per capita is more than what most governments in the developing countries allocate to health, the report recommends that governments increase spending on health, donors provide more support, communities participate more in paying for health care and public spending on health be re-oriented. The re-orientation, the report continues, should take this form:

- Shift spending away from specialised personnel, equipment and supplies in tertiary facilities towards widely accessible care in community facilities and health centres.
- Develop more effective policies to finance training for primary health care providers (particularly nurses and midwives), and for public health, health policy and management personnel. Limit subsidies for specialist training.
- Increase support for health information systems and operations research to guide public policies, including estimates of the national burden of disease and cost-effectiveness of different

interventions.

- Develop national essential drugs lists, new treatment protocols, and alternative uses of facilities.
- Increase capacities and accountability at lower levels of the national health system.
- Place greater reliance on the private sector, both for essential and non-essential services, and provide subsidies to the private sector for the provision of essential services.
- Regulate the quality of health services, both public and private and of health insurance schemes.

While the relevance of these recommendations will vary from country to country, in low-income countries a "...renewed emphasis on basic schooling for girls, strengthening of public health programmes and support for expanded public financing of essential clinical services should be at the top of the policy agenda."[2] The international community must be prepared to provide increased assistance for health policy reforms and for health research that focuses on the major health problems of developing countries.

WDR 93 was published in June of the year and by October 1993 it had created so much interest within major international organisations that IDRC convened a meeting in Ottawa (Ottawa Conference) which was co-sponsored by the WHO, World Bank, and IDRC. The three day conference titled **Future Partnerships for the Acceleration of Health Development** brought together 150 representatives from developing countries, development organizations, governments and academia to "...examine weaknesses in national and international programmes for equity oriented health development in developing countries" and agreed on "...practical steps to increase the scope and effectiveness of partnerships and investments for health"[3].

Three major conclusions/recommendations were reached at this conference. These were:

- that WHO should take the lead in spearheading health sector reforms internationally.
- that the World Bank should invest in capacity building to undertake the reforms.
- an international organization should undertake to test the main hypotheses postulated by the report.

These recommendations led to IDRC/CIDA taking the responsibility of testing the feasibility of health planning based on local estimates of burden of disease and cost effectiveness considerations in the context of decentralisation. A project that became known as Essential Health Interventions Project (EHIP) and a secretariat to implement it was set up in Ottawa to provide leadership and support to the project, a steering committee known as the EHIP Steering Committee, later the International Advisory Committee (IAC) comprising representatives of identified stakeholders of the project was also formed..

1.2 History of TEHIP In Tanzania

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[2]World Development Report, Investing in Health, World Bank 1993

[3]Future Partnerships for Acceleration of Health Development, the Report of the Ottawa Conference, IDRC, 1993

In June 1994 the first Project Design Workshop was held by IDRC in Ottawa to consider essential issues related to the design of a project of the kind IDRC was proposing. Among other things the matter of selection criteria for the host country and districts where the project was to be based were identified.

The Tanzanian proposal for hosting an essential health interventions project was received in August 1994 and in October of the same year a second Project Design Workshop which involved experts in the field of health sector reforms and project methodology was held in Ottawa also.

In November/December, an assessment mission by IDRC, WHO and the World Bank visited Tanzania and, jointly with the Tanzanian Ministry of Health and the National Institute for Medical Research, met key health sector players in the country as well as visited the four districts which had been proposed as possible sites for the project, namely, Morogoro (Rural), Kisarawe, Rufiji and Mafia Island. Although the political mapping exercise carried out as part of the pre-implementation process points to some controversies especially in the selection of Rufiji, selection criteria laid out in the June meeting were applied in the selection of Morogoro Rural and Rufiji as project districts.

The two districts differ very much from each other. While Rufiji is littoral, has a population of 179,000 and is dominated by the river, Morogoro (Rural) is larger with a population of 535,000 and is mostly mountainous. It would seem that whatever else may have influenced the choice of the two districts other factors were also brought into play. These included proximity to the project headquarters, and at least for Morogoro convenience in the form of the presence of a project (the DFID-supported Adult Mortality and Morbidity Project - AMMP) that had already started collecting baseline data which was critical to the new project. An added advantage for the choice of Rufiji is the general poor state of health indicators. One may therefore argue that if the project can beat the challenges presented by Rufiji, then it can be done anywhere in Tanzania.

The year 1995 saw much preparatory work taking place. In February, a meeting was hosted by the World Bank in Washington to work on the macro design of the project followed in April by a formal award of a contract by the IDRC to the Tanzanian Ministry of Health to establish a TEHIP office in Dar es Salaam. Following this meeting top positions for the project were identified and applications invited. As a result of this the current Project Co-ordinator and the Research Co-ordinator were interviewed for the posts and selected on secondment basis from the Ministry of Health from where they set up office.

In July a consultative workshop was held in Morogoro where too many expectations were expressed, most of them unrealistic and outside the presumed focus of what is essentially a research project. The Morogoro Workshop was followed in October by a meeting of the **International Advisory Committee (IAC)** which was previously known as the **EHIP Steering Committee**, held on Tanzanian soil for the first time. Perhaps as a result of the Morogoro workshop initial enthusiasm on the project was dampened and the IAC recommended a delay on the start-up date.

Early 1996 was characterised by a flurry of activities that included the following:

- Workshop for Research Design
- Call for letters of intent and proposals for research

- Selection of research consortia
- A Scientific Advisory Committee (SAC) meeting

The project got off the ground finally in 1996 with the signing of the Project Document by the Ministry of Health and IDRC in September and the arrival of counterparts from Canada - the Project Manager and the Research Manager - in December. The project moved to its current premises in the building owned by the National Institute for Medical Research in late 1996 but it was not until 1997 that full localisation of the EHIP project took place with the disbanding of the International Advisory Committee whose function had been primarily to set up the political foundations for the project, and its replacement by a local **Project Steering Committee (PSC).** At this time the project became known as the **Tanzania Essential Health Interventions Project (TEHIP)**. It is also in 1997 that the Project Secretariat moved from Ottawa to Nairobi. Partly to hold down costs and partly to bring decision-making closer to the field, the post of Executive Director of the project (who had been involved with the project since its conceptualization), was amalgamated with that of the Regional Director of IDRC at the Eastern African Regional Office (EARO) in Nairobi.

The four-member team then proceeded with the task of advertising for the other key positions of Finance and Administration Manager, Administrator, Project Accountant and Project Secretary. In December of the year a Project Officer who was to act as liaison between EHIP (Nairobi) and TEHIP (Dar es Salaam) was appointed and based in Nairobi where she also handles other health related matters from other countries of the region.

1.3 Relationship of TEHIP to EHIP

The birth of TEHIP in October 1996 marked the transition wherefore EHIP the secretariat became TEHIP the field project. For three years EHIP had been a depository of ideas where IDRC and its partners sought ways and means of testing the theoretical postulates posited by the World Development Report 93 in a real field situation. EHIP made all the necessary preparations required to the point where this field testing could take place. TEHIP became that vehicle through which some of these central hypotheses of the World Bank could be examined. EHIP is "... 'global' focussing on the overall conceptual design and development. (Level two) deals with the implementation of the project in Tanzania. Level one is... EHIP, while level two is ... TEHIP."[4]

When TEHIP became operational EHIP became eclipsed as literally all essential health intervention activities up to that point in time passed on to TEHIP. But it is important to remember that the relevance of EHIP was meant to go beyond Tanzania and therefore beyond TEHIP. While EHIP continues to exist as a secretariat a lot of its former activities related to the setting up of the TEHIP pilot have taken a back seat as TEHIP grew stronger. Its role, however, has continued to be important for several reasons:

- it has continued to play a supportive role to TEHIP in roles that TEHIP could not take on its own e.g. in setting up this evaluation.

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[4]TEHIP Project Document, IDRC, June 1996

- it has continued to provide publicity for TEHIP in order to garner political and resource support from the Canadian and Tanzanian communities and the wider international community, for example, in preparing the TEHIP Newsletter.

- continues to maintain international interest and support for EHIP ideas world-wide. In this regard EHIP is seen as longer term organisation which will still be there when TEHIP goes.

1.4 Background to the Evaluation:

1.4.1 Development of the Evaluation Framework

Although the Project Document calls for the contracting of the services of a Project Evaluator "...to evaluate TEHIP throughout the course of the project beginning in Year # 1 (1996 - 1997)"[5] no such person was contracted until October, 1998 when the project had been in existence for more than a year.

Two main attempts in March 1996 and two years later, in March-April 1998, resulted in frameworks that were not wholly acceptable to the project. Perhaps one of the difficulties of developing a framework for this project is its rather unusual design where research and development go hand in hand feeding into each other and where the research component is at the same time performing a monitoring and evaluation function for project development activities. The more common designs involve straightforward service delivery projects where the evaluator need only look comprehensively at whether what the project set out to deliver has been delivered and set out objectives been met.

The evaluation being reported here has benefited from both framework development attempts in that rather than develop a brand new protocol from scratch it built on the earlier ones and added its own conceptual frame.

Due to these problems of getting the evaluation function off the ground in time the project may have suffered from lack of a tool "...to allow responsiveness to emerging needs and questions as the project evolves"[6]. Also the attempts at developing an acceptable framework ate deep into the evaluation budget so it is not entirely clear whether funding for an evaluation function of the type envisaged in the Project Document is available.

1.4.2 Evaluation Objectives

This is the first evaluation of EHIP/TEHIP. In the absence of a baseline the information contained in this report will be very important in subsequent evaluations in that it will offer an opportunity for comparison. The evaluation therefore tried to be as comprehensive as possible.

The Objectives of this evaluation were:

- To review and document the processes of project management, both external to and within Tanzania, including data collection, establishment of priorities, allocation of resources, and delivery of the minimum or essential package of health services.
- To provide ongoing feedback to project staff, the TEHIP Steering Committee and the EHIP Scientific Advisory Committee regarding project implementation in order to facilitate mid-course corrections.

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[5]TEHIP Project Document

[6]Institutional Assessment, a Framework for Strengthening Organizational Capacity for IDRC's Research Partners, IDRC 1992

- To assess project outcomes including, capacity building, health impacts, and the feasibility and sustainability of using analytical approaches for district health planning.
- To ensure prompt reporting to other project stakeholders, including donors, government of Tanzania (at national, regional and district levels), project managers, and communities on the progress of the project.

1.4.3 Evaluation Design and Methodology

This evaluation only looked at the macro aspects of the project because the micro aspects are being tracked by the research component of the project. Indeed to look at the micro aspects of the project could have resulted in contamination of the research processes and results.

For the same reason given above, this evaluation did not look at outcomes or impacts of interventions. It would in any case be premature to look at impacts at this stage since interventions have only really been getting under way recently. However where impacts were observable without too much intrusion the evaluation took note of them and have reported on them. Impacts will be looked at in greatest detail in the summative evaluation scheduled for the year 2001.

The Evaluation, coming as it did midway through the project, should be considered mid-term and formative in that it is expected that the project will make use of the pertinent findings and recommendations in the evaluation to make mid-course corrections.

The Evaluation Team was composed of four Tanzanian professionals with backgrounds and experience in Health Policy and Administration, Human Resources Development/Capacity Building, Health Economics, Financial Analysis, Public Health and Medicine. All, to varying degrees, have been involved in institutional evaluations previously. As all the evaluators were not closely connected with the project this essentially fulfilled the conditions for an external evaluation. However, the Head of the Evaluation Unit, IDRC Ottawa, the Project Team, the Project Officer, the Executive Director and the Research Officer, EARO were involved in the development of the framework for the evaluation and throughout the course of the evaluation. Almost all of them were very extensively interviewed as key respondents in formal sessions and also informally. The evaluation, in this sense therefore, sought to involve as many of the TEHIP players as possible.

In all, 18 different questionnaires were developed from the parent questionnaire appearing in Appendix 6 of this report. In addition to the questionnaire each member of the Evaluation Team kept a journal in which important information was recorded. Frequent discussions ensured that members of the Team were well-informed of what the other members were doing and contributed to keeping the evaluation focussed.

In the preparation of the evaluation framework the following IDRC text was referred to:

> ".Institutional Assessment, A Framework for Strengthening Organizational Capacity for IDRC's Research Partners" [7]

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[7]Institutional Assessment, A framework for Strengthening Organizational Capacity for I D R C Research Partners, IDRC, 1962

In the preparatory, data collection and data analysis phases the Team made use of the Project Document extensively and especially the Logical Frame.

Data were collected using the methods shown in Table 1: below:

Table 1: Levels and Methods used in Data Collection in the First EHIP/TEHIP Evaluation

Data Collection Strategy	Principal Data Collection Strategies used by level of responsibility or role						
	MOH Policy Makers	**Project Mgt and Secretariat**	**Partner Stakeholders**	**District Health**	**District Administration**	**Facility Workers**	**Communities**
Focus Group Discussion	Not Used	Not Used	Not Used	Used	Not Used	Used	Used
Questionnaire: self-administered	Used	Partly Used	Partly Used	Partly Used	Not Used	Not Used	Not Used
Questionnaire, in-depth interview	Extensive Use	Extensive Use	Extensive Use	Extensive Use	Extensive Use	Not Used	Not Used
Observation/checklist	Not Used	Not Used	Not Used	Used	Not Used	Used	Used
Document Review	Extensive Use	Extensive Use	Moderate Use	Moderate Use	Limited Use	Limited Use	Not Used
SWOT Analysis	Not Used	Extensive Use	Limited Use	Moderate Use	Not Used	Not Used	Not Used

Data collected was for the most part qualitative as there is not much quantitative information coming out of the project at this point in time with the possible exception of financial figures. Extensive document review took place and a list of the more important sources is provided in Appendix 5 which contains also the names of key persons met and interviewed as well as places visited by the team.

Where deemed necessary, cross-validation was sought, and several methods and several sources were used to obtain the same information in triangulation.

1.4.4 Limitations of the Evaluation

The evaluation got off to a rather bumpy start with the removal of one of the members of the evaluation team for reasons cited as conflict of interest. His departure meant that a replacement had to be recruited, inducted into the team and trained. He also had to be given time to catch up by reading key documents of this extremely complex project. This change resulted in a costly delay.

There were also delays brought about by failure to keep appointments on the part of some key respondents but in the end a good percentage of the people who had been identified as important sources of information were met and interviewed. The list of persons met and places visited is included in Appendix 5.

While it was possible to visit Morogoro (Rural) District and conduct the evaluation there as planned, it was not so easy in Rufiji District. The Team could not cross the inundated Rufiji River which at this time has a span of upward of fifteen kilometres. To cross the river, the Team would have been required to waddle through waist-high water and mud for several kilometres to reach a canoe and about 5 to 12 hours to get to the district headquarters, Utete-Rufiji. Fortunately, however, half the District Health Management Team (DHMT) for Rufiji live on the Eastern side of the River and so it was possible to interview them at Kibiti without risking neck and limb! Also it was possible to visit two health facilities, at Ikwiriri and Kibiti, and to talk to their staff and service consumers. The project's research station is also located in Ikwiriri so it was possible to visit the staff working there also and observe them at work.

Lack of a baseline has been cited as a shortcoming of this project. Partly this is due to the fact that a baseline is considered a normal requirement of "the more common service provision projects" and its presumed absence is considered a fatal flaw in the project design. Actually there is enough data to constitute a baseline especially in Morogoro Rural District where the Adult Morbidity and Mortality Project (AMMP)has been collecting data for seven years now. This data is actually available to TEHIP and can be used when future data comparisons become important. In Rufiji the project is collecting (with the collaboration of AMMP) household information that includes morbidity and mortality data.

CHAPTER 2

Project Design

The Project Document is well written with a Logical Framework orientation. It is a mark of how well written the Project Document is that only one revision has been required since it was released in October 1996. Assumptions are analysed well alongside Risks.

2.1 Project Aims

2.1.1 EHIP Goals and Objectives

The Project goal of EHIP is global while that of TEHIP is local. In other words, EHIP is to the world what TEHIP is to Tanzania. The goal of EHIP therefore on a global scale is to test the feasibility and measure the impact of an evidence-based approach to health planning at a district level.

The objectives of EHIP were/are:

- To set up a demonstration project to test whether resource allocation decisions can be made rationally and effectively on the basis of district level analyses and lead to the effective delivery of selected health interventions and improvement in population health.

- To document lessons learnt from such a pilot project for future development of health care systems not only in the host country where the project is staged but in other developing countries also facing crisis in the health sectors[8].

2.1.2 TEHIP Goals and Objectives

The Project Goal of TEHIP is to test the feasibility and measure the impact of an evidence - based approach to health planning at the district level (in Tanzania).

The objectives of TEHIP are:

- To strengthen district level capacity in Rufiji and Morogoro-Rural districts to effectively plan, set priorities and deliver health services using burden of disease and cost effectiveness analysis for resource allocation;

- To increase and strengthen district level capacity to effectively deliver the selected health interventions;

- To assess and document the overall lessons learned in district health planning and management information systems and processes; and

- To measure the overall impact of delivered health interventions in terms of burden of disease

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[8]TEHIP Project Document

reduction. For this to happen TEHIP focuses on two key issues: the financing and delivery of essential clinical and public health interventions and improving the planning and management of health services at the district level. As part of the first issue the project has also assisted in rehabilitation of health facilities in order to facilitate the delivery of the interventions.

2.1.3 Development Goals and Objectives

The development component of TEHIP is meant to build capacities to plan and manage, with local participation, health services and resources, and to deliver more effectively and with increasing coverage essential health interventions to communities. Funding from the project will be used to augment, not replace, current GOT funding. Although "local participation" and "community voice" are mentioned in various places in the project, it is one of the weakest inputs into the project and is yet to be addressed sufficiently.

The Ministry of Health is currently undertaking Health Sector Reforms as part of the larger Social Sector Reforms of the government. Policy makers in the Ministry have indicated that the project is very much in line with the reforms. The contribution of TEHIP can be depicted as in Fig 1:

Figure 1: Contribution of TEHIP to the Health Sector Reform Programme of the Ministry of Health, Tanzania

TEHIP STRATEGIES	HSR OBJECTIVES		
	Improving Health Outcome	Reaching the Disadvantaged	Containing Health Costs
Improve planning and management			
Delivery of essential public health			
Delivery of essential clinical interventions			
Improvement of coverage			
Cost-tracking			
Cost effectiveness interventions			
Burden of disease measurement			
Infrastructural development			
Improved Health Information system			
Community preference			
Community involvement			
Improved drug supply			

KEY:		Much Contribution		Medium contribution		Minimal Contribution
		No Contribution				

2.1.4 Research Goals and Objectives

The Research component of TEHIP is set up to track the inputs being provided by the Development component (i.e. planning and management, financing and delivery of essential health interventions) and to answer the following " **three essential project questions**" which are:

Question One: In the context of decentralisation, how and to what extent, can District Health Management Teams (DHMTs) establish priorities and plan the allocation of resources according to local estimates of burden of disease and knowledge of the cost-effectiveness of relevant interventions?

The Research Component is seeking to find out whether given local estimates of burden of disease and the cost-effectiveness of certain interventions, the DHMT can or can be enabled to establish priorities and plan the allocation of resources.

Question Two: How and to what extent are these district health plans translated into the delivery and use of the essential health interventions ? In other words how are the plans generated from Question one applied in carrying out the determined health services delivery.

Question Three: How, to what extent and at what cost does this have on the burden of disease ? If it is possible to plan based on local estimates of BOD and cost effective considerations and to implement the essential interventions, does it make a difference in terms of reduction of morbidity and mortality?

The three essential project questions "guide the overall design" of the project. The research component is organised as follows:

Table 2: Programmatic Organisation of the Research Component

Component	Domain	Content
A	Health systems research	District health planning, prioritization, and resource allocation processes.
B	Behavioural research	Household health-seeking behaviours in relation to essential health interventions.
C	Demographic and epidemiologic research (impacts)	Morbidity and mortality.
D	Practical tools	Research and development of practical tools for routine district health system analysis and planning.

2.1.5 Research Design

TEHIP research is farmed out to networks of Tanzanian researchers based in Tanzanian institutions. This Consortium Approach, as it is known, requires organisation of teams of researchers of various disciplines and expertise to undertake research in each of the research domains. Collaboration between research teams based in different institutions is allowed. While international collaboration is "...permissible when and if required ... the lead must be taken by Tanzanian researchers and institutions."[9] .

[9]Guidelines

The research component has benefited Tanzanian researchers who are chronically underfunded. TEHIP provides researchers with funds to undertake their research over a long period covering a specified area of interest to TEHIP as shown in Table 2. Each component has several sub-components known as modules which are complementary to each other, and eventually to all the research undertaking and the project as a whole.

Invited proposals from researchers are screened and eventually reviewed by the Project's Scientific Advisory Committee (SAC) which may have discussions with the researchers before the final decision is made.

Three of the four research components of the project have already been taken by various consortia. Component A which covers District Health Planning, Prioritization, and Resource Allocation (The Health System Component) has been taken by a consortium led by researchers from the University of Dar es Salaam's Institute of Development Studies (IDS) and comprises researchers from the Institute of Public Health (IPH) and others.

Component B (Household Health-seeking behaviours in relation to Essential Health Interventions) was won by the Ifakara Health Research and Development Centre (IHRDC) and a coalition of researchers from there and the Sokoine University of Agriculture (SUA)- Institute of Continuing Education (ICE), the University of Dar es Salaam -- Department of Sociology and Statistics, Muhimbili University College of Health Sciences (MUCHS) Institute of Public Health

Component C (Demographic Surveillance) is done by the DFID- supported Adult Mortality and Morbidity Project (AMMP) and is based at the NIMR Headquarters and field stations in Morogoro town and Ikwiriri in Rufiji

So far preliminary results from Component A and B have been submitted but are not published yet. Component C will be a while before any results are made public and as for Component D several activities are already underway such as cost-tracking and the SHARMS initiative.

The research component is working within a budget ceiling of Canadian Dollars 3 million. Within this ceiling it has not been possible to cover all the required research and therefore Component B4 (Community Participation) had to be deferred.

Already at this early stage TEHIP has attracted a lot of interest. Indeed, the amount of requests coming in for Project staff time in activities that are not necessarily related to TEHIP are many and when obliged to, quite taxing. Even for TEHIP related activities there are many requests for premature decisions e.g. on release of research findings and their utilisation.

In addition to TEHIP research the Project is also engaged in other research pursuits, most prominent among them anti-malaria initiatives especially MARA -- the Mapping Malaria Risk in Africa -- and the Insecticide Treated Nets (ITN) initiatives which have given TEHIP and Tanzania especially much positive exposure. TEHIP is also engaged in the evaluation of the IMCI package in collaboration with WHO and often has collaborative links with universities and health institutions such as CDC.

Through all these activities TEHIP has built a name for itself and Tanzania in general and so its staff participate in many scientific meetings and symposia as valued participants or facilitators. It has contributed to human resources development in health research through formal and informal training in aspects of research and in supporting a Tanzanian student for post graduate work leading to the PhD degree.

Although there are many advanced facilities at TEHIP that potential Tanzanian researchers could use and despite open invitations, it is rather disappointing that this offer has not been taken. One may use the computer facilities to access the latest information on just about any topic of health research interest as well as read from the collection at the TEHIP office which contains much useful documentation.

2.2 Project Strategies

2.2.1 Funding Strategies

Formal agreement on funding for the project was concluded and signed on October 14th 1996 through a Memorandum of Understanding between the Ministry of Health Tanzania on behalf of the Tanzania Government and the International Development Research Centre on the Canadian side.

The Tanzanian contribution of CAD 3.6 million (Tsh 1.4 billion) or CAD 4.2 million or CAD 4.2 million (Tsh.1.7 billion) depending on what part of the Project Document one refers to, was to be effected through maintenance of current levels of funding of the health services in the two districts as well as for technical management services. The funds will pay for employees' salaries in the district and those seconded by the Ministry of Health to offer specialised services in TEHIP.

Table 3: Partners' Contribution to EHIP/TEHIP for the Period of Four Years

	IDRC	CAD'000	TZ GOVERNMENT	TZS'MILL
1	Delivery of Essential H. Interventions	8811	Support for Rufiji District	860
2	Research Projects	3011	Support for Morogoro Rural District	784
3	District Health Facilities Improvement	600	Other support from MOH	19.08
4	TEHIP Mgt. and Administration	2680.55		
5	WHO Technical Support	1100		
6	EHIP/TEHIP Evaluation	240.75		
	Total	**16443.3**		**1663.08**

Source: Project Document

Canada's contribution of CAD 16.4 million through IDRC were to finance both research and development activities of TEHIP.

It has been noted that while total project cost is given as CAD 20.6 m in one part of the Project Document (Paragraph 1.9, Project Inputs) the same document quotes a different figure of CAD 20.0 m in Paragraph 5.0 (Project Finances). Reconciliation of the two figures needs to be done.

Since this Funding Strategy is operational only for the four years of project life, tentative future funding strategies need to be designed if the project continues beyond this period. Whatever the outcome of the project, some of its activities will need to be continued for it would be unethical to simply abandon all the activities. This is probably one of the strongest arguments for community participation right from the beginning so that alternative strategies that includes some form of community funding could be introduced. This would create a sense of ownership or responsibility particularly on maintenance of the facilities and possible application of lessons learned in improving delivery of health services.

2.2.2 Site selection - Tanzania:

The choice of Tanzania as a staging site for EHIP was very opportune indeed because of several factors. During the SWOT Analysis with the Project Team the following were listed as the major strengths of the project, among them factors related to the selection of Tanzania. These factors were:

- Fact that the project came about as a result of a request from the GOT
- Project is congruent with the Health Sector Reforms and Social Sector Reforms which the government is currently implementing
- The country is stable and has a flourishing democracy
- Integration with MOH activities at the district level
- Project addresses thorny issues which have been plaguing the MOH for a long time

The choice of Morogoro Rural and Rufiji districts did not follow strict random sampling procedures and the reasoning behind their selection is not very clearly spelt out. It is quite evident that their selection was based on judgmental sampling that may have taken into consideration state of coverage, existing complementary programmes e.g. the AMMP in Morogoro (R), proximity etc. Although it cannot be ascertained, political and parochial considerations cannot be ruled out entirely.

2.2.3 Selection of Implementing Agencies:

The implementing agencies of the project are the Ministry of Health and IDRC, represented in Tanzania by the Project Manager/Project Coordinator and Research Manager/Research Coordinator. The Ministry seconds the Project Co-ordinator and Research Co-ordinator who maintain very close contact and receive required support from the Ministry. The two IDRC-appointed managers and the MOH-seconded Coordinators work in a counterpart system which appears to be working quite well so far. All decisions are jointly made and regular consultation takes place.

The IDRC representatives in TEHIP and the project in general, receive technical backstopping from the IDRC-EARO office in Nairobi through the Executive Director, the Financial Controller, the Project Officer and others to a greater or lesser degree. Sometimes the project accesses and receives support from Ottawa also, for example for short term consultancies.

At the district level the implementing organ is the District Health Management Team (DHMT) headed by

the DMO with the political and administrative support of the District Executive Director and the District Commissioner. Other relevant departments are involved through their membership in the District PHC Committee.

The integrated team at project headquarters is responsible for mainly building the capacity of the district and its implementers through training, disbursement of resources and other technical support. The day to day implementation of the project is handled by the DHMT and workers in the units.

The role of the regional tier in the government administration is not spelt out or even given prominence in the project write-up. There is an identified role for the Regional Health Administration and the region in general in the Health Sector Reform Strategy, in the Social Sector Reforms and the Local Government Reforms. The project should consider bringing this important governmental administrative and technical layer at this early stage.

2.2.4 Community Voice:

"Community Voice" is one of the Project's strategies mentioned in the Project Document but it is the observation of the Evaluation | Team that it is very weak. This is not a criticism of the Project but of how communities are often left out of decision-making in projects that affect their lives. This is not surprising. Very few projects incorporate "community voice" for many reasons. Sometimes it is because its presence in the write-up and in the planning stages is forced, for good measure, by political considerations; sometimes it is just an afterthought since community participation is still in vogue. Very often it is because while everyone shouts "community" very few really know how to go about bringing in its involvement. In any case it is a very difficult component to incorporate but its absence is the reason for many project failures. It is not surprising that when something had to be removed in order to remain within the research budget the one thing that was deferred was "community voice".

While not presuming to know the reasons for this omission, it is the opinion of the evaluation team that not enough attention is being paid to this most important TEHIP strategy. As one can see in Fig.1 community involvement contributes to all the three major Health sector reform objectives of reaching the disadvantaged (and thus improving coverage), containing health costs and improving health outcome of the community in general.

It is already known that the relationships at the interface between the community and the health care delivery system are at best tenuous, at worst governed by outright suspicion and even hostility. This very much determines the level and pattern of contact between the potential consumers of the service and the providers. No matter how the service is improved, there will be no impacts unless it is used in the right way. We already know that 80% of malaria deaths in Morogoro (Rural) occur at home and 50% of those would have had no contact with the official health service at all. This is enough reason to reinstate community participation to its place of prominence but there are others.

There is need to distinguish between community participation as defined by when people "volunteer" their labour to renovate a dispensary and when communities are able to sit and analyse their situation and plan their interventions. The two are a world apart. The "voluntarism" that is often referred to is usually a result of coercion and, besides maybe helping with costs a little, it has no other redeeming value at all and it definitely has no lasting effect.

The desired community participation is one where the community is organised and is a true partner in free decision-making.

2.2.5 Integration:

There are many players in the health field in both districts. Just to illustrate the intensity of action in the health field, Morogoro (R) has the following significant health care providers:

Table 4: Health care providers, their main activities and levels of collaboration with TEHIP in Morogoro (R) District (for illustrative purposes only)

Health Care Provider	Major Activity	Level of Collaboration
UNICEF	Child survival especially immunization	Mutual consultation. IMCI partner
World Vision (T)	Various in the social sector. In health mostly maternal and child health	Sharing of reports
DFID	Adult Mortality and Morbidity Project (AMMP)	Official technical collaborator in morbidity and mortality studies Official collaborator in Component C of research
KEPA a Finnish Organisation	Community-based rehabilitation. Rehabilitation of facilities and equipment; solar power	Technical consultation.
DANIDA	Drug kits, EPI/Vaccines,	Official facilitator of the cold chain. Main donor in the Health sector. Support includes HSR and HMIS
GTZ	Construction and rehabilitation of facilities (in the national parks)	Sharing of reports
Catholic Church	Clinical care. Has hospitals and dispensaries. Outreach programmes. Radio communication.	Major health care provider. Provides report to DMO. Training facilities.
Mtibwa Sugar Company	Clinical care. Has a major hospital. MCH services	Supervision Reports to DMO
UMATI	Major player in MCH and especially FP	Has donated supplies e.g. delivery beds.

Integration here refers to the extent of co-ordination of activities of different organization.

In TEHIP integration is important for several reasons:

1. All significant activities in health have the potential of producing confounders to the project's impacts. For example, a significant health care provider who uses other interventions in treating children may be responsible for higher morbidity or mortality or for other outcomes.

2. Other providers may have special contributions which TEHIP may not be in a position to offer for economic or other reason. This is the case with AMMP project where TEHIP decided not to "re-invent the wheel" when the MOH/DFID project has the data that TEHIP needs for its work.

3. Other providers may reduce the work burden of the DHMT staff if it is shared with others e.g. the supervision of neighbouring dispensaries by Mtibwa Sugar Company freeing the DHMT for other equally important work.

It seems that all the significant health care providers in Morogoro (R) whom we looked at are well integrated into the project -- participating in training, reporting, assisting with supervision, providing the required interventions.

CHAPTER 3

Environmental Context

3.1 Stakeholders' view of TEHIP in general

As identified in the Project Document and also after the start of implementation local stakeholders in the TEHIP have been identified as EHIP itself, the Ministry of Health, the Ministry of Regional Administration and Local Government, Regional Authorities, i.e. the Office to the Regional Administrative Secretary, the office of the Regional Medical Officer, the District Executive Director, the District Medical Officer and the community. Other stakeholders include the Government of Canada and its organizations - the Canadian International Development Agency (CIDA) and the International Development Research Centre (IDRC) -- as well as international organisations such as the World Bank, WHO and UNICEF. Their roles are examined in greater detail in Chapter 4.

From interviews carried out during the evaluation all the above stakeholders seem to have a positive impression of the project. From the Ministry of Health's point of view the TEHIP objectives are in line with the national health policy of reducing morbidity and mortality (the burden of disease) through the implementation of various initiatives, some of which are also to be found in the TEHIP ideology. The Ministry relies on TEHIP to find a workable formula, applicable in the whole country for providing health care in an equitable fashion with the meagre resources at hand.

TEHIP came along as the Ministry of Health started to work towards Health Sector Reforms in 1993. As mentioned earlier (Ref. Fig 1) the principles of TEHIP are in line with the Ministry's Health Sector Reform objectives. To underscore this, the Ministry has been working very closely with TEHIP e.g. with the Health Management Information System, the Health Systems Research Unit the Building Unit of the Planning Directorate in aspects of health information and the support for rehabilitation of health units respectively; the Preventive Services for matters related to policy and the Primary Health Care Secretariat for technical matters.

The Ministry of Regional Administration and Local Government both at central-ministerial and regional-administrative levels and district authorities as implementors and beneficiaries at the same time, assign great value on the project. Through different kinds of support they receive from the project, for example, training, drug supply, transport facilities and funding, the two districts have managed to implement programmes which would not have been implemented in the absence of its support. A recurring observation during the Evaluation Team's visit to the districts was the optimism with which DHMTs and the District Administration in general view the future of health services in the era of TEHIP and beyond. In both districts respondents reported of the extreme frustration of having ideas without the wherewithal to implement them, of coming to the office in the morning and going back in the evening without performing a day's worth of work. Those days have been replaced by too much work but it is a change they are happy to accommodate.

For many members of the DHMT this is the first time in their working lives that plans and budget and implementation have any correlation at all. In the past planning was carried out as a matter of routine and no relationship existed between the plans and what was allocated.

It was common to get a very small fraction of what was requested and therefore only a minimum of planned activities could be implemented.

The project has therefore acted as an incentive because district plans have a chance of becoming a reality with the support the districts get from the project. Many districts in Tanzania fail to implement their health plans because of setbacks that include lack of planning skills. The introduction of training in planning and budgeting at the district level and other TEHIP's effort at Human Resources Development have started to bear fruit and are much appreciated.

Service providers at peripheral facilities report greater satisfaction of their clients for services provided but paradoxically the improvement in services has accelerated demand to the point where the facilities may fail to cope. In one facility that the Team visited the Head of the Dispensary reported that they now see up to 200 outpatients per day instead of the 20 or so they were used to. This tenfold increase, the Clinician observed, could overwhelm even the improved capacity.

Supervision is taking place, thanks to ready availability of transport but the supervision system needs to take into account the difficulty of supervising all facilities from the centre. This is not only too much time-consuming and a burden on a health management team already visibly overstretched but quite unnecessary and in the end unsustainable. A supervision cascade involving other units as well should replace this.

The communities which are directly benefiting from the project have noticed an improvement in services even if few know of TEHIP as a project, which is just as well since TEHIP should ideally not resort to being another well-known but unsustainable vertical project. Through the project, the Essential Drug kit which used to last for 15 - 20 days, now lasts for a whole month as much because of good management associated with the project as with the additional supplies that come along as a result of the IMCI initiatives. That is what communities want. The Health Financing studies [10] done in 1993 showed that patients normally only go to health facilities if they have drugs.

From the interviews made with the patients and the providers it was reported that the scramble for drugs at the beginning of the month is a thing of the past. There are just as many patients attending the Outpatient Department at the beginning of the month as at month-end.

The World Bank has expressed much interest in the project and intends to use the results coming out of the research to guide its own programmes in the country. UNICEF reportedly consults the project regularly and co-ordination in Morogoro, where it runs a Child Survival programme, is very close.

CIDA considers TEHIP a flagship Canadian project with great potential to influence direction of major international donors including itself.

3.2 Infrastructure and ancillary services

The provision of quality health services to a greater or lesser degree depends also on the condition of health facilities. Generally in Tanzania, the physical quality of the health facilities is very poor and most fall short

[10]Brian Abel=Smith and Pankaj Rawal, Health Financing Studies in Tanzania, 1993

of acceptable condition. A survey conducted in 1983/84 by the Ministry of Health/SIDA showed that only 660 dispensaries out of 1800 were in good condition, while 810 were classified as fair and 330 as below acceptable condition[11]. Another situation analysis of health facilities in Mbinga and Songea Rural health centres and dispensaries showed that 20% and 16% respectively were in bad condition[12]. The situation of the facilities in the two TEHIP districts is not different from the situation described above.

Mutombozi dispensary, in Morogoro Rural, which was visited by the Team was built in the thirties but no form of rehabilitation has been provided in living memory.

Rehabilitation of some of the dilapidated facilities has started. To date three facilities in Morogoro Rural District and four in Rufiji have been rehabilitated. At least the one district authority we saw seemed to consider this more important than perhaps some of the other TEHIP inputs. The participation of DED's in this activity is widely acknowledged including motivating communities to participate. In the end the communities donated more than 50% of the labour required to carry out this highly visible activity. We make a comment about the shortcomings of Community participation in this project elsewhere.

Apart from the obvious value of providing a good place to provide services in, rehabilitation of health facilities in this project is a good entry point to better community participation and involvement. The idea of community participation is very important because experience in Tanzania has shown that many health facilities which were built by the government without community involvement depreciated after a short period because no rehabilitation or preventive maintenance were done by the users who considered them to be government property and therefore government responsibility. The only way to sustain these facilities is to involve the communities themselves as designed by TEHIP. Establishment of a community fund might be a good way of preventing future rapid descent into deterioration.

TEHIP has assisted very much in installing or improving infrastructure. Each of the districts has two computers and access to telephone and telefax at least at the district level. An E-mail facility is available. Morogoro is more easily accessible by telephone and telefax from Dar es Salaam at least but peripheral facilities are hard to reach even by road. During the rainy season 50% of all facilities in Morogoro are unreachable. Each of the districts has been allocated one hard-top Land cruiser and 7 motor cycles although not all have been requisitioned.

Rufiji is dissected by the River and so while it is easy to reach the Eastern side of the district it is next to impossible to reach the other side where the district capital is located. Fortunately there are DHMT members on the Eastern side of the river as well and therefore things do not come to a complete standstill when the floods hit. The research station is also located on the eastern side at Ikwiriri, and is therefore easily reachable.

UMATI, the Family Planning Organisation, has assisted with provision of infrastructure such as beds and delivery equipment.

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[11]Ministry of Health/SIDA, Evaluation of Health Facilities Report, Unpublished, 1984

[12]Peter Ilomo, Situation Analysis of Health Facilities in Songea (R) and Mbinga Districts, Ministry of Health, 1992

Drugs and vaccines are available in sufficient quantities. The cold chain works. The minimum essential equipment for a well functioning dispensary is reported to be available and were seen during the Team's visit to four health facilities.

3.3 Decentralization

Decentralization is the transfer or delegation of legal and political authority to plan, make decisions and manage public functions from the national level to the district, local bodies or sub-ordinating organizations[13] . Decentralization is more often than not an uphill process because it rarely receive wholehearted support from authorities who naturally do not wish to devolve power and resources. What often passes for decentralisation therefore is actually de-congestion or deconcentration where responsibilities are assigned to the periphery without adequate power and resources to implement them. The most ambitious decentralisation process in Tanzania took place in 1972 with the following objectives:

a) To transfer real power to the regions and thus reduce the load of work at the centre and on remote areas.

b) To bring political and administrative control over services to the point where they are actually delivered by improving accountability and effectiveness, and promoting people's feeling of ownership of programmes and projects executed in the districts.

c) To free local managers from central constraints and as a long term goal, to allow them to develop organizational structures tailored to local circumstances.

d) To improve financial accountability by establishing a clear link between the revenue generated in the districts and the provision of services they finance.

e) To improve the capacity of local councils to plan, finance, and manage the delivery of services to their constituents.

The fact that policy-makers are still talking of effecting decentralisation twenty-seven years down the line from the time decentralisation was pronounced is indicative of implementational problems, to put it mildly. It is quite obvious that decentralisation has not fully taken root.

The difference between decentralisation practice then and now is that whereas the region became the centre of decentralised power in the seventies, the main focus now is the district. This type of decentralisation is aimed at transferring administrative and political power to the district to empower communities to participate and take responsibility for effectiveness, efficiency and equity in the provision of health care. The aim of carrying out decentralisation to its logical conclusion is important because if it is left halfway, at the district level the government will have merely shifted power from one bureaucratic entity to another one just a rung down the administrative ladder. Decentralisation must go further to the communities.The design of the TEHIP project is in line with the decentralization policy.

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[13]Randinelly et al, Paper presented by Issa Makumbi during the Eastern African Region Health Planners and Trainers Conference, Kampala, Uganda

The implementors in this case are the local authorities with support from the central and regional levels. Unfortunately TEHIP involved neither the local authorities nor the communities during the design stage of the project and in this regard it is as top-down as the other health projects that are designed outside and imposed on the "beneficiaries". This initially had a negative image among the district health and administrative persons. Perhaps this was the reason almost the whole of the first year was used to mobilise the districts to prepare them to implement the TEHIP ideas.

During the second year of implementation, the project started working well in the context of almost full decentralisation. The district has completely taken ownership of the project and it has become part and parcel of the district activities. The districts fully accept the project because it is an expression of their major perceived needs. DHMTs report having adequate control over resources and decision making related to health matters in the district. There is no gross interference from the district administration. The DMO is a co-signatory of Account Number 6 alongside the DED and therefore financial resources designated for health may not be translocated to other activities of the district council.

Throughout the implementation of TEHIP, the resource envelope for the district health services has expanded. Currently, the per capita health allocation for these districts is approximately US$4 and TEHIP is contributing US$2 therefore increasing the resources available for health services to the tune of USD 6 per capita. The per capita expenditure in the thirty-five districts going to implement the Health Sector Reforms is estimated at USD 6.6 during 1999/2000. When TEHIP finally folds up, as all projects must, and with increasing demand for services prompted by TEHIP one wonders how sustainable this financial envelope is. In other words the districts have to start thinking on this important aspect.

A worrying aspect of the kind of decentralisation currently existing is the weak independent resources base of the district. The districts are still quite incapable of raising their own funds to run their own social services and therefore they depend heavily on Central Government subvention. The Central Government subvents money to the districts in three ways:

1. Pays the salaries of all health staff (including support staff).

2. Foots the bill for drugs.

3. Pays for "other charges" which is bureaucratic language for things such as energy.

It was reported by a District Executive Director that there are no problems with regard to this money being disbursed to the district anymore. It comes as budgeted and on time. The DED believes districts will gradually allocate money to health services to the point where they are carrying most of the burden of their health care.

3.4 Local Government Reforms

The Local Government reforms agenda which is part of the decentralisation policy of 1972 started in 199(and in that agenda the government set its vision for the future of Local Government in Tanzania. The local government reforms encompass the social sector reforms in Health, Education and Water.

From the Local Government Reforms documents, Local Governments are expected and encouraged to:

i) be more autonomous.
ii) operate in a transparent and democratic manner.
iii) be responsible for their own staff.
iv) have more trained human resource capacity.
v) have more financial resources.
vi) have greater financial management capacity.
vii) provide more equitable and better quality services.

Although TEHIP was designed prior to the establishment of Local Government Reforms, its success will depend very much on the implementation of these Local Government Reforms especially during the period beyond the project's life span. The TEHIP objectives in the district including human resource development, strengthening planning processes, integration of activities, testing the different processes can be seen as part of implementing the Local Government Reforms because they are all part of district-focussed capacity building.

TEHIP activities should ideally involve the participation of the whole population which is also one of the aims of local government reforms. The local government has the responsibility for social development and provision of public services including health within their areas of responsibility therefore local governments are naturally supportive of TEHIP activities.

According to the Local Government Reforms thirty-five districts have been selected to start implementing the reforms soon. Any of the remaining sixty five may apply to join the first thirty five if their financial base is healthy among other criteria. Both Rufiji and Morogoro (R) having the added advantage of being hosts to TEHIP, one of the most outstanding health sector reform projects in the country, could apply to start the other local government reforms processes effecting decentralisation even further but have elected to enter in Year 2.

District Health Boards are mentioned in HSR and Local Government reform documents but none of the two districts has a functioning board. The presence of these boards would have been very instrumental in overseeing the implementation and sustainability of the project ideas and functions because they are directly answerable to the people through their district councils. Apparently the issue of boards is still controversial and is still being studied in several pilot districts. Meanwhile the District PHC Committee is the only body overseeing health in the district.

CHAPTER 4

Organizational Contex t

Since the very beginning of the project a number of partners have been associated with it. This chapter discusses the role of each.

4.1 Roles of Partner Agencies of EHIP/TEHIP

4.1.1 International Development Research Centre (IDRC)

In 1993 while CIDA was consideering scaling down its support to the Health Sector in Eastern Africa, it found the EHIP proposal a challenging one and agreed to provide the financial support required to initiate the project.

The main roles of CIDA in EHIP/TEHIP are summarised in the Project Document as follows:

- Capitalizing on its wide and long experience working with governments and institutions, IDRC will provide technical support especially on the research endeavours.
- EARO Nairobi will represent IDRC on the (former) EHIP International Advisory Committee (now known as the PSC.).
- EHIP will assist TEHIP in monitoring the project including the research component.
- IDRC will assist TEHIP Project Manager to establish effective financial management systems and to provide on-going advice and guidance on financial administration.
- IDRC will advise TEHIP staff to operate the defined financial management and accounting system.
- Provide continuous support to TEHIP on financial reporting and accounting.

According to the Memorandum of Understanding (MOU) IDRC and the Ministry of Health are named as implementing partners for the project. In the project document the role of EHIP Secretariat in Ottawa which subsequently moved to Nairobi, together with TEHIP in Dar es Salaam is to manage the delivery of resources to Tanzania both at the National and at the District level. They are overall responsible for the general direction and financial control of Canadian inputs. IDRC is as interested in the project lessons and outcome as are the people in the project districts because lessons learnt there can be replicated in other areas where IDRC has programmes.

In the project document seven activities have been listed as IDRC/EHIP responsibility namely:

Activity number 401 - Prepare Project Approval Documents:

EHIP Secretariat, through its Executive Director, will prepare a Memorandum of Understanding between Canada and Tanzania and the Project Document which outlines the project plan. The Project Document shows that it was signed by IDRC on behalf of the Canadian Government and the Principal Secretary of the Ministry of Health on behalf of the Tanzanian Government, on the 14th October 1996. A separate MOU between the two governments was signed by the Ministry of Finance and the Canadian High Commissioner on the same date.

Activity Number 402 - Recruit and Select Senior TEHIP Project Managers:

The Senior Project Staff were recruited and contracted following the correct recruitment procedures of advertising, short- listing and interviewing. The process assures the choice of Managers who possess the necessary qualifications and experience. This is evidenced by the high degree of professionalism shown in the implementation of the project.

Activity Number 403 - Liaise with the Government of Tanzania:

The Executive Director is charged with the responsibility of liaising with the Government of Tanzania. She is a member of the PSC, which she also co-chairs. However, it is not clearly described how the co-chairing role is to be shared with the Permanent Secretary. Is it alternatively, yearly or by convenience? Clarification is desirable. Recently in March, 1999, the Executive Director visited the project in Rufiji where she met with people and saw the implementation of activities. Her visit was viewed positively by the MOH. The Project Coordinator acts as the main link between TEHIP and the Government of Tanzania, a role he is reported to be playing well.

Activity Number 404 - Liaise with Donor Agencies:

The Agencies collaborating with TEHIP include DFID, CIDA, UNICEF, WB and WHO. These Agencies were very useful in the developmental stages of the project but at this stage of implementation their role has very much diminished. With the exception of DFID the role of the others has been reduced to mere membership in one or the other of the project committees. After the developmental stages, on the macro level, the two agencies which matter most to TEHIP are IDRC and the MOH and on the micro level, the AMMP. Details of collaboration with these agencies, are shown separately.

The Project Manager attends the monthly Health and Population donor meetings where most significant health sector donors are regular participants.

Activity Number 405 - Provide Project Support and Transfer Resources:

Support and transfer of resources has been effected, although initially with some operational and logistical difficulties. In particular, the use of a computer accounting system sometimes negatively affected transfer of funds. However, as the project gains experience the process of transfer of funds is no longer a major problem. This matter is mentioned again under "Funding Strategies".

The Financial Controller in EARO has also provided required computer training, training on IDRC financial procedures, and has participated in the internal audit of the project together with an officer from IDRC, Ottawa.

The Project Officer has provided an effective link between the project management in Dar es Salaam and the Executive Director and Financial Controller in Nairobi and also with IDRC Headquarters in Ottawa where further links with other IDRC projects have been forged e.g. eco-health.

Activity Number 406 - Attend Project Management and Advisory Committee Meetings:

The Executive Director has attended the statutory International Advisory Committee/Project Steering Committee meetings to which she is co-chair. This is where annual plans and budgets are approved. She has been involved and has contributed to the direction, progress and performance of the project since its conceptualization.

Activity Number 407 - Monitor and Evaluate EHIP/TEHIP:

Monitoring of progress achieved by the project is the responsibility of IDRC/EHIP Secretariat. Accordingly, the Secretariat in conjunction with the Ministry of Health is charged with the task of contracting a Project Evaluator to perform a comprehensive project evaluation of EHIP/TEHIP from year 1 to the conclusion of the project in year 4. The evaluation part has not been carried out according to plan until now. This is the first comprehensive evaluation of EHIP/TEHIP. Two earlier attempts to produce an evaluation framework were unsuccessful.

Monitoring, on the other hand is done through a number of activities. The quarterly reports which are copied to EHIP and the MOH form an important part of the monitoring process. The Project Officer participates in PSC meetings where she takes minutes. She also attends the SAC meetings in which she is the Secretary. This monitoring function moved to Nairobi from Ottawa in December 1997. The move gives IDRC better ability to support from much closer and at a lower cost. Ideally, it should have moved to Dar es Salaam but it is more effective when located in Nairobi because the Financial Controller and the Executive Director are located there. From EARO they are therefore able to plan and provide support and feedback on other projects in the Region also.

Financial Management:

SWOT analysis indicates the presence of a strong financial management. However, IDRC uses an old computer programme for the accounting system which is not only outdated but is restrictive in scope and will not meet the procedures followed by the Government of Tanzania. It is recommended to put in place a more appropriate software.

4.1.2 The World Bank

In the project write-up, the role of the World Bank (WB) is to provide EHIP with technical assistance in project design as well as advice on cost effective analyses. A WB Officer interviewed reported that the World Bank has not made any monetary contribution since the inception of the project. The WDR93 document which acted as the blueprint to EHIP design is the most important WB contribution to date. Some technical support is provided through the regular participation of a local WB Health Officer in the Project's Steering Committee meetings. No support is provided by WB in cost-effective analysis as planned and described in the Project Document. EHIP might wish to remind partners of their assigned roles.

The WB, however, has interest in TEHIP work and is closely following development through its Dar es Salaam Office. TEHIP on the other hand shares the lessons learnt from its research component with the WB and the MOH in their study in Igunga district. IDRC and the Project Team acknowledge the

intellectual contribution of WB during PSC meetings. The Executive Director has been to the WB to discuss future funding options but no additional funds have been made available yet.

4.1.3 The World Health Organization (WHO)

WHO Geneva has been involved in the project conceptualization and design from the beginning. Initially WHO was also interested in implementing the project because it was pessimistic over IDRC's ability to implement a Health-related project given IDRC's low profile in the health sector. The current role of WHO is to provide advice and technical expertise regarding the development of packages of essential health interventions. Some highlights on WHO's contribution to TEHIP:

A specific MOU between WHO and IDRC was signed on May 13th 1995 in which IDRC agreed to provide financial support for a four year period beginning July 1st 1995 to June 30th 1999 where WHO would for its part provide technical support to the health interventions taking place in the project. The first year payment was CAD235,788 or US$170,860.

WHO support is provided through the country office in Dar es Salaam. TEHIP has been established in the WHO Country Office. The most important WHO inputs are given through its support to the Districts in implementing these selected interventions:

- Integrated Management of Childhood Illnesses (IMCI) packages
- Malaria control through the use of Insecticide Treated Nets (ITN)
- Treatment of TB and LEPROSY using DOTs - Directly Observable Treatment Schemes
- Management of sexually transmitted diseases through the syndromic approach (which is also a strategy in controlling HIV).

WHO has seconded a technical officer who is a paediatrician by training. The Officer teams up with the rest of TEHIP staff in building district capacity for planning and implementation of the selected interventions. As a member of the secretariat, the WHO-TEHIP Project Coordinator attends all management and statutory meetings while the WHO country representative is a member of the Project Steering Committee (PSC). From WHO Geneva initially three but now two experts attends the SAC. The WHO support is rated highly valuable and contributes significantly to the project's goals and objectives.

4.1.4 Edna McConnell Clark Foundation:

This organization has since dropped out. One of its last recorded activities in TEHIP was its participation in the first PSC meeting in Morogoro. Its main assigned role was to provide research support and guidance in the implementation of the project. But apparently its line of interest is with school health. However, the evaluation team has not found any recorded official reason why it is dormant.

4.1.5 UNICEF

UNICEF was expected to contribute its experience in policy matters on the delivery of health services at the district level. Its contribution is through its membership in the Project Steering Committee. It does not contribute financial or material inputs. However UNICEF supports the integrated CSDP which targets mothers and children in Morogoro(R). This complements very strongly with the TEHIP- spearheaded

IMCI interventions. It was widely reported in the field that there is much integration between TEHIP and UNICEF. The Evaluation Team saw collaboration in implementation of many activities.

4.1.6 CIDA

CIDA has been the main inter-governmental bridge between Canada and Tanzania. With funds from the treasury. CIDA made a one lumpsum transfer to IDRC of US$16.0 million at the very beginning of the project and did not require IDRC to account for it. According to the agreement this is the whole amount. IDRC is charged with the responsibility of managing the funds. IDRC administers some funds directly and transfers to TEHIP some amounts according to agreement. However, in its 1998 annual report, TEHIP lists initial delay in remitting funds to the MOH/TEHIP account as the most significant constraint. Apart from financial support, CIDA has membership in the Project Steering Committee where it is represented by the First Secretary from the High Commission in Dar es Salaam. Their main contribution in the TEHIP meetings is in project plans, activities and the budget. CIDA has contributed in mainstreaming TEHIP in the HSR process through its high level contacts with government officials.

4.1.7 UNDP

In the Project Document UNDP appears as one of the organizations having a role in the project. However there is no direct role played by UNDP except as a UN lead organization.

4.1.8 DFID

The most important role of DFID in the project is the AMMP which DFID supports in three Districts including Morogoro Rural. The project provides epidemiological data which is required in the component C of the TEHIP research. TEHIP has proposed to AMMP to collaborate in starting a similaer project in Rufiji District.TEHIP will use the epidemiological data thus obtained from AMMP for its research component C in the same way as in Morogoro. Otherwise, a solid and reciprocal relationship exists between TEHIP and AMMP.

4.2 Roles of Central Ministries - Tanzania

4.2.1 Ministry of Health:

The Government of Tanzania, represented by the Ministry of Health, is responsible for the following activities:

Activity Number 501 - Sign Project Document (Project Plan)

The MOH and IDRC signed a MOU on 14th October, 1996 in Dar es Salaam. This endorsed the plan and implementation strategy. It confirms the acceptance and commitment of the MOH to the project. This further reconfirmed the MOH intention expressed at the Ottawa conference where Tanzania showed her interest in the project leading to the subsequent submission of its proposal.

Activity Number 502 - Assist TEHIP Establish a Project Office

The establishment of a suitable office was a problem at the beginning as not much office space was available at the MOH. Initially, in year one, all staff were located in one room within the Ministry's building complex. Subsequently, TEHIP rented space from the NIMR compound which was adequate to accommodate all project staff. There is also a conference room, which is adequate for about twenty people. TEHIP has provided to AMMP two office rooms and shares the rental charges. An open office arrangement has been adopted and this is reported to promote accessibility. Does it offer privacy in discussions with visitors or on confidential matters ? When asked about their feelings on the office arrangement which is rather unfamiliar in the Tanzanian context, all staff claimed they were comfortable with the arrangement. The conference room is availablefor confidential discussions if necessary. The Accounts department has a separate office.

Activity Number 503 - Manage and Administer TEHIP

The TEHIP Project Manager and the ACMO-P (now known as the DPS - Director of Preventive Services) representing the Ministry of Health are jointly charged with managing the project. In this regard, the Ministry has been able to provide the following support to the project:

- The DPS, through participation as Co-chair in the Project Operations Committee and Project Steering Committee meetings, has been party to all major planning and management decisions.
- The Ministry of Health assisted TEHIP to procure office accommodation.
- The Ministry has seconded to TEHIP the Project Coordinator and the Research Coordinator as well as seconding to WHO, the WHO Technical officer.
- According to the Project Document, the MOH is supposed to facilitate, through the PMO (The Ministry of Local Government and Regional Government) health funding support to the Project Districts. There is no evidence that this is happening at the Central level. At the District level no regular funds have come from the Local Government to the Project Districts.
- The MOH has been able to review and approve project plans and budget usually in the PSC meetings.
- From the Project Document, it was expected that the Ministry of Health would also provide support to the project in Rufiji and Morogoro (Rural) Districts through other Central Ministries, like the Ministry of Regional Administration and the Ministry of Local Government. This has proved to be a difficult role for the MOH to assume. To date no technical support from any ministry has been forthcoming.
- It was also expected that the MOH will maintain a clear line of communication with participating Government of Tanzania Ministries, Institutions and Agencies. There are, however, no activities or strategies on how the MOH was to do this. Again, no adverse consequences have resulted from their absence so far.

- The MOH was expected to participate in the monitoring and evaluation of the project. In practice the MOH has been involved in monitoring of the progress of the project through reports and meetings but has not independently monitored or evaluated TEHIP progress. The MOH also monitors the project's progress through its representatives in TEHIP, the Districts and through its membership in POC and PSC. TEHIP reports are sent to the MOH and this offers another means through which the MOH can monitor progress.

Activity Number 504 - Liaise with other GOT Ministries:

This activity is covered under activity 503 also.

Activity 505 - Provide Support to Decentralization

The Ministry of Health has provided support to the process of decentralization and formation of DHMTs. The MOH has provided policy guide and training together with resource allocation in the form of salaries, drug kits and equipment and motor vehicles. These are from vertical programs run from the MOH such as TB/LEP, NID, EPI and Malaria Control. This is also covered under the section on Health Sector Reforms.

Activity Number 506 - Attend Management and Advisory Meetings:

The Permanent Secretary, the Chief Medical Officer, the Director of Preventive Services and one Research Officer from the Directorate of Planning have attended the following statutory meetings:

• EHIP International Advisory Committee	- The Principal Secretary
• EHIP Scientific Advisory Committee	- Senior Medical Officer, Planning
• EHIP Project Steering Committee	- The Principal Secretary - The Chief Medical Officer
• EHIP Project Operations Committee	- The Director of Preventive Services (Co-Chair) - Head PHC Secretariat

4.2.2 Prime Minister's Office, Ministry of Local Government and Regional Administration

The Central Government at the Regional and District levels is under pressure from demands from other sectors as well. These include demands from the political, economic, educational, and health sectors. The Regional and Local Government Authorities are expected to fund all these plans and activities submitted to them but their capacity is low.

- The PMO/Ministry of Local Government and Regional Administration has, through the DED's supported and fully co-operated in the project implementation strategy. For example they have mobilized political support in Rufiji where there was initial reservations from some communities.
- Has supported the process of decentralization to the DMO and DHMT in both Mororogo (R)and Rufiji.
- Funding has continued in personnel salaries in the districts and drug kit supplies from the Central Government. No funds from the Local Government's District Councils have been given except only token amounts in Morogoro.
- In data collection and delivery of essential health interventions the Regional and District authorities have played important roles in advocacy, motivation and mobilization.
- The PM/MLG are represented at the PSC; and DEDs are members of the POC.

The Regional Medical Officer is providing only marginal technical support related mainly with policy. Being the secretary to the Regional Primary Health Care Committee, the RMO has acted as link between the Regional Administration and TEHIP, but this was observed as a very weak link.

4.2.3 Ministry of Community Development:

The team was not able to verify any significant role of the Ministry of Community Development other than its membership in the PSC, represented by the Assistant Commissioner for Community Development.

4.2.4 Ministry of Women's Affairs and Children:

Here also it was not possible to verify any significant role played by the Ministry of Women Affairs and Children. However, women and children are a significant proportion of the target beneficiaries and therefore the Ministry should be brought back in.

4.2.5 Ministry of Education:

We were not able to verify any significant role played by the Ministry of Education. The DMO and DHMT's did not list this Ministry as a key player. However, they listed the Ministry of Education as one they collaborate with in the compilation of lesson plans regarding health education teaching in schools.

4.2.6 Ministry of Agriculture:

This Ministry has not played any significant role.

4.2.7 Ministry of Finance:

The Ministry of Finance has continued to fulfil its obligations through the PM in its payment of funds/allocation from the Treasury accordingly. This is supporting salaries and drug kits. No defaulting was recorded. The MOF signed the MOU on behalf of the Government of Tanzania.

4.3 Coordination with existing Projects and Programmes

4.3.1 AMMP

The Adult Morbidity and Mortality Project collects cause specific morbidity and mortality data in its three project sites, Morogoro Rural, Dar es Salaam and Hai. The project conducts yearly census to obtain estimates of age, sex, causes of death and morbidity. This is essentially component C of TEHIP research agenda and some of this data could be used as baseline data for TEHIP. TEHIP therefore collaborates with AMMP in Morogoro and uses AMMP data. TEHIP and AMMP have agreed in principle to jointly start a similar project in Rufiji. (See 4.1.8)

4.3.2 Child Survival and Development Programme (CSDP):

This UNICEF- supported project aims at improving chances of child survival through childhood illnesses, and growth and development to normal and productive adults mostly through immunization and educational interventions. Their strategy includes incurring of substantial amounts of money for payment of allowances as well as for providing vaccines. Perhaps for this reason CSDP is very popular in the field. Despite this observation there were no negative impacts on TEHIP. Health workers respect TEHIP for what it is. CSDP has not made life more difficult for TEHIP.

4.3.3 National Institute for Medical Research (NIMR)

Relations between NIMR and TEHIP are candid and hold much potential.

- NIMR is facing hard financial times. Its top long-serving management changed in 1997/1998. Its philosophy and operational arrangement is being reviewed. Under these circumstances, NIMR has not been able to assume its prominent role as the foremost national health research organ. Even under these circumstances NIMR contribution to TEHIP has been in:
  - Participation in the initial assessments.
  - The initial drafting of project design.
  - Joint weekly health science seminars.
  - Provision of technical advice and support as a member of the Scientific Advisory Committee.
  - Rental of real estate to TEHIP.
- NIMR has a very long experience in Malaria research which it can share with TEHIP.
- NIMR could be the institution that could inherit and become the custodian of TEHIP ideas and functions should it have an extension or need to institutionalize.
- Relations with NIMR hold great potential and should be cultivated.

4.4 Project Organizational Structure - EHIP

There are three committees that oversee and support the work of EHIP/TEHIP. Some respondents felt that three committees may be a bit too many especially when it is considered that there are also other small functional entities within the project. In all, it is estimated that there are over one hundred EHIP/TEHIP sittings a year or about two sittings a week which are considered to take too much time. One suggestion given was to trim down the committee structure further to, say, two while increasing the role and mandate of one or spreading the mandates wider between the two remaining committees. In the beginning, it is argued by the protagonists of this view, three committees may have been necessary but maybe three full-fledged committees can no longer be justified and the Evaluation Team recommends to the management to examine and review the structure and functions of the committees.

4.4.1 Scientific Advisory Committee (SAC)

The SAC is charged with the responsibility of providing leadership in the development of plans and continuous professional support necessary to address the three essential project questions:

- In fulfilling its role, the SAC has been meeting once a year. When necessary, a "mini-SAC" comprising of a selection of persons from the SAC is convened for example when an issue has cropped up that demands SAC counsel.
- SAC provides advice and guidance on project design and plans.
- SAC has continually provided technical monitoring and evaluation of research activities.
- SAC has provided guidance and direction on scientific issues and on ethical matters.
- SAC reviewed and selected the research consortia and their proposals.

TEHIP being a research and development project values the SAC very much, it was noted. The composition of the SAC is highly professional, since its membership selection is based on individual

qualifications and experience. Those interviewed were very happy with the membership and performance of SAC.

4.5 Project Organizational Structure - Tanzania

The process followed in recruiting and appointing all project officers was competitive and transparent. This gave the project the opportunity of obtaining the best in the job market. The process followed entailed advertising, interviewing and contracting/secondment.

4.5.1 TEHIP Project Staffing:

What appears as a confusing or crowded set up of "counterparting" between National and IDRC - EHIP staff is not so in practice. There are clear rules, regulations and lines of communication within the TEHIP project team which are observed. There is evidence of strong teamwork and real collegiality. There is much consultation and professionalism in the project set up and operations.

There is no evidence of any discrimination based on gender, colour, religion or political affiliation. However, it is noted that the project is very much male-dominated while the consumers of its services and targets of its interventions are overwhelmingly women and children. It is said that this gender imbalance is not intentional and in any case does not differ much from the existing picture in the country. The only reason there are few females in the project is because of the existing reality in the country and the world in general. While there is no statutory affirmative action in place, the project promotes women's participation. Also it should be noted that there is good women representation in the committees. The Evaluation Team recommends more deliberate gender sensitivity and would like to suggest the inclusion of the Ministry of Women's Affairs and Children into the POC in order to get more views from this important ministry which is charged with the role of looking after women's affairs.

There is no evidence of friction or hostility. The selection process for the project staff was fair. IDRC-EHIP Secretariat and the DPS of the MOH provide further closer support for project management and direction.

The four counterparts - Project Manager/ Project Coordinator, Research Manager/Research Coordinator are ably supported by the Finance and Administration Manager, Project Administrator and Project Office Manager each of whom has a contract from TEHIP. Financial remuneration for the Tanzanian staff, as mentioned elsewhere, is satisfactory but there is worry as to what will happen to them after Project life as jobs are hard to come by nowadays.

4.5.2 Project Steering Committee (PSC)

In many ways the PSC acts as the Board of Governors, responsible for providing over all project direction and policy. It approves project annual work plans and the budget. This committee is chaired alternately between the MOH and IDRC-EHIP Secretariat. The Project Manager acts as its secretary but sometimes the Project Officer too. The Senior staff attend as ex-officio.

In practice the PSC has met according to plans initially once a year but now twice yearly. Sometimes it is felt that it could be a bit more critical or exploratory. It has endorsed 100% of all project plans and

budgets as have been prepared and presented to it by TEHIP management without offering much challenge. It is obvious that the TEHIP Management takes great trouble in preparing documents before the meetings but the PSC could provide more challenge and examine alternatives in order to be of greater use to the project.

4.5.3 Project Operations Committee (POC)

The POC is a very important link between the MOH, TEHIP and the Districts. As the process of Health Sector Reform gains momentum, and with it, decentralization to the Districts many decisions will take place outside the Regional or MOH headquarters level. The TEHIP research activities are increasingly taking place at the districts. The need of strong and effective operations committee can not be overstated. Some of its achievements have been documented as:

- it has established an effective delivery system of TEHIP resources to the districts;
- it has assisted in coordinating project services and supplies;
- it has established effective communication channels and linkages between interested parties;
- it has reviewed documents, annual work plans, budgets, performance and progress:
- it has been effective in monitoring progress and performance activities.

This committee meets quarterly and is co-chaired by the Director of Preventive Services. It is however proposed that the DED or DC chairs the committee for the DMO, the DHMT and the District Health Services are directly under the Local Government. A chairperson from the Local Government will be merely putting in practice the main doctrine of the National Health Sector Reforms - this being in reality a health sector reform project. If chaired by someone from the MLG it would give the project strong ownership by the MLG which should actually be the organization with the greatest interest in HSR.