

# Fixing Health Systems

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## Building Better Health

Enlisting the aid of communities to improve the health system

*The Tanzania Essential Health Interventions Project shows how health systems benefit when local communities and officials contribute to key decisions and participate in efforts to improve health services. Whether it is making bricks to rebuild dispensaries or speaking up at village meetings, people are assuming responsibility for their futures.*



IDRC: P. Bennett

Community participation is central to the TEHIP approach.

The villagers were arguing. Did Utunge need new classrooms for its school or was it more important to rebuild the community's dilapidated dispensary? A 78-year-old woman spoke up: "How do you educate a sick family?" she asked. Amid ululations from women at the meeting, the

argument was effectively settled. A committee was struck to develop a plan of action. With the villagers contributing labour and locally available materials and the district council making up the shortfall, Utunge had an improved dispensary within 6 months and 6000 people had access to better health services.

Utunge is located in Rufiji district, one of two rural districts that are the focal points for the Tanzania Essential Health Interventions Project (TEHIP) — a collaborative project between Canada's International Development Research Centre (IDRC) and the Tanzanian Ministry of Health. TEHIP provided local health-planning teams in Rufiji and Morogoro districts with small funding increases, along with tools and strategies that allowed them to target their new resources on the largest contributors to the burden of disease and on health care delivery. The results have been dramatic, including an average decline in child mortality of more than 40% over 5 years.

### Local input

Community participation is central to the TEHIP approach. "When you engage and build capacity within the community, it becomes a competent part and parcel of the intervention," says Dr Gabriel Upunda, Tanzania's Chief Medical



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Officer. But in the project's early days, it was not clear how best to harness this potential. Tanzania had embarked on an ambitious decentralization program that devolved responsibility for health care planning to the country's 123 districts. As part of this process, community members were expected to play a role in developing local health plans.

"In practice, this was difficult to do because the communities did not have the opportunity or the capacity," says Charles Mayombana, a Senior Research Scientist with the Ifakara Health Research and Development Centre. Mr Mayombana was part of the research team that set out to address the problem.

The TEHIP team had observed that "community participation" approaches in research and development projects over the past two decades had left many in the South skeptical of its value. Accordingly, TEHIP worked with health managers and workers to make community participation — and its outcomes — more meaningful to local people but only when there were manifest improvements in health delivery to stimulate this process. The project adopted two main strategies. One centred on mobilizing and animating communities to refurbish run-down health care facilities. The other sought to develop a "community voice" tool to help people identify local health needs and set priorities. These priorities would then be fed into the district planning process, with community and district working together to determine plans of action.

"We wanted to get the District Health Management Teams to listen to the community voice," says Dr Upunda. "It is easier to make changes with the communities, rather than imposing change from above."

## Slowly, slowly

To unleash this process of change, the TEHIP team undertook "participatory action research" (PAR) in four villages — two from each district. Researchers guided the communities through several stages of PAR, using techniques that included group discussions, games, maps, calendars, and even mirrors. Villagers began to identify problems, their source, why they persisted, and how they could be solved. "Slowly, slowly people became interested and they started to see what can be done," says Mr Mayombana.

Although "community voice" used health as its entry point, not surprisingly, researchers soon became aware that communities had additional concerns. For example, all four villages identified leadership, delegation, teamwork, and village structures as primary problems. Solutions varied. In one village, the leadership changed; in Fulwe, a planning committee — a separate entity from the village council — was launched to oversee local development initiatives.

## Beyond health

Members of the Fulwe planning committee sit at school desks placed in the shade of trees. Guinea fowl run underfoot and children play soccer in the background, framed by the roller-coaster outline of the Uluguru Mountains. The committee is discussing progress on one of their priorities — constructing a new school. A site has been secured and each of the eight hamlets that make up the village has contributed thousands of bricks. Once the bricks are transformed into buildings, children will no longer need to walk for one hour to reach their classrooms.

The Fulwe planning committee is also considering an offer from a donor that is interested in starting an agricultural project in the village. "In the past, the village would have passively accepted the money," says Mr Mayombana. "Now they are discussing it in light of their plan and priorities." The Fulwe experience shows how the community voice tool, funded as part of the district health plan, can be used as an entry point for broadened citizen participation in local governance. (See also box: *Escaping from crocodiles: How water came to Kilimani.*)

## Rebuilding ruins

Villagers are taking other matters literally into their own hands, such as the rehabilitation of health care facilities. After decades of neglect, many dispensaries and clinics throughout Tanzania were in ruins. The roof of the dispensary in Kiroka, for instance, had so many leaks that staff had a hard time finding a dry spot to store medicine — the clinic officer even threatened to abandon the building.

Lack of funding was clearly a problem, but there was also a popular perception that the health facilities were a government responsibility. People looked to district authorities to solve even simple problems, like a broken lock.

Today, more people are looking to themselves for solutions, with TEHIP supporting these “self-help” initiatives. At the outset of the project, it was clear that the districts did not have sufficient funds to undertake a full-scale renovation program — Morogoro alone had more than 90 facilities. But with communities providing labour and some materials, the undertaking became feasible.

TEHIP invited Tanzanian experts in community mobilization and animation to develop a training program and to supervise pilot projects in both districts. Six communities — three in each district — engaged in participatory exercises that culminated in rehabilitation work plans. The plan for each facility clearly set out the expected contributions from the community and the district authorities. Work took 6 to 7 months to complete.

## Costs less

The process has been now replicated in close to 40 communities, with some villages going well beyond the standard dispensary blueprint by providing the health facilities with better latrines and water supplies. Not only has the approach proved 40% to 60% cheaper than conventional subcontracting, it has also been possible even in remote areas where subcontracting is often not possible. In addition, it has been used to upgrade other village structures such as mosques, schools, health workers’ houses, and other local amenities.

“What is crucial in harnessing popular participation is making people feel that indeed the facility is their property and that the government’s role is just to provide help where it is needed,” says Dr Saidi Mkikima, District Medical Officer for Rufiji. “It is amazing to see what communities can achieve once the sense of ownership is established.”

Celebrations on the completion of each facility underscore this idea of local ownership.

During the festivities in Hanga, for instance, the local member of parliament presented a certificate to the village chairwoman, effectively transferring ownership of the newly refurbished facility to the community. The certificate represents a contract between people and government — the village is responsible for ongoing maintenance costs and repairs while the government ensures that the facility is staffed and has adequate medical supplies. The outcome is a health facility where people feel confident that they can get good care.



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## Escaping from crocodiles: How water came to Kilimani

Kilimani, a village in Rufiji District, illustrates the scope of the community voice approach. Five priorities emerged from PAR activities in the village, including the need to improve access to sources of safe and clean drinking water. At the time, women had to walk 4 kilometres to fetch water from the Rufiji River.

Members of the research team organized a meeting with the Rufiji District Health Management Team to discuss measures to address this priority. In consultation with a technical advisor, appointed by the district water engineer, community representatives developed an action plan. They discovered that the World Bank would fund the lion’s share of the cost of installing piped water in Kilimani if the villagers raised a portion of the money themselves. Villagers decided to create a fund based on contributions from the cashew nut harvest. They raised US \$1 600 by the deadline. The Rufiji District Council contributed US \$1 230 and the World Bank gave close to US \$60 000.

In April 2004, the Hon. Edward Lowassa, Minister for Livestock and Water, officially launched the water project in Kilimani. Today, tap water is no more than 200 metres away from village homes. A report on the use of the “community voice” tool in Kilimani also notes: “(Women) are now safe from the crocodiles, which used to snatch them when fetching water from the river.”

## Training on the tools

Like the community voice tool, the facility rehabilitation strategy is a way to engage local people in the larger process of district planning and implementation. And both approaches are being widely disseminated through Ministry of Health training courses for district health workers. As well, TEHIP has produced a step-by-step manual in English and Kiswahili on community-based rehabilitation.

Back in Kiroka, the dispensary with the leaky roof is now a tidy facility with an adequate supply of most essential drugs. The clinical officer no longer threatens to abandon the building in despair. Instead, he serves approximately 7,800 people who depend on the dispensary for health services. Remarks Mzee Shaaban Mwinyimvua, one of Kiroka's opinion leaders: "We don't complain anymore. We have the means to solve the problem."

*This case study was written by Jennifer Pepall, Senior Communications Advisor in IDRC's Communications Division.*



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### Fixing Health Systems

More detailed information on community participation in Morogoro and Rufiji can be found in *Fixing Health Systems*, by Don de Savigny, Harun Kasale, Conrad Mbuya, and Graham Reid. The book describes the Tanzania Essential Health Interventions Project — its origins, impact, important lessons, observations, and recommendations for decision-makers and policy analysts. The full text of the book is available on a thematic Web dossier, which leads the reader into a virtual web of resources that explores the TEHIP story: [www.idrc.ca/tehip](http://www.idrc.ca/tehip). These resources include a short video, *Building Better Health*, that is a companion piece to this case study.

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



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