CHAPTER 5

Information Management

5.1 Information System:

Information is the life blood of any organization. An efficient system contributes significantly to achievement of goals and objectives. The information system in TEHIP is for the most part very well set up and has capacity to meet most of the information needs of the project.

The system consists of a network that places the TEHIP Headquarters at its hub with connections reaching the EHIP office based in EARO, Nairobi, the two project districts, the important stakeholders, various international and national level collaborators and partners through various means of communication.

The district through the DHMT and the District Administration are themselves sub-centres of information coming in from the health facilities and fellow providers in the field. In turn the health facilities are small centres of information coming in from the communities and individuals. All this information is collected, collated and compiled, even analyzed and filtered on its journey upward to its main destination in the TEHIP Headquarters. Formally and informally it is communicated upward through some of the following channels:

1) Telephone:

There are telephone lines available to all Project Staff at Headquarters as well as faxes and e-mail. In addition to office and residential lines, all managers have mobile phones. The Tanzania telecommunication system, recently modernized, makes communication with the outside world reasonably easy.

Morogoro (R) is well-connected by phone, fax and e-mail twenty four hours a day but Rufiji is served by a very old manual system that closes down at 8.00 p.m. and a radio call. Outward to Nairobi, the TEHIP set-up is well-connected. There, too, the Executive Director, Project Officer and other resource persons are easily accessible.

2) Mail:

Both districts are reachable by surface mail through the Tanzania Postal service. In addition the main courier services (DHL and Expedited Mail Service (EMS)) are available especially for Morogoro. Nairobi and the rest of the world are also reachable by all these means as well as a pouch service that connects it to Dar and then to Ottawa and elsewhere. Nairobi and Dar es Salaam are also served by a number of airline services.

3) Computer-based System:

Desktops/laptops are available to all Headquarters Staff. Two desktops are available in each of the two project districts. Besides their use in data work and word processing the computers are also used to store information and to communicate through e-mail. In all, nineteen computer sets are available to the

TEHIP/project district set up in Tanzania as well as thirteen printers and one scanners.

4) Road:

Traveling to Morogoro by road is not difficult at all as it is connected by a tarred all-weather road to Dar es Salaam but traveling within Morogoro to the participating health facilities especially during the rainy season is very difficult. It is reported that 50% of all facilities are unreachable by road during the rainy season.

In Rufiji district, on the other hand, the Rufiji river during the rainy season can become an effective barrier against reaching the district headquarters where the District Medical Officer's office and the District Hospital are. During the rainy season, traveling in Rufiji can be difficult and even dangerous although some of the villages are more reachable than those of Morogoro. Four four-wheel drive vehicles are available at the headquarters and the districts have one each. Morogoro and Rufiji have one motor-cycle each used by their cost-tracking accountants but Morogoro has an additional seven motor-cycles for its peripheral health facilities. Rufiji has one boat also.

5) Radio:

Communication with the District Headquarters in Utete may be accomplished through borrowed radio but plans to instal a project's own solar-powered one are well underway. Since Utete, even though a district headquarters, has no electricity.

6) The TEHIP News:

Launched recently, EHIP has started publishing a colour newsletter called TEHIP News which is used to publicize the work of TEHIP in the region and abroad. The first edition hit the scene a few months ago and a second edition is already in preparation. From all accounts the newsletter is very much appreciated. Plans to present TEHIP News on the TEHIP website are well-advanced.

7) Other Media:

TEHIP has received modest coverage in the public media in Tanzania and outside. Frequent exposure of TEHIP staff in international research and general health events has publicised TEHIP far and wide.

5.2 Tracking Inputs and Outputs

5.2.1 Inputs:

Project inputs refers to financial, physical and human resources.

Financial Resources:

The Tanzania Government's contribution is quoted in the Project Document as CAD3.6 million under 5.0 (Project Finances) and as CAD4.2 million under 1.9 (Project Inputs) as well as in exhibit 7b (Cash flow Budget) in the same document. The variance is a result of quoting different minimum levels of financial

support for the districts. Furthermore, the contribution is not administered through TEHIP but through both Local and Central Governments. As such, from an expenditure perspective this input does not appear in the project's financial statements. . However, information obtained from interviews with MOH and visits to the districts confirms that the government contribution is being effected. To enable better follow up and monitoring, we recommend that reports on every cent spent on health in respective districts should be made available to TEHIP.

On the other hand, IDRC's actual funds released and spent so far are as follows:

Table 5: Actual IDRC Contribution to EHIP/TEHIP (in CAD)

	1993-1996	1996/1997	1997/1998	1998/1999
1. EHIP SECR.	1181403	761633	280940	224285
2. TEHIP activities:				
- Support to MOH	255547	110878	-2986	0
- Support to District	0	0	439085	1076448
- Research Activities	0	0	625625	414779
- TEHIP Mgt. & Adm.	0	493288	907468	989910
- WHO Tech support	154275	241976	66640	0
- EHIP/TEHIP Eval.	18787	4969	8786	25381
Sub-Total	428609	851102	2044618	2506518
Total	1,610,012	1,612,735	2,325,558	2,730,803
Original Budget		4,002,250	4,289,850	4,404,100
Total as % of Budget		40%	54%	62%

Source: EHIP Budget Revision

Prior Years' Costs:

The Evaluators have an observation regarding expenditure under MOH, WHO Technical Support, and EHIP/TEHIP Evaluation. This expenditure during these years (1993-1996) should not have been recorded on TEHIP Account as the MOU was not signed yet. Furthermore, the EHIP budget revision statement and the TEHIP budget (modified to incorporate the actual start-up costs) show different figures of CAD 1,610,012 and CAD 1,389,951 respectively.

As per above data, support to MOH of CAD 363,439 is an additional expenditure item to the activities funded by the IDRC contribution. This will change contribution to the project total costs from CAD 16.4m to CAD 16.9m. Clarification on Support to MOH may be necessary.

Given the rate of fund utilization improving from 40% in 1996/97 to 62% (in 1998/1999), it can be concluded that despite the observed improvement, there is need for increasing spending capacity. Such financial information is found in EHIP's budget revision document which gives expenditures so far and forecast for the rest of the project years.

Physical Resources:

Establishment of TEHIP Office in Dar es Salaam was done. Provision of the premises with reasonable security was facilitated by the MOH at NIMR premises. Furnishing of the office was done by TEHIP and completed. Rent of US$42,117.60 is paid annually.

The TEHIP Headquarters has two Toyota Land cruiser hard-tops and 2 Suzuki four-wheel drives, all still in good running condition and facilitating movement to project districts and town-running. The transport status in the district has been covered elsewhere.

There are also seven desktop computer sets and four laptops at Headquarters as well as six printers. The office is well served with sufficient software for office work and communication. Details on some physical resources are shown in Table 6.

Table 6: **TEHIP Inventory of Important Physical Resources Showing their Location** (for indicative and illustrative purposes only)

DESCRIPTION		QUANTITY							
	EHIP	TEHIP HQ	MOROGORO DED	RUFIJII DED	IKWIRIRI (RUFIJI) RESEARCH	MOROGORO DMO	RUFIJI DMO	MOROGORO RESEARCH	TOTAL
Toyota Land cruiser		2			1	1	1		5
Suzuki 4WD		2							2
Motorcycles			17		16				33
Desk Top Computers		7	1		2	2		2	14
Laptops		4		1	1		1		7
Printers		5		1	2	1		2	11
Scanners		1							1

Source: **Tanzania Essential Health Interventions Project, Purchases made on behalf of TEHIP, TEHIP Districts or TEHIP Research Components**

Human Resources

Recruitment of professionals and supporting staff has been finalized. Attractive packages which include salary, allowances for leave passage, education, house, transport and medical are motivation to employees. Unfortunately, gratuity for TEHIP employees was not included in the MOU.

Essentially the EHIP office is set up to support TEHIP in financial, administrative and technical matters. Most of this support comes to TEHIP through the Executive Director, the Financial Controller and the Project Officer on a day to day basis. Wherever necessary the office contracts the services of short term consultants for identified tasks.

5.2.2 Outputs

- **Visible outputs of the projects are:**

Provisions of Answers to the three essential project questions.

Though the implementation schedule of Research Projects was delayed due to late start of the project, delay in getting the consortia together and inadequate funding, two research reports have been submitted to TEHIP Dar es Salaam. These were from Household Behaviour and Health System components. Obviously the studies that look at impacts will come out much later.

District Health Management Teams are already using Health Management Information System (MTUHA) and preliminary data from research as evidence with which to plan.

This demonstrates acquisition of more skills through provided training to improve performance. More demonstration on ability to plan using evidence will be achieved once adequate research results are made available.

Districts report increased supply of drugs and increased use of Facilities.

Progress is reported in each quarter. Details on IMCI training are given elsewhere.

- Extent of improvement and expansion of health interventions of IMCI, ITN, EDP is documented in quarterly reports. **See SECTIONS 4 and 7** of this report.

- Since the project is under implementation, full output is to be observed at the end of the project.

5.3 Documenting Changes in Costs

Information on documenting changes in cost is found in the financial reports through a comparison of plans and budget against actual expenditure. Explanation of variances both negative and positive shows existence of changes in costs. However, variances do not reflect changes in costs only, but also increase or decrease in expenditure items. For instance, there have been cases where revision of budget was done to reallocate unspent funds to proceeding years budget as a result of low spending capacity at the districts.

5.4 Coverage with TEHIP Interventions

Rufiji District has a population of 179,000 persons some of whom live in the so-called islands of the expansive Rufiji river delta. The project attempts to reach at least 80% of the population with the essential interventions through established services such as immunizations (EPI), essential drugs (EDP), MCH clinics and the like. In Rufiji, a motor boat has been made available for outreach services.

Morogoro (R) has a large population of 539,000, has a larger array of health care providers but almost half of its facilities are unreachable during the rainy season. Most of them are accessible in the dry season.

The essential health interventions being implemented in these districts are:

Public Health:

- Water and sanitation comprising of education on hygienic use of water and sanitation and promotion of latrine construction;
- MCH including FP and immunization (EPI);
- Health education including Nutrition education;
- ITN - Insecticide Treated Nets for malaria prevention

Clinical Interventions

- Integrated Management of Childhood Illnesses (IMCI);
- Management and Control of TB and leprosy using DOTS (Directly Observable Treatment Scheme);
- Syndromic management and control of STDs including HIV/AIDS.

Interventions target under-fives and mothers because most DALYs in this part of the world are contributed by infant and maternal mortality.

Training on these interventions is shown under separate headings. In addition to the above interventions the project has been supporting rehabilitation of run- down health facilities and provision of supplies. These have been discussed in the relevant sections.

5.5 Monitoring and Evaluation System

While routine and periodic monitoring have been done on a continuous basis, the designed evaluation system as described in the project document was not followed. Evaluation was to be done on a yearly basis but two attempts made to prepare evaluation frameworks were not accepted. The third was accepted in the third year of the project. Evaluation is being done after 2 years of implementation.

5.5.1 Routine and Periodic Monitoring

This is done through follow up on reported progress by districts in the Quarterly reports and making physical visits. Districts send monthly reports to TEHIP and TEHIP send reports to EARO on a weekly

basis and prepares quarterly reports to members of the various project Committees, IDRC, MOH, UNICEF, WHO, WB, and CIDA.. It has been observed that while quarterly financial reports provide the required information by IDRC, other users such as MOH may need brief information on previous quarter's performance and budget for the next quarter of the same year. For instance, the fourth report was expected to summarize yearly performance. Information on cumulative performance is an important indicator when assessing achievements over periods and also serves as quick reference. Although monitoring is one of the activities of the project no specific allocation is provided for it.

The research component may be considered routine monitoring as it tracks inputs of the project.

5.6 Financial Aspects

Financial Monitoring and control is handled jointly by the Executive Director through the Financial Controller and the Project Manager in Dar es Salaam through the Finance and Administration Manager. The Financial Controller and the Finance and Administration Manager established an accounting system which adheres to the IDRC format.

5.6.1 Periodic Financial Reports

Financial reports are included in the progress reports which are produced on quarterly basis. They are produced within three weeks of the close of previous reporting period containing details on the amount received during the quarter summary of expenditure and the closing balances. Additional information on foreign exchange rates at the date of report, previous quarter income and expenditure as well as budget of the proceeding quarter should be included in the report.

5.6.2 Financial Audit

The existing accounting and administration manual is silent on financial auditing. An internal audit was carried out in the second year of the project operations but the report is not yet out. It was a concern of the evaluators that while Internal Audits need to be carried out more frequently, external audit should be done at each year end. Good accounting practice requires external audit as an external auditor is the one who produces acceptable audit accounts for official and public use.

5.7 Analysis and use of Funds vs Budget

5.7.1 Tanzania Government Contribution to TEHIP

As the contribution of Tanzania Government is done through local government by paying for salaries, maintenance of real estate and payment of salaries for MOH seconded staff in the districts, its verification is not easy.

5.7.2 IDRC Contribution to EHIP/TEHIP:

Table 7 shows the pattern of IDRC contribution to EHIP/TEHIP.

Table 7: IDRC Contribution to EHIP/TEHIP, Actual Funds Released against original budget (In '000 CAD)

Item	Apr 1996- March 1997			Apr 1997- March 1998			Apr 1998- March 1999		
	Budget	Actual	% Var	Budget	Actual	% Var	Budget	Actual	% Var
Support to MOH		110.9	100	0	-2.9				
Delivery of HI	1865.5	0	-100	2228.5	439.1	-82	2643.5	1076.5	-61
Health Facilities	250	0	-100	250	625.6		100		
Research Projects	866	0	-100	815	907.5	-23	665	414.8	-38
TEHIP Mgt & Adm.	668.75	493	-26	667.6	667.6	38	665	989.9	41
WHO Techn. Support	300	241	-19	0	300	-78	250		
EHIP/TEHIP Evaluation	52	5	-90	18.8	28.75	-69	80	25.4	-68
Total	4002.25	851.1	-79	4289.3	2044.7	-52	4404.1	2506.6	-44

Source: Project Document for Original Budget Figures, EHIP/TEHIP Budget Revision not: Actual figures for support to districts are given as one figure in the EHIP/TEHIP Budget Revision Statement and in the original budget as separate for each expenditure item in the Projects"s July document.

5.7.3 Use of funds against budget:

Use of funds against budget has been as follows:

Utilization of funds have been below or within the approved budget, an indication that the project is managed according to budget lines . The budget was revised to reallocate unspent funds to future years.

Table 8: Use of Funds at District Level:

ITEMS	April 1997 - June 1998			July 1998 - March 1999			July 99 -June 2000
	Budget	Actual	%Var	Budget	Actual	%Var	Budget
Delivery of Essential Health Interventions	117423	629612	-46	1769160	1178560	-33	1924153
Health Facilities Improved	245	66.763	-73	245285	103849	-58	151273
Total	1419723	696373	-51	2014445	1282409	-37	20775416
% Grand Total	**34%**	**25%**		**47%**	**38%**		**59%**

Source: TEHIP Budget

It is from the above data that districts are said to have not utilized allocated funds by 51% in Year 1 and 36% in year 2. Differences in actuals is due to different reporting periods. Among the reasons for the below budget performance include:

a) Delays in release of funds while waiting for the other district to reach the same level of activity implementation.
b) Consultants contracted tend to take longer to finish their assigned jobs.
c) Availability of equipment and supplies to be purchased such as paraffin, refrigerators, motor bikes. radio call and photocopy machines.
d) Training programs on IMCI and STD's delayed due to uncompleted District Health plans.
e) Delay in availing mosquito nets to the targeted groups due to untimely payment of the consignment.

However, both the total budget and actual expenditure for the districts as a percentage of the project's expenditure shows an increasing trend.

(i) Research Project Funded:

There was a delay implementing activities so expenditure on this is below budget. Funds for year one could not be released before assessment and rectification of existing accounting system to conform with TEHIP requirements was done. Though not even half of the allocation has been exhausted, some research proposals were not approved due to under funding. An additional allocation to research is justified so that important research work may be carried out especially with regard to the community participation.

(ii) TEHIP Management and Administration:

Expenditure on the item was 19% below budget in Year 1 and just 1% in Year 2. The project is managed in accordance with the approved budget. Actually in TEHIP budget revision statement actual spending for the item exceeded original budget by 38% in 1997/98 and by 41% in 1998/99. The figure in the two statements slightly differs because they refer to different periods.

(iii) WHO Technical Support:

Payment to WHO technical support was 33% below budget in Year 1 and 34% in Year 2. The below budget expenditure has been constant for the two years perhaps revealing initial overbudgeting .

(iv) EHIP/TEHIP Evaluation:

Though evaluation was to be done after every year, it was delayed in the first year. Reports reveal that attempts were made but the draft evaluation frameworks were not approved. While the budgeted for work was not accomplished, the budget amount was exhausted. Besides, a smaller amount was set aside for the same and expected expenditure by the end of the period is to exceed that amount by a large margin. This practice requires supporting explanation from the administering offices of Nairobi and Ottawa.

CHAPTER 6

Human Resources Management

6.1 Staffing

From the TEHIP background paper and again from the interviews conducted the staffing levels at TEHIP office in Dar es Salaam have been established and all the positions filled with persons who have the requisite qualifications and skills. Proper procedures for their recruitment were followed. Initially, the project thought the staffing levels at the district level were adequate in terms of number and skills but later on it was realized that some required skills were missing especially with regard to new duties such as cost-tracking and statistical work. New staff e.g. data entry clerks had to be recruited.

The amount of work at all levels has increased dramatically because of the availability of resources i.e. Funds for supervision, transport facilities and therefore the DHMT's have to responsive to new challenges facing them, otherwise the work will suffer.

The workload at peripheral facility levels has also increased tremendously. The increasing case load referred to before may reach a point where quality of health care delivery is sacrificed especially if there is no change in the government employment policy. The government freeze on new appointments precluded an obvious solution bet deliberate efforts by DHMTs for even a partial relaxation of the freeze should be intensified.

Related to this is the matter of quality of staff of health facilities especially dispensaries, in Rufiji particularly. Roughly 66% of health facilities are manned by staff who are under qualified - that is, they do not have the qualifications for the responsibilities they are holding now. Consequent to this there was initial doubts as to their ability to adapt to the new working climate and things being introduced by TEHIP and especially whether they would be able to learn all the new techniques and management regimens.

At the beginning when the IMCI training packages were introduced they were indeed found to be unsuitable in terms of the language used and the time frame within which they were to be covered. When the trainers adapted the material to suit the trainees' standard without diluting their message and when the time was prolonged to 19 days instead of 11 the workers, it was discovered, could utilize the material to the complete satisfaction of the trainers.

The main implementors of this project, the DHMT and District Executive Director, are based at the district level. Both districts have these key persons in place. Both districts also have well-functioning District Health Management Teams comprising the DMO, the District MCH Coordinator, District MCH Nurse, District Health Officer and District TB/Leprosy Coordinator. Both districts lack a District Health Secretary who is usually the sixth member of the team. The absence of a Health Secretary is a matter of concern as he is usually the only person in the DHMT with Planning and Management training.. Due to the increasing pressure of work and sheer size or logistics both districts actually have two DHMTs.

6.2 Training

TEHIP's main intervention in the districts has been in training or what might be called capacity-building to enable the DHMT's and facility staff to undertake the activities delineated by the project. To this effect the following training activities were planned for in 1997/1998.

Table 7: Planned Training Activities (1997/1998) of the TEHIP Project: For Indicative and Illustrative Purposes Only

Type of Training	TEHIP Headquarters	Morogoro (R)	Rufiji (R)
Computer Training	All staff		
Software for Accounting	2		
Data Entry		2	55
Safe Driving	2	2	2
Cost Tracking		1	1
Sensitization		Leaders	Leaders
IMCI Training		169	115
Reproductive Health		169	115
Safe Motherhood			100 TBA
Family Planning			78 CBD
STD/HIV Control		97	8
TB/Leprosy Control		11	64

In training health workers for the essential health interventions a training cascade where the trainers from TEHIP, Dar es Salaam impart their knowledge and technique on the DHMT and other identified TOT's is operational. The TOT's in turn train facility staff who then impart their knowledge to the workers in their facilities.

Adult training methods which are especially suitable to persons who possess as much experience as DHMT and facility staff are used.

Following difficulty of training staff who do not possess the requisite background to grasp some of the subject matter, the trainers have adapted the training materials to suit the trainees. They have also extended the recommended training period to allow for slower but more complete absorption of the material. Since then no further problems in this regard have been reported.

Special training where needed was also done. Two accountants were trained on cost-tracking as well as 2 data entry clerks. All the staff at TEHIP Headquarters who needed computer training received it. Two Finance and Administration staff at headquarters received training on accounting software in Nairobi.

Training in planning and management for DHMT's followed a diagnostic exercise where learning needs were identified. These needs formed the basis for the training input.

Although this may not strictly qualify as training, the DHMT in collaboration with the project conducted sensitization sessions for district leadership to orient and familiarize them with HSR objectives and operations.

6.3 Supervision and Follow-up

Any training that does not have a planned follow-up and supervision is a waste of time. Supervision and follow-up should always be part of the training cycle or spiral that starts with training needs assessment and ends with deployment only to start with re-assessment. Follow-up and supervision of TEHIP activities in the two districts is done by the TEHIP team from Dar es Salaam during planned visits specifically earmarked for this activity or during visits for other activities such as training.

For staff working in the facilities, supervision and follow-up is carried out by members of the DHMT who pay regular planned visits. The presence of reliable transport and funds for fuel has promoted this activity very much but distances to be covered and the number of facilities and staff who should be supervised is enormous. For supervision and follow-up to be executed properly the DHMT would have to do little else but this. For this reason the Evaluation Team would like to recommend that supervision activities are decentralized so that other hospitals and health centres are given power and facilities to supervise the dispensaries near them. This would ensure that the activity is given the serious attention it deserves. The DHMT could then concentrate on supervising the bigger centres and get time to do other activities.

A checklist prepared by the Morogoro (R) DHMT is an excellent idea for simplifying the supervision and follow-up process. Continuing education must be considered an essential part of supervision and follow-up. Continuing education aims at maintaining and even upgrading knowledge and skills at the level during certification or graduation. The project needs to comprehensively look at the continuing education needs of staff and draw up a plan to address this. Refresher courses, availing of literature, exchange visits within the project and outside e.g. with the Igunga district where community financing initiatives are being tried are some suggestions.

6.4 Technical Support

The Project Document lists WHO and the Ministry of Health as sources of technical support. WHO has provided a MOH-seconded pediatrician to work full time for the project. However, his services are paid for by the project. The WHO support is very much appreciated by the TEHIP and EHIP management and is considered a major input into TEHIP processes. WHO input has consisted mostly of training and availing of necessary materials. WHO technical support is also made available through its membership in the PSC and the SAC.

The MOH has provided technical support through the PHC Secretariat, the HSR section and the Planning Directorate in general. The Ministry is represented in the POC and PSC and has some of its staff sitting in the SAC. It is also represented in the weekly management meeting. Technical support from the MOH has been available wherever it was needed and TEHIP staff are frequently invited to training events as facilitators or participants. The presence of a link between the Ministry and TEHIP (the Project Coordinator) ensures that the Ministry is at all times aware of what is happening in the project and can lend a hand.

The Ministry has also participated in training of DHMT's and others in the field and in carrying out activities related to the rehabilitation of the health facilities in Morogoro (R) and Rufiji.

In addition to these two organizations, the Project through EHIP has contracted the services of 'international consultants' for various activities. Notably among these have been Nancy Hutchinson from Canada, Dr Susan Zimicki, USA, Dr Lucy Gilson from South Africa, to name a few. Other consultants who provided technical support were from national institutions such as the Iringa Public Health Institute which introduced the SHARMS initiative and CEDHA, Arusha. Drs Stansfield, Hillman and Hillman, all of Canada, drew up the first and second evaluation protocols.

The project has built good working relations with reputable scientific and health institutions in Tanzania and abroad such as the Universities of Dar es Salaam and Sokoine, Ifakara Research Centre, NIMR, CDC Atlanta, the London School of Tropical Medicine and Hygiene.

Other sources of technical support have, however, not been explored sufficiently even though they exist or have even been identified as possible sources. NIMR, it has been mentioned before, could have a more significant role in a project located literally at its doorstep. NIMR is the leading health research organization of the country. The Health Systems Research Unit in the Ministry of Health should be collaborated with more for obvious reasons and especially sustainability. If there is one role to which the Regional Medical Office is suited, it is in providing technical support to districts without taking over power from them.

6.5 Operational Research

Not much is said about operational research in the project document. While the research component of the project will provide the MOH with answers to the three essential questions, the district will be left with little capacity to maintain surveillance on its own health delivery system so that this guides all its actions as the research component is doing during the project implementation. This is also one role which the Health System Research Unit could play already at this point.

Research is a major component of TEHIP whose expected outputs are well anticipated. The three questions asked in relation to the DHMT's capacity in establishing priorities and plan, the translation of plans into delivery of essential health interventions and the impact on the Burden of Diseases have to be answered by the research findings.What is missing in the project document is the need to strengthen or develop the operational research capacity at the regional and district level so that increasingly this is done by the existing local entities themselves.

It is important to start to incorporate this component into the project at this stage. Local health systems research should be used as one way of obtaining data for decision-making in the planning process and management of health care. As the project continues with its research agenda it is important to think of how the Health System Research Unit in the Ministry of Heath can be utilized in building research capacity at the district level since the unit through the support of WHO has done similar capacity building in other districts. Also the National Institute of Medical Research should be involved so that, some research on the impact of the project can be monitored even beyond the lifetime of the project.

Findings from the research done should be used in planning processes.

CHAPTER 7

Assessment of The Utility of Ehip/Tehip

7.1 TEHIP Outputs

The TEHIP project has been around for two years and therefore most of its hoped for outputs are yet tc be realised. However, some outputs have become apparent already.

7.1.1 Capacity Building

Institutional, individual and research capacities have been built through TEHIP.

Institutional Capacity

This refers to the structure and functions of the human resource and physical facility of the institution. In its short lifespan TEHIP has built a name for itself as a serious, productive enterprise. It is highly regarded by its peers in the research world and it is increasingly sought after on matters related to burden of disease and cost effectiveness analysis.

Its staff have been asked to provide training in BOD, DALYs, malaria and its interventions and many collaborative links have been forged through this reputation.

TEHIP staff and DHMTs have received on the job training on computer programming, on research methodology and on accounting programmes.

TEHIP funded research has collected important information related to health systems and health interventions which is accessible to interested Tanzanians especially researchers.

The research component of TEHIP has already collected information on household health behaviour, and on morbidity and mortality. It has also got information on the situation with regard to health planning and management practices in the districts.

Extensive training has taken place (refer to the training section) at all levels. Districts have been given facilities for data handling, communications and transport.

In the headquarters TEHIP employs seven Tanzanians. In the districts, a total of 80 persons are engaged in TEHIP related work.

For the communities, TEHIP has meant more supplies and therefore better treatment at less or no cost. It has also meant that medical care is available in the nearest health facility therefore saving time. Some of these facilities are better having been renovated by TEHIP funding. And the workers are reported to be more efficient and of better temperament than before even though the team could not ascertain this.

Individual Capacity

Training has been adequately covered under the relevant section. TEHIP has the capacity to support training leading to the Masters and PhD levels and it would like to utilise this capacity. At the moment one Tanzanian has been proposed to do a PhD.All research being undertaken is suitable for Masters or even PHD work.

Research Capacity

Research Strategies are covered in the relevant sections. TEHIP built enough research capacity not only to guide its implementation but to guide the Ministry of Health in making policies and implementing health programmes. When TEHIP ends in a few year's time the Ministry will be able to have a data base which it can use nationwide.

TEHIP's research capacity has not been utilised well enough at the national level by Tanzanian researchers and academicians. Perhaps TEHIP needs to advertise itself more in this regard so that Tanzanians at the national level can take advantage of it.

Research (it has been mentioned elsewhere) is underfunded yet this is essentially a research development project. The team recommends a review of the budget with a view towards revamping the research budget so that it stays on course.

7.2 TEHIP Efficiency

7.2.1 TEHIP Costs

TEHIP Costs include the Operating and Administrative costs for both head office, districts' selected activities and also Research Facilitation costs. They are discussed elsewhere.

7.2.2 TEHIP Benefits

Among TEHIP benefits are:

- Provision of assistance to Health Sector Reforms.
  A cost tracking system which will help the districts and the nation to find out how to prioritize the allocation of resources is being developed. However this will take time before the data is out and in a useable form. The project has started improving the planning system at district levels by providing training and working tools to DHMTs.

Funding research will facilitate availability of useful information through research results.

- Improved and Expanded Health Interventions. TEHIP districts has introduced IMCI in the and other interventions such as ITNs in the district.
- Has rehabilitated some health facilities in the two districts -Mtombozi, Hembeti, Mikese in Morogoro Rural.
- Provided employment through project management and administration at head office and

districts
- Provided exposure and opportunity to Tanzanian researchers to work on various areas in the health sector.

7.2.3 TEHIP Costs Relative to Benefits

While it is easy to trace TEHIP costs, benefits cannot be quantified within a given short period of implementation. Adequate information on benefits will be documented through the research after the project life span.

However one may without the support of data or methodological rigour point to the anecdotal information coming from the health staff and patients, that death rates especially for infants have gone down dramatically. Morbidity and mortality data should be able to furnish the project with the details.

CHAPTER 8

Use of Findings Within Tanzania and Other Countries

8.1 Effects on Social and Health Sector Reforms

Tanzania is currently implementing health sector reforms which are part of the wider social sector reforms affecting also the water and education sectors as well. The Health Sector Reforms have been prompted by government need to re-examine the current health services delivery so as to achieve the National Health Policy objective which have been given as:

1. *To upgrade the health status of the population by increasing life expectancy through reduction of disease burden and improvement of maternal and child care services, disease prevention and treatment of common diseases.*
2. *To ensure that resources set aside for health services are utilised for that purpose and distributed equitably.*
3. *To ensure a sufficient number of adequately trained health personnel at the different level available.*
4. *To facilitate community participation and specifically involve the communities in the prevention of communicable diseases.*
5. *To ensure community and inter-sectoral involvement in health on the understanding that health is a multi-sectoral responsibility.*
6. *To ensure that individual, families and communities take a larger share of responsibility for their own health.*

According to the Ministry of Health the attainment of the objectives of the health sector have been constrained by inadequacy of resources, both financial and human, inadequate managerial capacity including poor planning, poor implementation, lack of appropriate prioritisation and overall decline of economic performance which has magnified these problems.

Underpinning these reforms is the government strategy of decentralisation through which the policy objective number 2,4, and to a certain extent number 5 and especially number 6 are expected to be achieved.

In Chapter 2 of this report (see Figure 1) it was shown how TEHIP Strategies and selected health sector reform objectives are congruent. The objectives of TEHIP are to strengthen the planning, management and resource allocation capacity using evidence from research and to improve delivery of service and measure the impact of different health interventions in order to test whether it is feasible for a health system of a poor country such as Tanzania to undertake such policy initiatives.

In developing the Plan of Action (1999/2000) and Plan of Work (2000/2002) which are the implementation strategies of Health Sector Reform, inputs so far from TEHIP in the two districts were incorporated.

There are many structural similarities between the water, education, and health sectors, All these are service sectors and traditionally in Tanzania they were highly centralised, gave their services free of charge

to the people and have in recent years faced decline in terms of performance and financial allocation. The other two sectors which have not travelled along the reform road as long as the health sector would like to learn how to undertake and consolidate their own reforms.

8.2 Sustainability

According to TEHIP project design and objectives, sustainability is not an important issue because the project is set up only to "test the feasibility..." of doing these set of activities and to track the outcome. TEHIP is a research project, an experiment. As with all experiments any outcome is useful and thus if at the end of the project the findings are that it is not feasible then the experiment is as successful as if it is found out that it is feasible. For this reason therefore the project was not meant to be sustainable or to go beyond a determined project life.

However, if the interventions are found to be useful there will be political and social pressure to continue them and from an ethical point of view the government would want them to continue. In other words then, sustainability is as important here as it would have been were this a service delivery project.

Fortunately TEHIP became so integrated in the district health system that it is difficult to separate what is TEHIP and what is non-TEHIP. At the national level, however TEHIP is not so well integrated. It is located far from the Ministerial Headquarters and has its own systems and regulations. From this point of view it looks very much like the usual vertical programmes. Although the reasons for this are very well understood and appreciated TEHIP and the Ministry of Health need to start looking for ways of bringing closer integration.

Related to this is the issue of finding a suitable home for the TEHIP idea and concepts once Canadian funding is no longer available. TEHIP, the project, needs to become a programme; to be institutionalised. The National Institute for Medical Research and the Health Systems Research Unit of the Ministry of Health are probably the best institutions to link TEHIP with.

Funding aspects are probably the greatest threat to the sustainability of TEHIP. Tanzania is so highly dependent on foreign sources of support to the health sector that nearly 54% of its health sector funding comes from outside. Indeed the whole health sector is not sustainable viewed form that angle. The allocation of these foreign funds translates to US$ 2.1 per capita which is just what EHIP allocates in the project districts. The implication of these statements is obvious. Should the Canadian support end can the districts raise up the US$2.00? Can the central government? Will there be other donors given the fact that Tanzania is recipient of one of the largest foreign health sector support in the world ?. Canada is not a major health sector supporter. Indeed in 1990 (when it made its largest donation) its support to the health sector world wide was a paltry 4.1% representing 0.028% of its GDP.

Only activities that have a strong local funding base can truly be sustainable so the two districts should look inward for support to its own health service. The team is encouraged by reports from 10 districts where community financing initiatives are reported to be doing well. It is recommended therefore that community financing be introduced as a means of getting revenues to supplement the district budget. Prepaid schemes and user fee strategies assist the district in solving some of the problems facing health facilities e.g maintenance of facilities, drug supplies, kerosene etc.

8.3 Replicability in Other Districts

The two districts do not deviate too drastically from other districts in Tanzania. What differences Rufiji or Morogoro may have with a third District are offset by similarities the district may have with Morogoro or Rufiji. There are more similarities between the two districts with any Tanzanian district than there are differences. Whatever findings come out of any of the two districts will most likely be replicable in any other district.

The Evaluation Team has a few doubts on the affordability issue dealt with in the previous section. The two districts may be typical of other districts when it comes to geography but there may have been artificialities introduced by the project. For example will the other districts afford the research input that may be required and which is not budgeted by the districts? Even though the TEHIP headquarters strives to stay out of the picture, contact between the well-endowed headquarters and DHMTs is more or less constant. Are some of the findings being noted now and in the future the result of a hawthorne effect? If this is the case then replicability may be threatened.

Baring these observations, it looks as if the project could be replicated in other districts. In this regard we recommend an extension of the project in order that the project may be given a chance to take root and EHIP to document it well.

8.4 Application of Findings Outside Tanzania

The reasons for setting up TEHIP was to test the feasibility of an evidence-based approach to district health planning. Eventually the findings from this experiment will be made public for other countries to study and make decisions on whether they are applicable or not to their local context. Each country being quite unique in terms of health status, health care delivery, financial allocation and so forth, the findings of TEHIP will not have universal application. Put differently, what is applicable in Tanzania is not necessarily applicable to other countries of the world or even Eastern Africa. But there will be lessons for all health systems, with those health systems more closely resembling Tanzania's standing to gain more from the experiment.

> *"EHIP is not about finding a formula for efficient health care planning and resource allocation that can be universally applied. It is about testing certain principles of "process"-- which if found feasible could have applications in a variety of developing countries".*
> Strengthening Investments in Health, EHIP, IDRC, Undated

The responsibility of TEHIP which has been entrusted with the enormous task of giving to the world answers as to whether more evidence-based planning is feasible in a district health set up is to document most thoroughly all the lessons learnt for the health systems that may wish to replicate them. The documentation must be systematic and the time to start capturing the information is right from the start. It is not mentioned anywhere in the documents that the team reviewed how this documentation was to be handled and how it is to be presented. While the project seems to be handling all information coming out of the project very well, a system or method for eventually presenting it in a way that will promote its usage is needed. At the very least the project should start to think of these system as it may be necessary to begin the process of this final documentation before the end of the project. This is a role that should be coordinated by EHIP.Ultimately, however, the surest ticket to sustainability and replicability is the

performance ofthe project.If the hypothesis is proven by the project to work it is csertain that it will arouse interest wordwide and this will in turn generate resources.

CHAPTER 9

Conclusions And Summary of Recommendations

The evaluation team spent an enormous amount of time looking at EHIP/TEHIP from a distance and also from close-up. In the course of this evaluation many very extensive interviews were carried out and a lot of documents were reviewed. After all this the team agrees with many observers of TEHIP that this is a most complex project.

It is the opinion of the Evaluation Team that the project is very well run and is on course. It is very well designed with clear goals and objectives. It is well-supported by EHIP and other IDRC mechanisms. The counterpart system works well and a real team spirit, not easily seen in the beginning but becoming more evident as time passes drive the project. A high degree of professionalism is evident.

There are however, a few matters which the team would like to bring to the attention of EHIP/TEHIP, IDRC and the MOH. In this section we list and discuss these issues and where feasible we offer our suggestions and recommendations.

The team agrees with the suggestion given by some of the respondents to avoid the usual practice in evaluations where a long list of disconnected recommendations are given and to concentrate instead on a few which stand a chance of being implemented. In the Team's reporting style some recommendations are also found in the main body of the text.

9.1 "Community Voice" is the weakest link in the Project

Decentralisation, a cornerstone of both HSR and TEHIP was not meant to stop at the district level. Effective decentralisation must reach all the way down to the communities otherwise its full benefits will not be realised. The project must not be satisfied with mere donation of labour because this only rarely denotes "involvement". More usually this comes from coercion. The team believes that "community voice" as framed in the project document goes beyond merely getting the community to spend a few hours repairing a dilapidated dispensary. Without belittling this achievement the Team believes "community voice" is meant to involve the communities in assessing, understanding and prioritising their needs, in determining its preferences etc. This kind of "community voice"comes from genuine interaction and respect for the communities. It is the only kind which has any lasting benefits and is the bedrock of sustainability of any project.

Getting communities involved is a technology and there are individuals and institutions who possess that technology.

The Evaluation Team recommends that community involvement is reinstated to its former place of prominence as it was meant during the project design.

This implies returning the community participation research component which was dropped due to shortage to funds

Furthermore the Evaluation Team recommends the contracting of a short-term consultant associated with working with community-based programmes in the region to advise the project on how this component can be instituted.

9.2 The amount of work that is yet to be done is more than can be reasonably handled within the Project life.

The project is halfway through its time frame but in terms of research only two reports are out and despite the impressive volume of training much is yet to be done. Some key respondents believe that the project will not complete its interventions on time before the end of the project.

DHMTs and facility workers are overwhelmed by the array of training activities, supervision, meetings, reporting and clinical case load they have to deal with and reservations as to the absorptive capacity of facilities and individuals were expressed. At the administrative level there are worries about whether there will be enough time to gradually phase out and hand over. From a programmatic point of view the terminal evaluation at the end of the stipulated 48 months may not really provide information as to whether the project is sustainable or stated another way, whether any success that might be recorded are not due to the presence of a donor-driven project or Hawthorne effect.

The evaluation team recommends an extension of the project by at least one year, preferably two. This "phase two" should address itself to unfinished business which is bound to be considerable, to "phasing out" as some of the national level activities now handled by TEHIP are handed over to the national level institutions or institutionalised at the district/ regional levels. This period could be made to coincide with replication of TEHIP like activities in other districts if at the end of the four years the project is found to have been successful and to merit replication.

Further, the team recommends an ex-post evaluation carried out one year after the end of the project to observe how the TEHIP interventions have held on in the absence of a TEHIP superstructure.

9.3 The Sustainability of TEHIP is questionable not due to flaw in the design or implementaion of the project but because the external environment is not favourable

This report has made the point somewhere that TEHIP cannot be held responsible for sustainability or lack of it since it is outside its stated goals and objectives. From an ethical point of view, however, it would be tragic if all these improvements in planning and health care delivery were to stop -- assuming they are found at the end of the project to have been useful.

But TEHIP activities cost money, US$2.00 per capita, and depends on a working transport and communication system, motivated workers, maintained facilities, continuing education of old workers and training of new ones, and so forth. Yet demand on the improved service delivery and for drug and supplies to maintain these services is rising continuously. Can the MOH continue to fund these activities in the two districts? Are the MOH and the Ministry of Local Government taking steps to ensure that there will be

no worsening of health care delivery and health outcomes when TEHIP disbands?

The team is also concerned about the relatively low profile of the Ministry of Local Government compared to the Ministry of Health on the project. In the old system a project such as TEHIP could and maybe should be an exclusive responsibility of the Ministry of Health. In decentralisation a health systems project should at the very least have major operational linkages with the MLG if not outright ownership. This is not happening in TEHIP and the only observable role of MLG is in its representation in the PSC and the POC where it is represented by the DED. But more than this is needed. What are the districts' and Ministrys plans to raise revenue for the activities on a fully decentralised health care delivery system for that matter?

The report has mentioned the need to institutionalise TEHIP as a means of integrating its activities with others at the district level. This is also a measure towards sustainability. It is the nature of systems that what happens in one place must necessarily affect other places within it and therefore one cannot intervene in one part of the system without influencing another part. In this regard then what has been implemented as a result of TEHIP will affect the whole health system in Tanzania e.g. the increasing coverage in the districts will place a greater demand on the part of the system that produces or allocates manpower, on the regional health set-up which is charged by the system with technical support to the districts.

The Evaluation Team recommends greater integration of the MLG into TEHIP matters especially as they relate to the "post-TEHIP period". It is suggested that the time to start thinking about these matters is now and that the recommended second phase should be a time for putting into practice initiatives that cement greater ownership of the health delivery system to the MLG and the two districts. The community financing initiatives taking place in other districts in Tanzania need to be studied for possible replication into Morogoro (R) and Rufiji.

The Team recommends greater sensitivity on the part of TEHIP towards the health care system as a whole by diagnosing areas it might cause profound effects on. At the minimum TEHIP should work within a decentralised integrated system. Various governmental structures, divisions and departments in the Ministry which have delineated roles in the health system and which might affect TEHIP especially in the post-project days should have their roles within TEHIP defined immediately and brought in or their role enhanced as appropriate. The Team had in mind these governmental/ministerial structures:

- ***The Regional Medical Officer***
- ***The National Institute for Medical Research***
- ***The Health Systems Research Unit of MOH***
- ***Health Sector Reform Programme of MOH***

The quality of staff especially in Rufiji is substandard and a threat to sustainability. This situation is unfair to all concerned and although after deliberate efforts on the part of their WHO, TEHIP, MOH and DHMT trainers they managed to grasp the materials for some health interventions this should not be seen as a lasting solution. While commending the efforts of these trainers the evaluators feel that those facilities should be manned by the category of health worker stipulated by the Ministry of Health.

The Evaluation Team recommends that lobbying efforts to thaw the employment freeze should be continued/initiated with the government to address this anomaly.

9.4 The issue of future replicability of TEHIP in the region must start to be addressed now

The stakeholders of TEHIP must not lose sight of the fact that TEHIP is carrying out an experiment to test the feasibility of planning using an evidence-based approach and that it is doing this on their behalf through the organizational facility of EHIP/IDRC. TEHIP must never be relegated to another "flavour of the month", its lessons left to gather dust on office shelves. The fact that IDRC is primarily a research and not a service organization makes this a real possibility since research organizations tend to see the conclusion of a research assignment as an end in itself.

While TEHIP has aroused much interest from academic and research circles it has not had a commensurate interest from potential consumers of its lessons. And stakeholders' interest has not been maintained at optional levels. Edna McConnell Clark Foundation pulled out. There has not been any funding offers from any of the other stakeholders and there is no commitment from IDRC for the immediate post-TEHIP period.

Although the project has two years to go it is important that the TEHIP flame is kept burning bright through the transition into replicability elsewhere (if TEHIP lessons should merit this). And the time to start this is now. The Team sees this as an EHIP responsibility and wishes to commend the efforts that led to the development of the newsletter, TEHIP News and its website. The Team recommends an intensification of these initiatives gradually moving from mere information to promotion and marketing targeting especially potential consumers i.e., the neighbouring states and other countries in the regions. Alongside these efforts EHIP should also intensify fundraising to bring in more stakeholders and get old stakeholders' interest and commitment back.

9.5 A few finance and administrative matters require attention

No financial irregularities were reported or noticed by the Evaluators. The system works well and adequately meets the needs of the project. However there is room for improvement and the Team recommends the following:

- *Revisit the accounting software and adapt one which meets the generally acceptable accounting standards in Tanzania.*
- *In financial reports, the Tanzania Government contribution into TEHIP should also be accounted for.*

Also in the quarterly financial reports include the following:

- *Cumulative figures and forecast*
- *Figures in all currencies used*
- *Foreign exchange rate at date of report*
- *Brief review of the last report so as to show continuity*

- *An external audit should be conducted soon and yearly in the future*
- *Reconsider budgeting practices to marry the budget periods of EHIP and TEHIP.*

APPENDICES

APPENDIX I

List of Acronyms Used in The Document

	ACMO-P	*Assistant Chief Medical Officer, Preventive Services*
	AIDS	*Acquired Immuno-deficiency Syndrome*
	AMMP	*Adult Morbidity and Mortality Project*
	BOD	*Burden of Disease*
	CAD	*Canadian Dollars*
	CEDHA	*Centre for Educational Development in Health*
	CIDA	*Canadian International Development Agency*
	CSDP	*Child Survival and Development Programme*
	DALY	*Disability-Adjusted Life Year*
	DANIDA	*Danish International Development Agency*
	DC	*District Commissioner*
	DED	*District Executive Director*
	DFID	*Department for International Development*
	DHMT	*District Health Management Team*
	DMO	*District Medical Officer*
	DOTS	*Directly Observed Treatment Scheme*
	DPS	*Director of Preventive Services*
	EARO	*Eastern African Regional Office*
	EDP	*Essential Drugs Programme*
	EHIP	*Essential Health Interventions Project*
	EMS	*Expedited Mail Service*
	EPI	*Expanded Programme of Immunization*
	GOT	*Government of Tanzania*
	HIV	*Human Immunodefficiency Syndrome*
	HSR	*Health Sector Reforms*
	IAC	*International Advisory Committee*
	IPH	*Institute of Public Health*
	IDRC	*International Development Research Centre*
	IHRDC	*Ifakara Health Research and Development Centre*
	IMCI	*Integrated Management of Childhood Illnesses*
	ITN	*Insecticide-Treated Nets*
	MARA	*Mapping Malaria Risk in Africa*
	MCH	*Maternal and Child Health*
	MLG	*Ministry of Local Government*
	MOF	*Ministry of Finance*
	MOH	*Ministry of Health*
	MOU	*Memorandum of Understanding*
**	*MTUHA*	*Mradi wa Takwimu za Uhai na Afya*
	MUCHS	*Muhimbili University College of Health Sciences*
	NID	*Non-infectious Diseases*
	NIMR	*National Institute for Medical Research*

NGO	*Non-Governmental Organization*
OPD	*Out-patient Department*
PHC	*Primary Health Care*
PMO	*Prime Minister's Office*
POC	*Project Operations Committee*
PSC	*Project Steering Committee*
RHMT	*Regional Health Management Team*
SAC	*Scientific Advisory Committee*
SHARMS	*Strengthening Health Administration and Resource Management Systems*
STD	*Sexually Transmitted Diseases*
SUA	*Sokoine University of Agriculture*
SWOT	*Strength Weaknesses Opportunities and Threats*
TBA	*Traditional Birth Attendant*
TEHIP	*Tanzania Essential Health Interventions Project*
TZS	*Tanzania Shillings*
TB	*Tuberculosis*
UMATI	*Uzazi na Malezi Bora Tanzania*
UNICEF	*United Nations Children's Emergency Fund*
UNDP	*United Nations Development Programme*
USD	*United States Dollars*
WDR93	*World Development Report (of 1993)*
WB	*World Bank*
WHO	*World Health Organization*

APPENDIX 5:

Persons Met: Places Visited

Dr Eva Rathgeber, Executive Director, EHIP, Nairobi
Mr Sarwatt Salem, Financial Comptroller, IDRC, Nairobi
Ms Alice Mmari, Project Officer, EHIP, Nairobi
Ms Edith Ofwona-Adera, Research Officer, IDRC
Dr Graham Reid, Project Manager, TEHIP, Dar es Salaam
Dr Harun Kasale, Project Coordinator, TEHIP, Dar es Salaam
Dr Don deSavigny, Research Manager, TEHIP, Dar es Salaam
Dr Conrad Mbuya, Research Coordinator, TEHIP, Dar es Salaam
Mr Godfrey Munna, Finance and Administration Manager, TEHIP, Dar es Salaam
Mr Victor Lihembeko, Project Accountant, TEHIP, Dar es Salaam
Mr Robert Kilala, Project Administrator, TEHIP. Dar es Salaam
Ms Freda Zimamoto, Project Secretary, TEHIP, Dar es Salaam
Mrs Mariam Mwaffisi, Permanent Secretary, Ministry of Health, Dar es Salaam
Dr.Ahmed Hingora, Head, PHC Secretariat, Ministry of Health, Dar es Salaam
Mr.Evarist Manumbu, Director of Planning, Ministry of Health
Dr. Fupi, Regional Medical Officer, Morogoro
Dr. Harun Machibya, District Medical Officer, Morogoro (Rural)
Mr. Wilfred Mattee, District Nursing Officer, Morogoro (Rural)
Mr. Peter Nkulila, District TB/Leprosy Coordinator, Morogoro (Rural)
Mrs. Hadija Rajabu, Clinical Assistant in charge, Mutombozi Dispensary, Morogoro(R)
Mrs. Zamaradi Abdallah, Mother attending OPD, Mutombozi Dispensary, Morogoro
Mrs. Hajjati,Mother attending MCH Clinic
Mr. Mohamed Singano, Patient at Mutombozi Dispensary, Morogoro (R)
Mrs. Hawa Mfaume, Patient at Mutombozi Dispensary
Mr. Petro Kijanga, Patient at Mutombozi
Mr. Amadeus Mwananziche, Clinical Officer I/c, Mlali Dispensary, Morogoro (Rural)
Mrs. Hanachi, Mother attending MCH clinic at Mlali Dispensary
Mrs. Mwanaidi, Mother with sick child, Mlali Dispensary
Mr. John Gille, District Executive Director, Morogoro (Rural)
CH Aid, Mlali Dispensary, Morogoro (Rural)
Miss Farida Saidi, Patient, Mlali Dispensary
Dr. Ibrahim Muhinga, DHMT member, Rufiji District
Mr. Francis Bwakila, Clinical Officer I/c, Ikwiriri Health Centre, Rufiji District
Mr. Shadrack Bushiri, Clinical Officer I/c, Kibiti Health Centre, Rufiji District
Mr. Sadock Gwanda, Clinical Officer, Kibiti Health Centre, Rufiji District
Mr. Shadrack Bushiri, Health Officer, Kibiti Health Centre, Rufiji District
Mr. Ali Msumi, Medical Recorder, Kibiti Health Centtre, Rufiji
Clinical Officer, Ikwiriri Health Centre, Rufiji District
MCH Aid, Ikwiriri Health Centre, Rufiji District
Ms. Anna Mtutuma, District MCH Coordinator, Rufiji, DHMT Member
Mr. Makamba Mbegu, District TB/Leprosy Coordinator, Rufiji

Dr. Andrew Kitua, Director-General, NIMR, Dar es Salaam
Prof. Wen Kilama, Former Director-General, NIMR, Dar es Salaam
Dr. Emmanuel Malangalila, Programme Officer, World Bank, Dar es Salaam
Dr. Isiye Ndombi, Programme Officer, UNICEF Dar es Salaam
Mr. Brian Proskurniak, First Secretary, Canadian Embassy/CIDA
Ms. Victoria Mushi, development Officer, CIDA, Dar es Salaam
Dr. Leslie Mgalula, WHO-TEHIP Officer, Dar es Salaam
Dr. Peter Kilima, formerly Director of Preventive Services, Dar es Salaam
Dr. E.A. Mwageni, Researcher, on secondment from SUA
Mr. George Lihula, MA i/c, Ikwiriri Health Centre

APPENDIX: 6

Parent Evaluation Questionnaire

0 Main external environmental factors affecting the project by SWOT with 6 Senior Project staff (Project Manager, Project Co-ordinator, Research Manager, Research Coordinator, Finance Manager, Project Administrator) NIMR, MOH, DHMT, and WB.

STRENGTHS	*WEAKNESSES*
OPPORTUNITIES	*THREATS*

1. *What is your role in EHIP/TEHIP?*
   (List activities, issues, technical support, attendance, financial and other resources contribution, policy).

2. *What are the main external factors affecting the project?*

3. *Have you been able to fulfill your identified role?*

4. *Have you been able to contribute your share of the budget to the project since the inception of the project as agreed?*

5. *Have you been able to attend all statutory meetings since the beginning of the project?*

6. *What other resources have been contributed by the partners?*

7. *What policy issues have you dealt with regarding TEHIP?*

8 *What technical support have you provided to the project?*

9. *Who are other players (NGOs, other providers) in the project districts?*

10. *What are the roles of each of the players ?*

11. *What infrastructural factors facilitate or inhibit the implementation of EHIP?*
    (communication and accessibility of the two pilot districts - -water sanitation

transport, telephone, e-mail, computers, fax, courier service, posts)

12. *To what degree are you free to choose interventions according to your own plans and priorities?*
13. *To what extent are you free to allocate resources according to your plans?*

14. *In the context of decentralisation and TEHIP, what are the roles of the following officials, District Commissioner, District Executive Director, District Medical Officer?*

15. *Are there any influences or support from political leaders at the community level, Members of Parliament, District Commissioner, Councillors? If yes explain.*

16. *Have TEHIP Project concept and resources been used for any one's political or economic gain? If yes, explain.*

17. *To what extent have the following sectors been of benefit or loss to the project? (e.g in participating in meetings, in resource allocation, resource sharing, technical support): Water and Sanitation, Education, Finance.*

18. *How are the ongoing local government reforms likely to affect the project?*

19. *On the premises the project occupies now :*

    19.1 Who owns the premises?
    19.2 How did you come to occupy them?
    19.3 How much rent are you paying?
    19.4 Who pays the rent?
    19.5 Is space enough for everybody?
    19.6 When there is need for confidential discussions how is this handled?

20. *What are inbuilt preventive or remedial mechanisms to respond to adverse external environment ? e.g. manipulators wishing to exploit the project for own benefit?*

21. *Is the project open to exploit external opportunities?*

22. *Are you familiar with the project's Mission statement?*

23. *What are the main elements of the project's mission statement?*

24. *Is the Mission statement relevant and suitable to the local context?*

25. *Do you understand the Mission statement well?*

25. *Is the mission statement subscribed to and frequently referred to?*

26. *Is the project's Mission practicable in Rufiji and Morogoro rural?*

27 *How does the project approach of TEHIP ("funding for results") fit in with the administrative approach ("funding for routine") of the government? For example are TEHIP funds channelled through the vote system or administered separately?*

28 *Is there a sense of community or team within the project at the Headquarters?*

29 *When did you last have an office get-together (party)?*

30 *How do people refer to each other in the TEHIP office (e.g by first names, surnames, titles etc.)?*

31 *What social obligations do members have among themselves -- e.g. how do office staff participate in the event of funerals, weddings, birthdays?*

32 *Do people go out of their way in carrying out project duties -- e.g. How frequently do people work extra hours without overtime pay?*

33 *Do you feel you are part of a team?*

34 *What mechanisms exist in the project for managing both interpersonal and project related conflicts?*

35 *What remuneration do staff receive?*

36 *What is the ratio of wage variations among workers?*

expatriate : counterpart
expatriate : government-paid
highest paid : lowest paid
project staff : non-project staff

37 *Is there any incentive for particularly productive behaviour?*

38 *Is there any deterrent for unproductive behaviour?*

39 *Who are the informal leaders of the project and what is the extent of their influence (both positive and negative) on how things are run in the project?*

40 *How were project leaders of the project recruited and appointed?*
- *Advertisement*
- *Interview*
- *Head-hunt*
- *Secondment*

41 *How competitive and transparent was their selection?*

42 *What is the style of leadership in the project ? For example, do decisions have to wait for the availability of the top leadership and formal committee deliberations?*

43 *Are there any rules and regulations for staff and procedures? Are they always used?*

44 *On a scale of 1 (for very weak) to 5 (for very strong how would you rate the Project Management?*

	Human relations (PR)	*Communication*	*Consultation*	*Hard work*	*Listening*	*Expertise in his field*
P.Manager						
P.Coordinator						
R.Manager						
R.Coordinator						
F.Manager						
Administrator						

45 *What is the organizational structure of the project (steep or flat)?*

46 *Is the structure conducive to meeting project's goals, objectives and mission?*

47 *Are there Job Descriptions, Terms of Reference, Contracts and are they appropriate?*

48 *Is there adequate co-ordination?*
- *Lines of Communication*
- *frequency of staff meetings*
- *notice board/bulletin/newsletter/circulars*

50 *Is there policy on equal opportunity and is it enforced/encouraged? Are there gender considerations (affirmative action)? (staff roster, composition of committees)?*

51 *Have you ever felt discriminated on account of your gender, colour, religion or political affiliation?*

52 *What are the roles and influences/powers of the community in the project e.g.to influence and*

determine direction of the project?

53 *Is the Project Steering Committee equivalent to a "Board of Governors"?*

54 *What is the professional mix in its composition?*

54 *What is the effective role of the Project Steering Committee e.g in the last two years what major project aspects has it altered, modified or advocated?*

55 *Is the composition of PSC representative of all stakeholders?*

56 *Does the PSC have the following attributes?*

Clear terms of reference
meets regularly as required
provides policy guidelines as required
makes major decisions regarding the project
deals with issues referred to it promptly
assists management in dealing with challenges from the external environment

60 *What has been the most outstanding contribution of PSC to the project?*

61 *What is the composition of the project's Scientific Advisory Committee (SAC) What are the qualifications and experience of its members and what are the members' institutional affiliation?*

62 *Is the composition of the Scientific Advisory Committee optimal for fulfilling the committee's mandates?*

63 *What are the mandates of the Project Operations Committee?*

64 *Is the composition of the POC optimal/satisfactory to fulfil the expected functions and mandates?*

65 *Do the Committees meet regularly as demanded by the project?*

66 *With regard to the listed attributes, what has been the performance of the three committees to date?*

67 *What has been the turn-over (attrition) of the membership of the Project Committees ?*

68 *What has been the most outstanding contribution of the various Committees?*

69 *Is the project implementation strategy described in the Project Document?*

70 *To what extent is TEHIP management participatory from the community to the national level?*

71 *How well is TEHIP linked to other related programmes at various levels vertically and laterally?*

72 *Has the project strategy ever been reviewed ? (When, give dates)*

73 *In your opinion what do you consider to be the strengths and weaknesses of the TEHIP project strategy? (see the list on pp10 of the Project Document).*

74 *In what manner and how often do you collaborate with your partners? (MOH, WB, WHO, MOF, IDRC, District, Community, UNICEF).*

75. *Who are the members of the consortium?*

76 *How adequate is the consortium in informing the TEHIP planning and execution functions?*

77. *What is the value of the consortium approach? (cost advantage and quality of output)*

78. *How is the consortium organised and what are its functions?*

79. *Is the consortium regarded as an integral part of TEHIP management and implementation process?*

80. *Compared to research costs of other individuals and institutions how does TEHIP fare?*

81. *With regard to the following infrastructural systems please comment on their availability and adequacy: electricity, water, transport, real estate, furniture, computer hardware, computer software, maintenance.*

82 *How much training/capacity building does the consortium approach bequeath the district/nation/community?*

83 *What infrastructure has been added to the two pilot districts as a result of the project ?*

84 *What is the distribution of project facilities in Dar and at the districts (analysis of inventory)? Motor vehicle, motorcycles, computer hardware, computer software, printers, scanners telephone, printers, photocopiers, telefax, email?*

85 *How is project property and facilities cared for? (Routine service and maintenance, cleanliness, service and maintenance record).*

86 *What is the financial commitment of each partner?*

87 *What has each partner actually released since the project began?*

88 *If there is defaulting what are the reasons?*

89 *Does the project have an adequate budget?*

90 *Is the money disbursed /released according to the budget?*

91 *Is the money spent according to the budget?*

92 *Are project funds released on time?*

93 *Are the financial regulations adhered to by all partners?*

94 *Are financial reports made and are they on time?*

95 *Is there an auditing system?*

96 *Has the project been audited according to the regulations?*

97 *Are the stakeholders satisfied with the financial regulations?*

98 *Are the stakeholders satisfied with the auditing?*

99 *Has there been any misappropriations in the project?*

100 *Have there been any audit queries?*

101 *What information and communication equipment does the project possess?*

102 *Does the information and communication equipment meet the needs of/satisfy the needs of the project?*

103 *Is the information and communication equipment adequate for local and international communication?*

104 *Can the project access important information from a variety of international and local sources?*

105 *Is the project easily accessible to international and local counterparts?*

106 *What are the means of internal communication within the project?*

107 *Is the project governed by written policies, guidelines and procedures?*

108 *Are you familiar with the administrative and financial regulations of the project? Give one example of an administrative regulation and one of a financial regulation*

109 *How frequently have the project regulations been reviewed?*

110 *Are there written action plans for the project's activities?*

111 *Who makes the project's plans?*

112 *Is the implementation of the project generally said to be smooth or are there frequent difficulties?*

113 *What mechanisms exist to address bottlenecks?*

114 *Are decisions made in a timely manner or are there frequent delays ? If there are delays, why?*

115 *Is the project on course or is it behind time? If it is behind time why?*

116 *Is there a monitoring and evaluation system for the project? If none, why?*

117 *Are there resources allocated to this function and are they adequate?*

118 *Is the reporting function outlined in the Project Document followed? If no, explain?*

119 *Is the reporting function of the project adequate?*

120 *How have the project-generated reports been used? (e.g. to modify project implementation)*

121 *Do the project reports contain forecasts?*

122 *What is the role of the EHIP-based Evaluation Officer in this project?*

123 *How have the project's financial inputs been used?*

124 *What is the average allocation of research grant per researcher / per research assignment/ per research report?*

125 *What is the cost of the project per beneficiary?*

126 *What is the rate of publication per researcher?*

127 *What is the level of participation per beneficiary?*

128 *Are there formal or informal linkages between the project and the research establishment in Tanzania, Africa and the rest of the world?*

129 *Are there written agreements or Memoranda of Understanding between TEHIP and the others?*

130 *What benefits does TEHIP receive from such linkages?*

131 *Is the research component of TEHIP (or aspects of it) sustainable beyond the four years of project life?*

132 *Could the research component of TEHIP (or aspects of it) have been decentralised to Rufiji and Morogoro Rural?*

133 *Does TEHIP have membership in established local and international networks?*

134 *How many research projects have been undertaken?*

135 *How many research papers have been presented in scientific fora?*

136 *In which scientific fora were the research papers published? (venue and dates)*

137 *How many times has the project featured in public/popular media?*

138 *Is the research agenda of the project on course? (time frame, volume)*

139 *Has the project research produced any significant new findings?*

140 *Has project-generated research been put to general or specific use?*

141 *What has been the contribution of TEHIP to the research climate of Tanzania and internationally?*

142 *What more contribution is TEHIP capable of making?*

143 *Has TEHIP provided any training to aspiring researchers in Tanzania and internationally?*

144 *What has been the result of this training effort?*

145 *How is TEHIP viewed generally by stakeholders and beneficiaries?*

146 *In particular, how is the research component viewed by stakeholders and beneficiaries?*

147 *Has TEHIP promoted itself sufficiently within Tanzania and Canadian societies in general? e.g. to gain political legitimacy and resource support)*

148 *Have research results been used to influence:*
- *project direction*
- *interventions*
- *planning and management*
- *policies*
- *practices of partners*

149 *Have research results been used to contribute to :*

- *body of knowledge on Health Sector Reforms (HSR)?*
- *health systems research?*
- *evidence-based planning?*
- *planning of selected health interventions?*

150 *Is the research component sustainable beyond the project life?*

151 *Could the research component have been decentralised to Rufiji and Morogoro?*

152 *How has TEHIP contributed to health policy direction (including HSR)?*

153 *How has TEHIP influenced partners' policies (Canada, UNICEF etc.)?*

154 *What is the level of participation of beneficiaries?*

155 *With whom are research results shared? (distribution list of research results to academia, political leaders, policy makers, Health care providers)*

156 *How are research results disseminated? (mail, internet, journal...)*

157 *In what languages are research results available? (in English, Kiswahili, French...)*

158 *In what style are research results disseminated?*

159 *Are research results also disseminated to non-scientific readers (and the communities...public?*

160 *Are research activities reported in quarterly reports?*

162 *Are research results easily accessible to all stakeholders and other interested parties?*

163 *Are the resources available to the DHMT sufficient to sustain the implementation of the selected health interventions?*

164 *Is there human resource development plan to sustain human resources after the project life?*

165 *Is the remuneration package of the staff sustainable?*

166 *Is there a phasing out plan?*

167 *What is the districts' capacity to contribute resources for running the project?*

168 *Are the lessons from Morogoro and Rufiji properly documented so that they may be replicated?*

169 *What are typical adoptability conditions in other districts (elsewhere)?*

170 ***Is there a plan to actually follow up Rufiji and Morogoro after current project life ? (to establish more long term relevance)?***

171 ***Is Rufiji and Morogoro representative of Tanzanian districts?***

172 ***What lasting contribution is TEHIP likely to have on the research landscape in Tanzania and internationally?***

APPENDIX: 7

Terms of Reference for the Evaluation

The Evaluation Consultant shall:

1. *Carry out the final selection of local evaluators and draw their Terms of Reference and submit these to the Centre for consideration;*

2. *Identify the training needs of the evaluators. Develop a curriculum, identify, collect and prepare training materials;*

3. *Conduct training of the evaluators;*

4. *Develop the evaluation tools together with the evaluation team;*

5. *Conduct desk study of key documents relevant to the evaluation;*

6. *Carry out data collection with the evaluation team;*

7. *Carry out compilation and analysis of data together with the evaluation team;*

8. *Carry out report writing;*

9. *Finally submit to the centre a detailed and satisfactory report of the work accomplished to the EHIP Executive Director in both hard copy and electronic format (Word Perfect 6.1/7.0 on a 3.5 diskette.*

APPENDIX 8:

Documents Reviewed

Ministry of Health, Health Sector Reforms Plan of Action, Dar es Salaam, 1996-1999

Ministry of Health, Health Sector Reforms, Dar es Salaam, 1996

Ministry of Health, National Health Policy, Dar es Salaam, 1990

Ministry of Health, National District Health Planning guidelines Pt I, Dar es Salaam, 1995

Ministry of Health, National District Health Planning Guidelines, PtII, Dar es Salaam, 1995

Prime Minister's Office, Local Government Reform Programme: Policy Paper on Local Government Reforms

TEHIP Quarterly Reports No. 1,2,3,4

Political Mapping of the Essential Health Interventions Project

TEHIP Guideline for the preparation of core research protocols

World Development Report 1993

TEHIP Research Protocol Component A

IDRC Guide for Institutional Assessment

TEHIP Background Paper

TEHIP Research Component B

TEHIP Consultant's Report by Lucy Gilson

TEHIP Cost Tracking Documents

National District Health Planning Guidelines

Policy Implications of Adult Mortality and Morbidity

Component A TEHIP Research

Dr. Tenga, Trip Report

Irene Matthias, Consultancy Report

APPENDIX: 2

APPENDIX: 3

APPENDIX: 4