

**Case Studies of Existing Public-Private Partnerships for  
Health Services Delivery**

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## Acronyms

ADO	Assistant Dental Officer
Ag DMO	Acting District Medical Officer
BAKWATA	Moslem Association of Tanzania
CBD	Community Based Distribution
CBDAs	Community Based Distribution Agents
CBHC	Committees on Community Based Health Care
COTC	Clinical Officers Training Centre
CO	Clinical Officer
CPR	Contraceptive Prevalence Rate
DAC	District AIDS Coordinator
DCCO	District Cold Chain Operator
DHMT	District Health Management Team
DHP	District Health Plan
DMCHCo	District MCH Coordinator
DMO	District Medical Officer
DPLO	District Planning Officer
DTLC	District Tuberculosis and Leprosy Coordinator
EPI	Expanded Program on Immunization
FP	Family Planning
FHI	Family Health International
GM	Growth Monitoring
GNDUC	General Nursing Upgrading Diploma Course
HC	Health Centre
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome
MTUHA/HMIS	Health Management Information System
HO	Health Officer
HS	Health Secretary
I/c	In Charge
IEC	Information, Education, and Communication
IGA	Income Generating Activity
IHDRC	Ifakara Health Development Research Centre
IMCI	Integrated Management of Childhood Illness
INGONET	Iringa Non-Government Organization Network
ITBNs	Insecticide Treated Bed Nets
IUCD	Intra- Uterine Contraceptive device
IUD	Intra-Uterine Device
LPO	Local Purchase Order
MCH	Maternal/Child Health
MOH	Ministry of Health
MP	Member of Parliament
MSD	Medical Stores Department
NGO	Non-Government Organization
NORAD	Norwegian Agency for Development
OPD	Out Patient Department
O/S	Out of Stock
PAT	Project Advisory Team
POP/FLEP	Population Family Life Education Program

PLWAs	People Living With AIDS
RAC	Regional AIDS Coordinator
RMCHCo	Regional MCH Coordinator
RMO	Regional Medical Officer
RNO	Regional Nursing Officer
SATF	Social Action Trust Fund
SDC	Swiss Development Corporation
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TAHEA	Tanzania Home Economics Association
TAP	Tanzania Aids Project
TARENA	Tanzania Registered Nurses Association
TBA	Traditional Birth Attendants
TOC	Trainers of Communities
TOT	Training of Trainers
TKAI	Tanzania Karatasi Associated Industry
UMATI	Family Planning Association Tanzania
VIP	Ventilated Improved Pit Latrines
WHO	World Health Organization

## **Case Studies of Existing Public Private Partnerships: Introduction**

This document contains case studies of public-private partnerships that were identified during the Rapid District Assessment of Existing Public Private Partnerships for Health Services Delivery, conducted in February and March 2001. That assessment explored existing partnerships in four key areas: core functions (planning, budgeting, training, HMIS, supervision, purchasing); service delivery functions (curative and preventive including HIV/AIDS services); special activities that often entail partnership (National Immunisation Days, construction /renovation of health facilities, emergencies and epidemics, refugees); and trust/mistrust among the public, private non-profit, faith and private for-profit sectors. The four districts included in the assessment were Arusha Municipal, Iringa Rural, Kilombero and Kasulu.

During that assessment, seven partnership situations were identified as rich examples for further study. (Other partnerships were described in the Rapid District Assessment report to which the present document is an annex.) These situations were explored further during additional site visits conducted in May and June 2001 by Dr. Tengo Urrio and Mr. Peter Riwa of Tanzania HealthScope Ltd. During those visits, the researchers conducted additional interviews with regional and district MOH personnel, local government officials, faith and NGO health personnel, for-profit health providers, ward and village leaders, businessmen and others involved in local partnerships. The research team wishes to thank the interviewees for their generous collaboration.

The current document contains the full text of the case study reports. This material will also be used to produce a brochure on public-private partnerships for general distribution to potential health partner institutions.

- Case 1: Renovation of Mount Meru Regional Hospital: Successful public/private partnership with strong business and political leadership
- Case 2: Construction in Kilombero District: Successful community construction partnership contracts for dispensaries and health personnel housing
- Case 3: Health planning in Kilombero District: Extending the District Health Management Team to include private sector partners
- Case 4: The Iringa NGO Network (INGONET): Village, ward and district partnerships to combat HIV/AIDS
- Case 5: The Iringa CBD network: Incomplete transition from a private project to a public programme
- Case 6: Iringa Rural District Council: Multi-sectoral tendering for purchase of goods and services
- Case 7: Joint supervision teams: Examples from Iringa Rural and Kilombero Districts

## Case Study 1:

### Renovation of Mount Meru Regional Hospital in Arusha Municipal District: Successful public/private partnership with strong business and political leadership

Staring at the leaking roofs and the cracked walls under peeling layers of paint in the seventy year old Mt Meru Regional Hospital during an official visit in 1996, the newly appointed Regional Commissioner, the Honorable Daniel Ole Njoolay, had an idea. On his own initiative, he proposed an innovative approach for mobilizing resources for rehabilitating the hospital, so desperately in need of repairs. To serve the catchment area resident population of 1.6 million, would require reinforcement of new roofs, new paint, new paving, toilets for patients and care providers, new equipment and new buildings.

Mt Meru Regional Hospital was established as a military camp in 1926 for treating casualties of the First World War. After the war ended, the colonial government decided to use the facility as a regional hospital. In time, it grew to contain 450 beds. However, due to inadequate maintenance over several decades, the physical structure of the hospital had progressively undergone unchecked decay.

Fully aware of the limitations of the traditional government sources to provide adequate funding in a short time, the Regional Commissioner ventured mobilization of resources from the private sector.

The strategy started with careful selection of a diversified committee of 19 members, including prominent businessmen based in Arusha, politicians (Members of Parliament and local councilors), media, and civil servants from the Department of Health and Regional Commissioner's Office.

The Regional Commissioner challenged the members to think of strategies for mobilising sufficient resources for rehabilitation of the hospital. The committee accepted the challenge and asked the

#### Mount Meru Regional Hospital Committee

**Chairperson:** Mr. Tosky Hans, Businessman, Fiber Board E.A.Ltd.  
**Vice Chairman:** Mr. Walter Maeda, Businessman, Hotel and Transport  
**Treasurer:** Mr. Beatus Kasegenya, Businessman, Audit Company  
**Secretary:** Mr. Kassim Mamboleo, Protocol Officer, Regional Commission  
**Vice Secretary:** Mr. Gulam Hussein Muktar, Businessman, Retail Shop

#### **Members:**

Hon Mr. Felix Mrema, Member of Parliament  
Ms Anna Rweyemamu, Businesswoman, Ethiopian Restaurant  
Dr Naftael Ole Kingori, Regional Medical Officer  
Mr. Shaukat Dalal, Manager, Pepsi Cola Company  
Rt. Major Alhaj Mollel, Civil Service: Councilor  
Mr. Kansara, Owner of a Bicycle Shop  
Mr. Mussa Mkanga, Civil Service: Councilor  
Mr. Greyson Mdeme, Civil Service: Regional Information Officer  
Mr. Sukhdev Chartbar, Representative of Daily News Paper in Arusha  
Mr. Leonard Kessy, Business: Public Transport  
Dr Omar Chande, Medical Officer i/c Mt Meru Regional Hospital  
Ms Elimbora Laizer, Nursing Officer i/c Mt Meru Regional Hospital  
Dr Thomas Kwai, Civil Service, Seconded to St Elizabeth Hospital  
Ms Mwamini Nyakwela, RNO, Mt Meru Regional Hospital

Regional Commissioner to be the Committee's patron.

As patron, the Regional Commissioner facilitated official launching of the “Mount Meru Hospital Rehabilitation Committee” (hereafter referred to as “the Committee”) by the Prime Minister, the Hon. Frederick Sumaye (MP) on the 29<sup>th</sup> November 1996. In his remarks, the Prime Minister commended the move. He reminded the committee that Mount Meru Hospital served Arusha residents and said that the move was in the right direction. To start the ball rolling the Prime Minister gave a generous donation of Tsh. 500,000 to the Committee. Successful fund raising activities led to the commissioning of the rehabilitation of Mt Meru Regional Hospital by the First Vice President in 1997.

By January 2001, the Committee had applied a battery of innovative strategies for mobilized funds. It had spent Tsh. 400 million on renovation and procurement of hospital equipment. According to the Regional Medical Officer, Dr Naftael Ole King’ori, the rehabilitation of the hospital is now almost complete. What remains to be done is the construction of an administrative building to house the office of the Regional Medical Officer, and of a kitchen and hospital laundry.

Thanks to this impressive rehabilitation work, Mt Meru Regional Hospital has attracted the attention of both local and international organizations. Internationally, Mt Meru Hospital been selected by WHO as a centre for Africa regional training in Integrated Management of Childhood Illnesses (IMCI). Nationally, Mt Meru and Morogoro Regional Hospitals have been selected by Muhimbili University College of Health Sciences as sites for training medical interns.

### ***Strategies for Resource Mobilization***

The Committee elected a secretariat from its membership and opened a bank account with National Bank of Commerce 1997 (Ltd), Uhuru Road, Arusha Branch under the name of “Mount Meru Hospital Rehabilitation Committee”. Strategies developed and adopted by the Committee mobilized resources both in cash and in kind. All in kind contributions for fund raising were converted into cash and deposited into the account.

#### **Lottery**

A lottery was organized on the 8<sup>th</sup> August 1997 to coincide with the National Farmers' Day celebrations. A number of items were obtained for auction including motor cycles, bicycles, refrigerators, deep freezers and a 7-ton truck which was sold to the committee at “*a give away price*” by a renowned car dealer in Dar es Salaam (Afri-Carriers Ltd.). The auctioning of the truck was such a moving event that it generated unexpected resources for the hospital.

The RMO told the story, "Afri-Carriers sold the 7-ton truck to the Committee at a "give away price". Lottery tickets were prepared and sold for winning available items. One man purchased tickets worth Tsh. 300,000 with the sole intent of making a contribution to the Committee. The man took the booklets and left them in his office. When he was informed that he was the winner of the 7-ton truck, he said, “I am very grateful but I made a contribution to the Committee and therefore still on my

commitment I am giving back the truck to the Committee”. The Committee took the truck back to Afri-Carriers Ltd. and sold it at Tsh 3,000,000 which was credited to the account of the committee."

### **Charity Walk**

A charity walk was organized on the 12<sup>th</sup> August 1999. The charity walk was popularized by two events. First, it was announced that the Father of the Nation, the late President Julius K. Nyerere, was going to receive the walkers. As usual, it was expected that he would give a moving speech. Secondly, the walk marked the 20-year anniversary of the Commonwealth Regional Health Community Secretariat, a regional health organization based in Arusha.

In preparation for the charity walk, each committee member was given a target of collections from his own network of friends and associates. Mt Meru Regional Hospital staff participated fully in the walk, wearing special T-shirts designed for the event. Hospital staff raised about Tsh. 800,000 through the sale of T-shirts. The huge turnout was met by former MP and Prime Minister the Hon. Cleopa Msuya, due to the untimely death of Mwalimu Julius K. Nyerere.

### **Fund Raising Dinners**

Fund raising dinners were organized at different times in Arusha and Dar es Salaam. The Prime Minister hosted the dinner in Dar es Salaam at his residence. Several dignitaries, prominent businessmen and businesswomen resident in Dar es Salaam with family ties to Arusha were invited. A colorful brochure was produced highlighting the history of the Hospital with photographs of the deplorable physical conditions of the structures and showing the amount of resources required. The appeal message read "***Hakuna Ngoma Isiyo na Kungwi***" ("There is no *ritual* without a *kungwi*/facilitator".) In addition to the appeal, it stated "***It is now the turn of Arusha residents living in and outside Dar es Salaam to support phase II and III requiring a total of Tsh. 75 million.***" A total of Tsh. 70 million in cash and materials was raised, including liters of wall paint and engine oil which were later sold and the proceeds deposited in the account.

### **Individual Requests and Voluntary Contributions**

#### **Voluntary Contributions**

Arusha being the "Geneva of Africa", the city is constantly hosting regional and international activities. Government officials playing host to these events also dedicate time to visit regional development activities. They often visit Mt Meru Hospital, which happens to be across the road from the International Conference Center.

During such visits by Government leaders, generous contributions have been made at different occasions. Examples include contributions of Tsh. 1 million by the President Benjamin W. Mkapa, contributions of Tsh. 500,000 and Tsh. 700,000 by the Prime Minister on two different occasions, and Tsh. 500,000 by the Arusha Member of Parliament.

## Individual Requests

Committee members and the Patron took the initiative to request voluntary contributions from individuals and organisations based in Arusha. About a million Tanzanian shillings were contributed by Arusha Municipal Council Workers, Mt Meru Hospital Staff, and small miners at Mererani mines in Arusha, the latter as a result of an appeal by the Regional Commissioner. Mt Meru Regional Hospital staff contributed through a three month salary deduction.

## Contributions by Big Business

The committee contacted prominent businesses resident in Arusha and asked for in-kind contributions. Some businesses were reluctant to make a contribution in cash for fear of misuse or malpractice. Such businesses asked for other options for making their contributions. Exercising flexibility, the Committee accepted contributions in the form of cash, building materials and direct participation in renovation and construction. Each company opting for direct participation was assigned a building to renovate. They then either conducted the work directly or engaged their own contractors.

Table 1 shows the businesses and groups which controlled renovation or construction of entire units, while Table 2 shows other cash and in-kind contributions. Companies spent between Tsh. 10-17 million each per building (probably a far greater amount than they would have contributed in cash). After the renovation or erection, the buildings were handed over to the Committee for inspection. Upon satisfaction with the work completed, the Committee handed the buildings over to the Hospital.

**Table 1 - Funding Sources for the Renovation of Mt Meru Hospital**

Source of Funds	Unit Renovated
Tanzania Breweries	Ward 1
Mt Meru Rehabilitation Committee	Wards 2, 3, 4 and 5
Tanzania National Parks	Ward 6
Tanzania Electrical Company (TANALEC)	Ward 7
Kibo Breweries	Ward 8 to be Doctors Plaza
Tanzania Bulk Supplies	X – ray Room
Canadian Embassy	MCH Unit
Japanese Embassy	Mortuary
Japanese Embassy	Central Laboratory

**Table 2 - Cash and In kind Contributions by Business**

Business/Company	Contribution
General tyres	Tshs 2,000,000
Remtullar Pirbhai	Tshs 3,000,000
Tanzania telecommunication Company Ltd	Tshs 500,000
Fibre Boards	Building Materials
Stanbinc bank	12 mattresses

## **Networking**

A high profile sub-committee was established in Dar es Salaam to mobilize resources inside and outside Tanzania for the rehabilitation of Mt Meru Hospital in

### **Members of the Sub- Committee in Dar es Salaam**

1. Mr Raphael Molell, Formerly Permanent Secretary of the Treasury
2. Major General Sayore, Ministry of Defense
3. Mr Simon Sayore, Tanzania Audit Corporation
4. Mr Solomoni Tareto Jeremiah, Dar es Salaam Stock Exchange Market
5. Dr Mollel, TKAI
6. Ms Rose Lyimo, Businesswoman
7. Mr Steve Moorria, Managing Director, Wang Computers

Arusha. The members of the sub-committee appear in the box. Through the network resources for building two new buildings were constructed, the mortuary and an MCH Unit and the central laboratory was renovated.

## ***Support from Embassies***

### **The Mortuary and Laboratory Buildings**

One member of the sub-committee contacted the Japanese Ambassador in Tanzania. Through the Ambassador, some funds were made available from the Food Aid Counterpart Fund. The Committee engaged the services of a quantity surveyor to come up with a bill of quantities to develop a construction budget for a new building for the mortuary and to renovate the central laboratory.

Through an open tender system, the Committee selected a contractor who signed a contract with them. Through its weekly Friday evening meetings, the Committee monitored the construction from beginning to end. The mortuary, with a capacity of 48 bodies, was erected at cost Tsh. 95 million including the cold storage equipment. In line with MOH policy encouraging “contracting out of non core functions“ Mt Meru Regional Hospital administration is exploring the possibility of contracting out the running of mortuary services.

### **The New MCH Unit Building**

At the request of the Committee Patron, the Department of Works in Arusha prepared an estimate of materials for the construction of a new MCH unit at Mt Meru Regional Hospital. The Patron submitted a request for assistance to the Canadian Embassy Dar es Salaam. (It is said the Patron knew the ambassador at personal level.) The Canadian Embassy approved the plan and estimate.

The Canadian Embassy instructed the Department of Works to undertake the construction the MCH unit building. With this instruction, there was no tendering. Construction started immediately and the building has now been completed.

## ***Key factors leading to success***

A combination of at least five factors seems to have contributed to the success of the private/public partnerships demonstrated in the renovation of Mt Meru Regional Hospital to a single factor.

## **Geography**

Arusha town is one of the growing industrial cities in Tanzania. Unlike many other towns, Arusha is the location of big manufacturing industries like General Tires, Fiber Boards, Kibo Breweries and others. In addition, the availability of good hotel services due to the booming tourist industry and the International Conference Centre has made Arusha a center for regional and international conferences bringing in top government leaders. For purely geographical reasons it was possible for Mt Meru Rehabilitation Committee to mobilize substantial amount of resources from the business community and access to regular visits and generous contributions from top government leaders.

## **Administrative Factors**

### **Transparency**

The Committee maintained transparency in its financial management. A bank account was established and the accounts of the Committee were maintained and audited by a professional auditing company. "Every shilling is accounted for" has said the RMO-Arusha. Transparency of this sort inspires confidence in potential investors and encourages repeat giving.

### **Regularity of Committee Meetings**

The Committee chose regular meetings as its modus operandi. Every Friday evening between 4-6 p.m. the Committee chose to meet at the small office of the Regional Medical Officer. He said, "During the meetings, members made contributions for the tea and coffee we took. Always members were punctual and the attendance was good. We discussed progress achieved and conducted physical inspections of buildings. However the attendance is still as good as it used to be probably because the work is about to be completed."

## **Public Recognition**

The Committee issued certificates of recognition to people and organizations for their contributions. National political leaders visiting the hospital issued the certificates, shook hands and took joint photographs. Participation of leaders in certain highly publicized activities such as the Dar es Salaam dinners and Charity Walk also gave political prestige to the project and undoubtedly attracted additional support to the project. Philanthropists liked the recognition they received and it may well have inspired other donations.

## **Personal Factors**

Personal factors no doubt played an important role. The initiative from the Regional Commissioner and the careful selection of committee members remains strategic and outstanding. As was said by the RMO, "If you don't tap it, you can't get it". Mobilization of the greater "Arusha family" of successful former Arusha residents was a particularly astute effort.

Likewise, the commitment of the Committee is demonstrated by good attendance in many meetings after office hours, innovative ideas on resource mobilisation and individual contributions to the project. The expression used by the RMO-Arusha, “the Committee was committed” paints the scene.

### **"Nothing succeeds like success"**

#### **Trust Created**

A lot of trust emerged between the public and private sectors during the rehabilitation of Mt Meru Regional Hospital. The source of the trust seems to have come from the confidence demonstrated by the public sector in the private sector through: a) selection of Committee members by the Regional Commissioner from the private sector, b) delegation of authority and responsibility to the Committee in undertaking the rehabilitation. “The committee worked independently without interference” (RMO- Arusha). As noted above, the transparency of the financial management procedures also created trust.

#### **Visibility of the Project**

The renovation and rehabilitation of Mt Meru Regional Hospital involved new buildings, new roofs, new paint, new pavements and other highly visible improvements which donors and committee members could see for themselves. This visual impression may have facilitated the process of resource mobilisation as “people could see what is being done with the resources”. Visibility attracted more donors and sympathizers. Similarly, the attribution of specific buildings to key business and local donors made their contributions highly visible and may have provoked a healthy rivalry among them to provide good quality work.

#### ***Future of the Committee***

The rehabilitation of Mt Meru Regional Hospital is almost complete. The question now lingering in people’s mind concerns the future of the Committee which has done such an impressive job. According to the RMO, two ideas are being entertained. The first is to wind up the Committee after completion of the work. The second one is to co-opt some of its members onto the Mt Meru Hospital Board to be established under the Health Sector Reform.

## Case Study 2:

### **Construction in Kilombero District: Successful community construction partnership contracts for dispensaries and health personnel housing**

Kilombero District is one of the five districts of Morogoro Region and covers an area of 14,818 sq. km. The population of 230,000 people lives in 5 divisions, 15 wards and 46 villages. The district has collaborated with the Swiss government since 1949. Support began with laboratory research and latter was extended to curative services, training and, in recent years, support for a district-wide health programme that involves improvement of quality of care, health promotion and protection.

Kilombero district, like all other districts in Tanzania, faces the challenge of providing accessible, cost effective and high quality health services to the people in an environment of inadequate resources for health. Hitherto, the development of the present health services delivery infrastructure and the building and renovation of the health facilities was done by the central government with very little participation of the community and the private sector. There was no significant involvement of the community in building repairs and maintenance nor in management of the health facilities. A social-cultural survey carried out in 1994 revealed that the district had an inadequate health services delivery infrastructure. There was a shortage of drugs, lack of community involvement in health interventions, weak community structures, women did not participate in decision making and there were cultural beliefs detrimental to health.

Forming partnerships between the public and private sectors was identified as one of the crucial new strategies for providing adequate health infrastructure. Kilombero District has found out that community involvement in construction and renovation of health care facilities has many advantages.

#### ***The preparatory stage in forming partnerships with the community-Community empowerment***

*"In order to enhance the speed of improving the health services, we thought that it was important to involve other partners, especially the people",* Kilombero District Reproductive and Child Health Co-ordinator.

In the Plan of Operations 1999/2000, objective 4-quality assurance of District Health Services, sub-objective 3 (Maintenance, rehabilitation and replacement of health facilities) addresses the problem of inadequate health services delivery infrastructure. The strategy was to involve communities in the improvement of the health services delivery infrastructure by involving them in the construction and rehabilitation of health care facilities. Five pilot villages (Mbingu, Sonjo, Sanje Kisawasawa and Namwawala) were selected to test this strategy before introducing it to other villages.

## **The community mobilisation process**

The process of community involvement starts with communication. Establishing communication is the first step in developing partnership between the community and the public sector. In Kilombero, the process was led by the district Trainer of Facilitators (TOF) and the CBHC Co-ordinator.

The process of community involvement includes:

- Community sensitisation on the community based approach
- Training of the Ward Development Committees on Community Based Health Care (CBHC)
- Community meetings to identify community problems
- Communities select TOTs
- Communities select TOCs (Trainers of Communities) to act as mobilisers and animators
- Training of TOTs and TOCs on CBHC and social mobilisation
- Community sensitisation through community meetings and continuous community mobilisation by the TOCs
- TOCs help communities identify problems, prioritise them, then identify resources in the community that can be used to solve those problems
- Communities form primary health care committees

Through this process, the community becomes empowered. The residents realise that solving their problems is their responsibility. They realise that they have resources in the community that can be used to address their problems. They can provide labour, building materials, expertise in building (masons, carpenters, etc.) The communities also identify resources from outside that can be used to supplement community efforts.

## **Defining the project through community mobilisation**

During the Community Mobilisation phase in Kilombero, intensive mobilisation activities were done in the five villages by a team from the DHMT led by the CBHC Co-ordinator and the district Trainer of Facilitators. Examples of problems the residents identified are inadequate numbers of classrooms, improper housing, inadequate social services (water and health). Health related problems included old dispensary buildings, shortage of drugs and equipment, inadequate number of and decrepit state of staff houses in the peripheral health units.

Residents were asked to prioritise interventions for the health-related problems they identified. They chose to address the physical state of the buildings and the construction of health facilities. Community mobilisation meetings were held in Mngeta, Msolwa and Signali villages to ensure their contribution and participation in construction of new health facilities. *“The communities experience their problems. They know their problems more than we know them, so the projects are community demand driven”*, the DPLO-Kilombero.

Some of the communities identified problems that were in the domain of other sectors such as education. The DHMT assisted them in discussing these problems with the other sector directors on the District Council.

In one village the community decided to build a dispensary. They identified community resources and requested external resources from a donor. Later, the community decided that it needed a health centre rather than a dispensary. The donor advised that a health centre was not needed according to the health centre:population ratio set by Ministry of Health. Furthermore, the donor had only budgeted for a dispensary! The donor thus advised the community to discuss the health centre proposal with other donors such as Plan International who might assist with the health centre if the MOH gave special approval.

### ***DHMT-Community Partnerships - a formal contracting process***

#### **Kinds of contracts**

The partnership between the public sector and the communities in the villages involved in construction/renovation of health facilities is formal and is sealed by the signing of binding contracts. This is an example of strict partnership defined by a legal relationship between two or more parties defining the responsibilities and rights of each partner.

There are 3 types of contracts:

- ◆ The DHMT and the community sign a contract with the village government that specifies that the village and the DHMT are partners in improvement of the health services in the village. The DHMT (DMO), the village government (Village Chairman and the technical implementers at village level - TOTs and TOCs - who are selected by the community) sign the contract.
- ◆ The contract between the village government and the District Health Management Team (DHMT) for the building or rehabilitation shows the contribution of the two partners. The village government signs to provide land, storage of project materials, building materials (sand, stones, soil, etc), water, clearing and preparation of the site etc). The DHMT signs to provide the building plans, contractors for skilled labour, building materials, roofing materials, doors etc.
- ◆ The contracts between the DHMT and the individual contractors. The village selects the contractors. The HO i/c of construction and the District Engineer provide technical advice to the village as to whether the selected contractor is technically competent or not. The contract shows the work to be done, the time frame, the amount of money to be paid, and states that the contractor will co-operate with the village government in implementing the project.

#### **The contractor uses local artisans**

The building contracts are awarded to local contractors. The local contractor hires expertise in the village (masons, carpenters, etc.) *“Thus, the money is paid to a local contractor and local ‘fundis’ (artisans). This is a strategy in poverty alleviation*

*where the money remains in the community, improves the economic status of the local population and can be used for family needs in paying school fees, etc. This could not have happened if we hired a contractor from outside who would bring in his own 'fundis'. The money would have been taken from the community and spent somewhere else", DPLO-Kilombero.*

Aside from the *fundis*, the community members and members of the building committee donate their time. According to the agreement with the DHMT, the community is required to provide labour for digging and building the foundation of the building. This participation increases the sense of ownership by the community.

Activities that require technical advise/expertise not found in the village are identified and assisted by the District Engineer and the HO I/c of construction.

### ***Who does what?***

#### **The building plans**

The building plans are obtained from the MOH. The MOH requires that districts use the standard building plans for health units in all the districts in the country. Experience shows that the plans have to be adapted to local conditions. In Kilombero, provisions were made to prevent the rampant infestation of roofs by bats. Bats have been responsible for the destruction of many roofs and ceilings of public buildings in the district, they make noise and their droppings stain floors and walls. The standard MOH plans for the roofs were therefore modified to allow enough light in the ceilings to be repulsive to bats (since bats shun light, a roof with enough light in the ceiling keeps away bats).

#### **Estimation of materials and days of labour**

Using the modified plans, the district assists in quantification of the activity in terms of material requirement, labour days etc. This appears in the bill of quantities that is presented to the contractor. For example, when the Sanje Community decided to put up a dispensary, the district assisted them in making materials and labour estimates. The dispensary was expected to cost Tsh. 11, 590,000. The community contribution in terms of materials and labour was estimated to be Tsh. 3,477,000 while the DHMT contribution was Tsh. 8,113,000.

During a community meeting, residents decide on which village will provide what quantity of materials. The village governments make sure that the local materials are on site and local labour is available. The community provides security for the materials brought to the site including those brought from outside. *'We bring to the site sand, gravel, bricks and stones, then we dig the foundation. After this we can now start using the materials provided by the donor.'* –Village Executive Officer - Sonjo village

#### **Technical supervision of the construction**

Supervision of the construction is the responsibility of both the DHMT and the community. The DHMT has established a new post of Health Officer i/c of

Construction to supervise the construction and renovation of health units. The District Engineer assists him. A Building Committee is formed by the village and prepares a duty roster to supervise the building activity. Two members of the Committee must be on site every day to oversee the construction and the issue and use of building materials. The village government and the Building Committee supervise the contractor together.

The possibility that something will go wrong and go unnoticed till the building has advanced too far is avoided by close supervision by the village government and by the Building Committee. Frequent supervision by the HO i/c of Construction and the District Engineer also ensures that the agreed standards are followed and that deviations do not proceed too far before they are identified.

In addition the construction plan is divided into phases. At the end of each phase, both the village and the DHMT/District Engineer must approve the work. The contractor is then paid for that phase and is allowed to begin the next. Thus the contract is performance-based and the contractor is paid according to the achievement of certain performance benchmarks.

The District Engineer and the DHMT also provide technical oversight for community contributions. At Mbingu village, the sand provided by the villagers for construction was found to be of low quality. The District Engineer advised them to bring in better quality sand.

### **Sources of funding**

The SDC is the main donor of these activities, from the community mobilisation and sensitisation activities to construction and renovation of physical structures. Plan International has funded construction of two dispensaries (Nawala and Michanga) and one health centre (Mngetta). Plan also provides ongoing support for Kibaoni and Mangula Health Centres. Irish Aid has provided funds for building a health centre at Mlimba. All these health units have been completed through the community mobilisation process. Mwaijak is involved in activities for prevention of the adverse health effects that result from the introduction of a new industry, the Ruaha electricity project.

Rarely do local businessmen participate by contributing more to these projects than other ordinary residents. The former Member of Parliament (recently deceased) is the only notable example that gave freely to health and other activities in the district.

### ***Results***

#### **Timely completion of projects**

Kilombero's community construction projects do get completed. Sometimes there are delays, but as supervision is regular and close, such delays are identified in time.

The speed of communities in bringing in the building materials can on occasion be slow. The cause of the problem at a particular site is identified early, as the DHMT is always in contact with the community. For example, at Sanje village the construction

that had started before all the local materials were on site was brought to a standstill while the remaining materials were delivered. Delivery was delayed because of conflicts in the village government. The youths in the village wanted the village government to resign if it could not organise delivery of the materials to the site.

In Nawalla village, there was also delay in bringing in the materials and the H/O in charge of construction had to go to the village several times to show his concern. Later, it was discovered that it was again a problem of leadership. The Ten-cell Leaders refused to co-operate with the Village Chairman. They thought that he was over-enthusiastic and wanted to take credit for the work. They accused him of going to the cells to call meetings without involving them. The Ten-cell Leaders thought that the Chairman was interfering with their work.

At Mbingu, work stopped because of a change in leadership when the Village Chairman, a good community mobiliser, was replaced. The problem however was not only with the village leadership. The village had planned to get a lorry from the district to collect the sand and the lorry was not available. Later, the Building Committee identified a nearby source of sand from which residents could deliver it by carrying it on their heads.

In the plan of operations 1999/2000, the three new dispensaries were completed (Mbingu, Sonjo, Sanje). The two new staff houses (Sanje, Namawalla) were also completed. Refurbishment of Signali dispensary was completed and so was the rainwater harvest at the same site. The VIPs that were planned for five schools have been completed. Two planned staff houses were not completed and were rescheduled for the following year.

### **Sonjo Dispensary - an example**

Sonjo Dispensary is a modern large building with 8 rooms (OPD, store, dispensing, injection, laboratory, MCH, labour ward and consulting room). The dispensary has 7 staff members including the Clinical Officer, Assistant Clinical Officer, Nurse Midwife, Nursing Assistant, MCH Aide and watchman. The six villages that are served by the dispensary shared the construction work among themselves. Each village made 6,500 bricks (of the total 40,000) and raised money to hire a tractor to bring them to the site. One village was cut off by floods and failed to bring in the bricks on time. After the rains subsided, the village brought in its share.

The building was not completed on time because the community had also to do farming and there was excessive rainfall during the year. *"It is important to take the community's timetable into account when implementing the project."* –The Clinical Officer, Sonjo Dispensary.

### ***Advantages of community partnership for construction***

In Kilombero, partnership with communities in the construction of health facilities has shown many advantages:

1. Reduction of building costs as local materials are used for construction. The communities contribute more than 25% of the cost of the project.

2. Security of the building materials is assured. Security was a big problem before this approach was introduced. Thefts occurred often. As the materials belonged to the district officials who had brought them into the village, communities did not show concern. Apprehending the thieves and bringing them to law was very difficult. With the community partnership approach, building materials belong to the community so the community provides security. If they are stolen, it is the community's responsibility. In Mbingu village for example, when building materials were stolen the community hunted the thieves down, caught them, and brought them to court.
3. The role of leaders is strengthened. Because the community proposed the project, it has a commitment to implement it. Success in implementing the project depends a lot on leadership at the lower levels i.e. at the ten-cell leaders and village level. "*Kama ngazi za chini zikilegalega na kazi inalegalega* (If leadership at the lower levels is weak then implementation is poor)" -Village executive officer, Sonjo village.
4. The communities have developed sense of ownership of the buildings "*We used our own sweat so the building is ours. This has implication on sustainability*" -H/O I/c of construction. The community sustains the project. Many of the buildings that were built without participation of the community are now in bad state of repair because of lack of maintenance. Where construction has been done in partnership with the community, residents have started maintenance funds for the buildings that have been completed.

In addition to owning the buildings, residents now feel that it is their responsibility to ensure that the services offered in the buildings are of good quality. They have realised that there is a problem with drug availability, so they have decided that each patient will pay a small fee for cost sharing. They have set up a Health Fund Committee that oversees the collection and use of cost-sharing money. They also have defined exemption criteria for impoverished residents. As a result, the villages of Sonjo and Mbingu have up to 4 million shillings in their account. "*After construction the dispensary is owned by the village, the buildings belong to the village, the medicines are bought by our contributions*", -Mkula Village Chairman.

5. The empowerment process is an eye opener. The communities have developed confidence that in their power to solve their own problems, so they adopt the same approach to find solutions to other health-related problems in the villages, such as contributing fuel for the HC ambulance to send critically ill patients to hospital. For example after building the dispensary they went ahead to solve the problem of the bad state of staff quarters. "*Now we have a dispensary but the doctors' houses are in a bad shape. You have seen those heaps of sand and 35,000 bricks that we have brought. We are now going to build a house for the doctor and our nurse.*" -Sonjo village chairman. In some villages, women groups have started non-health self help projects like setting up chicken barns.

### *Hope for the future*

In Kilombero, partnerships with the community for construction and renovation of health facilities has shown success and is bound to continue. The DPLO sounded very supportive of this approach as did the DHMT and community leaders. The approach

seen in Kilombero is very much in line with the Local Government and Health Sector Reforms because it:

- Decentralises management of health services through empowerment of communities to be involved in planning and provision.
- Forms partnership between the public and private sectors, including the community, donors, NGOs and private contractors.
- Uses alternative health financing mechanisms through community mobilisation and reduces costs through employment of local labour and materials.

More important, this strategy is bound to continue because it has achieved community empowerment. In Kilombero after completion of the health facilities project, the communities have identified and solved other community problems like lack of staff houses and inadequate medicines in the dispensary. The process will continue because communities have been convinced that it works.

Other districts are likely to adopt this strategy as districts do share information. In recent months, Geita District in western Tanzania sent members of its DHMT to study the Kilombero approach. The team went on field visits to the villages that have implemented the strategy.

### Case Study 3:

## Health planning in Kilombero District: Extending the District Health Management Team to include private sector partners

The District Health Management Team (DHMT) in Kilombero District is larger than that of many other districts. Its members are shown in the box. The District has found it necessary to enlarge the DHMT in order to include in decision-making all the officials responsible for the key units of the district health services. "*Their inclusion in the DHMT makes them more responsible and accountable.*" - District Health Secretary.

In addition to these members, the DHMT sometimes includes the CBHC coordinator. When he sits on the team, the DHMT is called **the extended DHMT**.

<u>Kilombero District Health Management Team</u>
District Medical Officer
District HS
District Nursing Officer
Health Officer - Construction
Health Officer - Vector Control
District Reproductive Health and Child Services Co-ordinator
DCCO
ADO
District Mental Health Co-ordinator
DTLC
District Ophthalmic/Optomtrist
Ag DMO

There are also 5 co-opted private sector members of the DHMT. They are: the Principal of the Clinical Officers Training Centre (COTC), the Principal of the General Nursing Upgrading Diploma Course (GNDUC), the Director of the Ifakara Health Development Research Centre (IHDRC), the Director of St. Francis Hospital (a District Designated Hospital), and the Technical Advisor of Solidamed Support Unit. The entire group is now named **the DHMT proper**.

### *Role of the co-opted members*

Co-opted members of the DHMT proper have some but not all of the powers and responsibilities of public sector members. Co-opted members can propose additional or new items to be included in the DHMT agenda. They can vote on issues and their ideas can influence decisions. Their role is a consultative one but they also provide technical assistance in training, research and other areas.

The co-opted members join the DHMT during the preparation of the Plan of Operation for the district at the annual All Health Actors Planning Workshop. During this workshop, in addition to discussing the DHMT plans, they also discuss the plans of their institutions and include them in the District Plan of Operation.

Co-opted members can make decisions that influence health services in the district. Although the tendency of the co-opted members is to concentrate on issues that pertain to their institutions, they provide technical input in areas affecting the entire district. Their technical advice is well taken. For example, the Medical Director of St. Francis may identify a health unit from which many maternal deaths are referred and propose improvement of the facility to reduce maternal mortality.

The co-opted members do not represent the DHMT in public events. *"We collaborate with the DHMT. They are in charge of the health services in the district. We do not represent them nor do they delegate duties to us, for at the end of the day they are the ones responsible for the good or otherwise results."* However the Principal of the COTC sometimes acts in the capacity of the District Medical Officer when he is away and when there is no other Doctor in the District who can act as DMO.

### **The role of St Francis representative**

St. Francis Hospital is the referral hospital for the district. By sitting on the DHMT, the Medical Director is able to explain the state of referral patients on arrival at the hospital and if there were delays or improper management at the point of referral. His feedback to the DHMT on the management of referral patients assists the DHMT in identifying areas of improvement in the district health services. Supervisors are able to follow up on health facilities that have problems in treating or referring patients to the hospital. For example, the hospital received late referrals from one dispensary where patients used to be referred early and with proper treatment. On discussions with the DHMT, it was discovered that the number of staff had decreased and this was the reason for the decreased Quality of Care at the dispensary. The DHMT therefore sent in more staff to replace those that had left. The St. Francis Medical Director also informs the DHMT of improvements undertaken at the hospital to improve the quality of care.

### **The role of the COTC Principal**

The COTC is linked to the DHMT through training and through activities such as National Immunisation Days and control of epidemics. COTC students go to villages and health facilities in the district during their field practice. The DHMT is informed of where the students go. When they return from the field, their reports are discussed and shared with the DHMT. The reports are also sent to the villages and health care institutions where the fieldwork was done to inform them of problems and progress of health services in their locations, as seen by the students.

### **The role of the IHDRC Director**

The IHDRC director assists the DHMT in carrying out operations research. The DHMT identifies a research issue. The Director of the IHDRC would then assist in the preparation of the research protocol, search for funding, and carry out the research in collaboration with the DHMT. Results are then linked to the district work plan.

For example, the DHMT wanted to identify factors that impede or enhance acceptance of Insecticide Treated Bed Nets (ITBNs). The research on ITBNs identified the users of the nets and how they use them. It was shown that men usually buy bed nets for themselves and not for women and children. There was need to therefore inform men on the benefits of buying the nets for women and children and mobilise men to procure bed nets for the use of the whole family. Other research topics identified by the DHMT and subcontracted to the IHDRC are FP acceptance by males and Community Perception of TBAs and their role in the district health services.

### **The role of the GNUDUC Principal**

The General Nursing Upgrading and Diploma Course is linked to the DHMT in the same activities and functions as the COTC. Plans to send pre-service training students to the field and where they will go and the activities they will perform are discussed during DHMT meetings. The DHMT draws on the expertise in the district in implementing its activities, and uses the school's trainers and facilities for in-service training of district health workers. The Principal of the school is co-opted into the DHMT to help plan health training activities in the district.

The Principal of the School presents to the DHMT the problems identified in the health care facilities and in the community during the students' fieldwork.

### **The role of the Solidamed Support Unit**

Kilombero District has enjoyed collaboration with the SDC in health services since 1949. Solidamed is the executing agency for the SDC. The technical Advisor of Solidamed works very closely with the DMO, assists in capacity building in management of the district health services and is a co-opted member of the DHMT.

### ***Operating a public-private DHMT***

#### **The DHMT as a forum for information sharing and decision-making**

The inclusion of private sector members has made the DHMT more informed about what the other sections of the health services are doing. It also is a forum for introducing new concepts. For example, when the CBHC approach was introduced into the district the DMHT meeting was used as a forum where members learned about the approach and its benefits. During the construction phase, community progress reports were presented at each meeting of the DHMT.

At the DHMT meetings, members are also made aware of the resources that are available in the various partner institutions. Thus, the DHMT is able to draw on the resources in the member institutions such as the COTC and the IHDRC.

#### **The All Health Actors Meeting**

The All Health Actors Co-ordination meeting was initiated by the SDC in August 1998. (A second meeting was held in April 1999.) The meeting was found necessary in order to officially institutionalise close collaboration among all health actors in the district, co-ordinate and harmonise health and health-related activities, approaches and management. The meeting serves as a forum where the donors can communicate to inform each other and the DHMT about their activities so that each knows what the other is doing. This communication helps avoid duplication.

Meetings are held quarterly. In addition, the All Actors Meeting sits as a planning group once a year in a three-day workshop to prepare the Plan of Operation for the following year. This Plan includes all the activities of all health actors in the district.

The DHMT has found the Meeting useful in determining where new projects are to be located. Formerly, donors decided almost single-handedly where they would like to locate new projects.<sup>1</sup> The DHMT found itself agreeing with donors on decisions that had been made without the Team. As a result, projects were concentrated in 3 divisions of Ifakara, Mngeta and Mangula. Since the formation of the All Health Actors Meeting, the DHMT and donors are making efforts to distribute resources more fairly. Projects are now being allocated to more needy areas like Mlimba.

### ***The future of health planning in Kilombero - forming an association of private sector providers***

The private for-profit sector in Kilombero includes six private dispensaries and eleven private drug shops. The DHMT does not have a co-opted member from among them. The DHMT supports the idea of forming an association of the private for-profit sector and would ask its representative to sit on the DHMT. The DHMT says that there are many benefits from such an association. For example, it would be easier for the DHMT to communicate with the private for-profit sector through a single representative. It would be easier to communicate changes in policy or in management protocols for epidemics and specific diseases such as malaria and STD's. This would assist towards improvement of the quality of care in the private sector.

Through an association, the private providers could form a strong voice to air their complaints and suggestions on how to improve services. Some of the dispensaries in the private sector are not generating profit and cannot invest in improvement of the quality of care. One of the private practitioners thinks that if they form an association, they would be credit worthy and could borrow from a bank to invest in the improvement of the quality of services. Potential advantages such as this one may result in formation of a private sector health association in Kilombero.

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<sup>1</sup> The main donors in the district are SDC (funds most of the health activities including research, building and renovation), Plan International (training, rehabilitation and construction of health facilities), NORAD funds Mwaijak an NGO involved in PHC services in the alleviation and prevention of the adverse effects of the presence of the electrical power station including STDs and traffic accidents. Mwaijak also assists in the construction of VIPs in the villages close to the power station.), Irish Aid (construction of health care facilities).

## Case Study 4:

### **The Iringa NGO Network (INGONET): Village, ward and district partnerships to combat HIV/AIDS**

Developing countries especially in sub Saharan Africa are still grappling with the problem of how to reach its people especially those in the rural areas with preventive and supportive services in HIV/AIDS. This case study from Iringa rural district shows efforts that have been made to form a network whose main objective is to reach the rural population with preventive and supportive services in HIV/AIDS

#### *What is INGONET?*

Many international NGOs, organisations and foreign governments have responded to the HIV/AIDS epidemic in developing countries. One of these is USAID which funded the Tanzania Aids Project (TAP). TAP saw the need to work in partnership with local NGOs on the principle that these institutions are more conversant with the problems of the people where the NGOs work and are the best avenue for reaching the people.

In 1994, TAP came to Iringa town and called a sensitisation meeting of the NGOs in the region. This meeting was the first step in getting the NGOs to communicate with each other in a formal way and to define mechanisms for co-operation. During the meeting, participants discussed options for a cost-effective approach to implementing HIV/AIDS activities and agreed that the best way was for all the NGOs involved in HIV/AIDS activities to come together and form a network to be called the INGONET.

INGONET stands for Iringa NGO Networks. The Swahili translation is: *Mtandao wa NGOs zinashoshuhulika na HIV/AIDS*, "a network of NGOs involved in HIV/AIDS".

Participants at the sensitisation meeting of TAP/NGO's defined the role of INGONET and objectives of the network as follows:

- Maximise the use of resources: resource mobilisation, allocation and utilisation to be done in a more efficient manner
- Avoid overlapping of activities and increase efficiency and effectiveness of activities done by the NGO's. Many NGOs were involved in counselling. INGONET would therefore find out which NGO does it best and allocate this responsibility to it. This NGO will also be allocated the task of building capacity in counselling in the other NGO's.
- Co-ordination of NGO activities: When NGOs combine their resources and work in partnership, they create synergy and strengthen their individual roles. Donors prefer co-ordinated activities because they can be more effective.
- To develop central support for activities, such as a central pool of trainers that would be called upon to train staff in any of the NGO's in the network. A notable example is the peer education programme where TOT's from each member NGO were trained in one group and then went back to their NGOs as trainers. This activity would not have been possible without support by INGONET.

- To increase collaboration between NGOs. INGONET brought NGO's together to do needs assessments, identify problems and prepare a common plan of action. INGONET also facilitated the formation of CBO clusters.

The main objectives of INGONET are therefore resources mobilisation, capacity building, co-ordination, and fostering collaboration among the clusters and NGO's.

### ***Staffing and organisational structure***

The organisational structure of the network follows the administrative structure of the region (region, district, ward, village), thus INGONET is the regional-level "cluster". A network of NGOs involved in HIV/AIDS activities form INGONET on the regional level. INGONET's salaried staff include a Project Manager, Accountant, Secretary and Driver. The rest of the staff are volunteers drawn from the steering committee. The chairman is elected every 3 years.

Clusters have been formed in 4 of the 6 districts of the region: Iringa Rural, Iringa Urban, Makete and Mufindi. These districts have ward clusters. Iringa Urban district cluster is composed of 18 NGOs (see box) and has 4 ward clusters. Some wards have formed village clusters as well. The village clusters are village committees chaired by the village leaders. In addition, there are clusters in the villages composed of other groups that do not necessarily fall under the village administration. They may be women or men or youth groups that are involved in HIV/AIDS activities.

<b><u>Iringa Urban Cluster NGOs</u></b>
TARENA(Tanzania Registered Nurses Association)
TAHEA (Tanzania Home Economics Association)
BAKWATA (Baraza la Waislamu Tanzania-The Muslim Council of Tanzania)
ICDO
UWT (the Women Association of Tanzania)
UVT(Youth Association of Tanzania)
UMATI (Family Association of Tanzania)
The Red Cross
The Scouts
ELCT
Anglican Diocese of Ruaha
Roman Catholic Diocese of Makete
Tosamaganga Orphanage Centre
Marie Stopes
BAKAWA (Baby Care and Women Association)

All the clusters are run by volunteers with a chairman elected every 3 years. The district clusters have steering committees that consists of the cluster chairman, a secretary who is the co-ordinator of the cluster and 2 members from each NGO and the District AIDS Co-ordinator, DPLO, Community Development Officer, Education Officer and Cultural Officer. The Iringa Rural cluster chairman comes from BAKWATA. (The previous chairman came from the Anglican diocese.) The vice-chairperson is from UMATI.

The activities of the network are planned and monitored by a Network Steering Committee at the regional level. Members include the INGONET Chairperson, Project Manager, accountant, the district co-ordinators (secretaries to the district clusters), the District Chairpersons, the RAC, and the Regional Social Welfare officer. The Regional Steering Committee meets quarterly, while the District Steering Committees meet monthly.

In addition to these forums where activities and the plan of action are monitored, there is a biannual meeting of all NGOs.

### ***Sources of funding***

At first, the main donor for INGONET was USAID through its Co-operating Agencies -- TAP then FHI (Family Health International) and finally DATEX. Resources are allocated according to the Plan of Action agreed upon at the Steering Committee meeting. The resources are transmitted from INGONET to the district clusters and on to the member NGOs that implement activities in collaboration with the ward clusters.

INGONET does not have an independent source of finances, but depends on donors. Since DATEX ended its support in October 2000, INGONET no longer has a donor. Nevertheless, staff have remained in office in the last 6 months. They are paid allowances from money that was accumulated from:

- NGO entrance (registration) fee of Tsh. 50,000
- Yearly contributions from each member NGO of Tsh. 20,000
- Allowances from participants. Each member given an allowance during implementation of activities pays 10% of the allowance into a special fund that is maintained by INGONET. (This procedure was adopted from TAHEA where members used to contribute 10% of their allowances into a central fund that was used in periods of emergency.)
- Sale of T-shirts
- Sources of funds for initial NGOs. For example, TAHEA receives support from the Social Action Trust Fund for its orphan activities.

This year's "International candle light day" that is held every year to remember those affected by HIV/AIDS was done without the usual fanfare of previous years that is used to bring home the message of HIV/AIDS.

### ***Planning and allocation of resources.***

Planning starts at the village level. Those villages that have clusters prepare the plans for their clusters. Where there are no village clusters, the ward prepares the village plans. The village plans are compiled into ward plans. The ward plans are compiled into district plans that are presented to the INGONET Steering Committee that prepares the INGONET Plan of Action. Thus the Regional Plan of Action shows the District Plans of Action.

The Regional Plan of Action is used to guide the allocation of resources. It shows the activities that were planned for each district and which NGO would implement them. When resources come into INGONET, the district plans of action are consulted in order to decide where they will be allocated and which NGO or NGOs will implement them. Likewise the district can identify a cluster that has the activities in its plan of action and allocate resources to it.

Some of the funds are set aside for capacity building. The funds remain at INGONET for the purpose of conducting training for the NGO's and for the clusters. INGONET organises the training and selects NGOs or individuals as trainers.

## **Results**

### **Institutional successes**

- Resources mobilisation has been more efficient: “*Working singly as individual NGOs we would not have mobilised so much resources*”, -The Assistant Project Manager. Some of the NGOs with strong leadership and technical capacity did not have sources of funding. Some of them have survived thanks to resource mobilisation through INGONET.
- The efficiency and speed of implementation has improved: This is a result of capacity building that was done in the individual NGOs, such as training of TOTs so that each NGO could conduct training themselves.
- Sharing of technical assistance among the NGOs also improved. Resources of any NGO in the network were made available to other NGOs.
- Political support increased. INGONET was recognised by the regional and district authorities as a network that was doing a good job in the prevention of HIV/AIDS. The Regional authorities gave transport to the central office. The office pays the running and maintenance cost for the vehicle.
- INGONET has helped bring leaders political leaders, religious and administrative leaders together to co-operate in activities that they would have hitherto done singly.
- Increased the collaboration between government and the NGOs in HIV/AIDS and other activities while formerly there was mistrust between the NGOs and government. Thus the governed departments became increasingly aware of NGO's contribution in HIV/AIDS and other activities.
- Capacity building - It was difficult to know which NGOs were genuine and which were facades. INGONET identified strengths and weaknesses of member NGOs. Those that could be strengthened were strengthened, for the benefit of improving efficiency in HIV/AIDS activities. In the process, the very weak ones (briefcase NGOs) fell to the wayside.
- Co-ordination of the NGOs: The NGOs used to work separately and even in competition without knowing one another. Through INGONET, the NGOs knew where their partners were working, what they were doing and identified areas of collaboration.

#### **HIV/AIDS/STDs activities done by clusters in collaboration with NGO's**

Sensitisation of communities –all clusters and NGO's  
Training of peer counsellors- The Red Cross  
Training in counselling -TARENA  
Orphan support-TAHEA  
Orphanage-ELCT  
Home based care-TARENA  
Support of cultural groups-UMATI

### **Health results**

Most importantly, the residents of Iringa region have become aware of HIV/AIDS. There is evidence of behaviour change and responsible leadership. For example, villages have introduced by laws that require bars in the villages to close at certain

times while formerly there was no closing time. Villagers have recognised that drinking facilitates the spread of HIV/AIDS, especially when the drinker stays out for long hours unaccompanied by his/her mate. There is notable behaviour change where couples now go to the village bar instead of going singly.

Risk of nosocomial transmission has been reduced. Traditional Birth Attendants (TBAs) have been trained on safe delivery and no longer deliver without gloves.

### **Social support**

In 1988/99, TAHEA did a census of more than 50,000 orphans in Iringa Rural, Iringa Urban and Makete Districts. The purpose of the census was to determine the size of the problem and the resources needed to support the orphans. After the census, a proposal was sent to the Social Action Trust Fund in Dar es Salaam. The SATF provided support for 320 orphans in 1999 and 904 in 2000.

The situation of orphans in the region is alarming. When the District Commissioner of Makete addressed a meeting where he gave survey figures of those affected with HIV/AIDS and the number of orphans in his district (13,000 orphans in the district forming 10.5 % of the population), the national press did not believe him. 77% of these orphans have lost their father, 10% their mother and 13% both parents. The number of orphans is increasing at a fast rate. In one village alone, the number was 307 in 1995, in 1999 the number had increased to 523.

On the problem of orphans, INGONET says that communities have accepted the problem of orphans as the problem of the community while formerly it was seen as a problem of the individual families. Communities are now making and implementing plans in orphan support. The community pays for the orphans to attend day care centres.

### ***Iringa Rural District***

The district implements HIV/AIDS activities in collaboration with the government. *“We do not work alone, we work with the DAC. We invite him to participate in every activity we do. He is also a member of the District Cluster Steering Committee. We also send reports of our activities to him”* -Secretary and co-ordinator of Iringa rural District Cluster.

Last year the Iringa Rural District cluster participated in the preparation of the District Health Plan. TAHEA will provide support to orphans and PLWAs, Ruaha Diocese health centres will provide home based care and counselling. TARENA will do TBA training in HIV/AIDS.

### **Results**

The cluster has achieved the following:

- NGOs have been involved in sensitisation and mobilisation activities in the rural areas and have gone to places not reached before. They have conducted promotion of condom use in villages and discouraged women in the village from involving

themselves in risky occupations such as selling local beer and instead involve themselves in Income Generating Activities. The cluster has assisted women in raising resources for IGAs to start vegetable gardens.

Cutting on the wall in the  
INGONET office

*Get drunk, get stupid,  
get AIDS*

- The cluster has spread HIV information in villages (Kipizero, Chamihu, and Imaga) known to be the main sources of housemaids who go to towns and come back infected. After sensitisation, parents are more reluctant to allow their daughters to go to the towns to work as housemaids and if they do, some of them, show concern, do follow-up on their daughters and even demand to see the perspective employer before allowing the girls to work for them.
- The Cluster has mobilised cultural groups to spread the message on HIV/AIDS. Local cultural groups are an effective media for spread of messages on HIV/AIDS as they use the local language in an appealing way. Such cultural groups as the Nyamihuu group, Ifunda Theater group, Mbigili women group, Imega Youth group have come forward to participate in district and local events e.g. during showing of videos in the villages.
- The cluster is involved in orphan support for primary and secondary education. The identification of who needs support is done during a census in the primary schools and in the villages to identify needy orphans. The orphans are assisted with school fees, uniforms, shoes, and a school bag. This year, the cluster with assistance from SATF, will provide support to orphans going to secondary schools as some of those supported in primary schools have now graduated to secondary schools. Pre-school support is provided by TAHEA. It provides school fees, kitchen equipment and foodstuffs to some nursery schools. TAHEA prefers this group approach because it believes that targeting individual orphans at this age and ‘favouring’ them by providing what other children do not have, may affect the orphans and the other children psychologically. TAHEA wants to provide uniforms to orphans but the dilemma is “*When you have orphans living in families where the other children do not have uniforms, and here among them an orphan child, a member of the family, appears in a bright clean uniform the other children end up sharing the uniform*”.
- Another achievement by the cluster is that more people living with AIDS are coming forward for counselling, to take the HIV test and to talk to people about their problems and even about their past. The cluster uses them as role models. A branch of PLWAs has been started in the cluster. It has 10 members and 5 have come forward to speak out during various occasions.

### ***Key factors for success***

**Leadership-** The Programme Manager has provided strong leadership. She came from the Department of Community Development in the district. She is considered to be a strong leader who is always ready to learn from the other partners and from the community. Recently, the Programme Manager has been appointed a Member of Parliament on the ticket of Special Seats for Women. This has been viewed differently

by some of the people interviewed. Some say that being an MP gives her more chances for giving information on the successes and mode of operation of INGONET and to attract more funding. Others say that her new responsibilities as an MP will not allow her to devote sufficient time to INGONET. Although this will not sound the death knell of INGONET, it will certainly diminish its further progress unless another equally strong Programme Manager is employed.

**Government Support** - The approach was accepted by the regional and district governments.

Involving **partners from the religious organisations**, Catholic, Anglican, Lutheran, and Moslem. They share a common mission of humanitarian, volunteer commitment and work towards the common goal.

**Involvement of the community** - The Programme Manager affirms that community involvement is a big reason for success and the reason that some activities have been sustained during this period of 'no donor'.

**Regular forums for communication, planning and monitoring** - There were steering committees and NGO biannual meetings.

**Planning for sustainability** - Having a source of funding is an important sustaining factor. Nevertheless, INGONET has had to look forward to the end of donor funding before it ends to plan for sustainability. The researcher facilitated an exit workshop for organisations that were being funded by DATEX (INGONET among them) as funding was coming to an end. The workshop emphasized strategic thinking and proposal writing skills. Its aim was to enable the participants to prepare fundable project proposals in efforts to sustain their activities after the present donor pulled out. (The workshop was the last funded activity and the donor support came to an end a few days after the workshop. INGONET is now undergoing a period of non-funding.)

The Iringa Rural District Cluster Co-ordinator says, *“The work requires a spirit of voluntarism (service to the people, not to oneself). You have to have or select partners with this motto. In involving an NGO partner, you have to consider the NGO’s objectives and mode of operation. You want to admit NGO’s with some financial base, with managerial capacity in planning, implementing, financial accountability and those that have already started some activities not necessary in HIV-AIDS but working in the social sector and in the community. The Project Manager must be a person who is capable of leadership, capable and has knowledge and experience in HIV/AIDS.*

*The other factor is transparency. This is important on the side of INGONET especially on the side of funding. INGONET has to have transparency to let the partners know which funds have come in, how and where they are being spent.”*

INGONET is only one of 7 networks formed to combat HIV/AIDS. The other are in Dodoma, Tabora, Arusha, Kilimanjaro, Mwanza, Tanga and Dar es Salaam. Many lessons in forming partnerships to work on HIV/AIDS activities can be learnt by studying the other networks that were formed on the same principles as INGONET.

## Case Study 5:

### The Iringa CBD network: Incomplete transition from a private project to a public programme

This case study aims to show the consequences of inadequate or non-existent partnerships. Transition from a private project to a public programme has resulted in collapse of the Iringa CBD network, despite the fact that the project was successful in attaining its immediate and short-term objectives.

#### *The project*

In 1995, a Tanzanian local NGO (here referred to as “the NGO”) initiated a Community Based Distribution (CBD) project in two divisions of Iringa Rural District (Mazombe and Kalenga). The first 2 Divisions contained 47 villages and a population of 97,824. A total of 95 CBD Agents (CBDAs) were trained to deliver Family Planning (FP) services in the community and do counselling and referral for STDs and HIV/AIDS.

Later, the project was extended to three more divisions, Pagawa, Ismani and Mlole, this time integrating FP with growth monitoring services. The second project area contained 53 villages and a population of 135,322. One health centre and 14 dispensaries served the area.

#### SUMMARY OF PROJECT ACTIVITIES

ACTIVITY	INVOLVED	REMARKS
Selection of project area	NGO headquarters, DMO, RMO	
Baseline survey	NGO headquarters, NGO Iringa, school teachers	CPR = 6.8%
Sensitisation of Regional and district leaders	Iringa, DMO, RMCH Co, regional trainer FP	Attended by 59 administrative and religious leaders.
Sensitisation of community	NGO Iringa, DMO, facility staff, Regional trainer FP RMCH Co	Reached 271 village leaders from 46 villages.
Recruitment of CBDAs	NGO Iringa and community	
Training of CBDAs 2 (One male one female) in each village. Some large villages had 3-4	NGO Iringa regional FP trainer	First phase training 95 CBDAs used the NGO protocol. National training protocol was not yet developed; second 120 CBDAs trained used national training protocols.
Training of CBDA leaders (supervisors) selected among the CBDAs. 20 were trained.	NGO Iringa regional FP trainer	Used the NGO protocols. Did not use national protocols, as supervisors of project are different from national CBD supervisors. The former are selected among CBDAs while later are health facility staff
Training of H/facility staff in FP clinical and counselling skills	NGO Iringa and Regional FP trainer	20 were trained using the NGO training protocols that had been adopted by MOH
Supervision /supply	NGO Iringa	The NGO registers and supplies forms were used. In MOH CBDA programme the CBDAs obtain supplies from the Dispensaries/HC.
Retraining CBDAs	NGO Iringa and Regional FP trainer	Used the NGO protocols
Retraining of supervisors	NGO Iringa Regional FP trainer	-do-

## **Relations between the NGO, the DHMT and the villages**

Relations were good during the implementation period. Contact was maintained with individual members of the DHMT. *“However we dealt with individual members of the DHMT and not the DHMT as a team,”* said the former Project Manager.

The dispensary and health centre staff were involved in the project from the beginning: during sensitisation and during training as the CBDAs did practical training in the health centres and dispensaries. The dispensary and health centre staff underwent a course in FP clinical and counseling skills. This was to ensure that they were equipped with skills to handle referrals from the CBDAs. In addition they are members of the Ward Steering Committee. One of the dispensary staff we visited was very much aware of the activities of the project and said that she had been involved in the project since its inception. *“ During the sensitisation of leaders and communities the dispensary staff was involved. After sensitisation we participated with the village leaders in selecting the CBDAs using a criteria that was developed at the sensitisation meetings. The CBDAs then went for training and when they came back to the village with equipments and contraceptives they reported to the village government. We noted a great transformation in these young men and women. Each had been provided with 2 pairs of clean uniforms, a bicycle, a pair of boots, an umbrella, and a box for storing supplies. They came back motivated and ready to work.*

## **Results of the CBD program 1995-1999**

The project reports to have attained its objectives:

- Raised CPR from 6.8% to 11%
- Family and community dialogue on FP increased
- Integration of FP and growth monitoring (GM) brought in more people to FP services. Integration gave Roman Catholic women more access to FP when they came for GM.
- Change of attitude towards FP as more were reached with information
- Decrease in misconceptions about FP
- Increased referrals for FP and STIs. CBDAs explained symptoms of STIs and many clients came for services and for referral to HC's and dispensaries.

A village representative reports, *"The village noticed the change in the new CBDAs and elevated them above the other members of the village. They were ready to give them additional responsibilities like some of them were elected as ten cell leaders (a cell consists of 10 homesteads) members of the Village Development Committee, member of the school committee etc. They had changed in the state of cleanness. A board written "This way to a CBDA " was placed on the path that led to a CBDAs house and this added to their importance. They were clean and smart and the villagers admired them in their uniforms. Husbands showed more respect to their wives CBDAs as they were now educated, had status in the community, were clean and they (the husbands) could see people consulting them and confiding in them. Even in-laws showed more respect for them and used to refer to them as nurses or even doctors."*

This success make the subsequent collapse of the system even more cruel.

## *The Transition Plan*

When funding for the project was coming to an end, the NGO's headquarters informed the MOH that it would like to hand over the project to the DHMT in Iringa. The National CBD Co-ordinator accompanied by the District MCH Co-ordinator, the Regional MCH Co-ordinator and the Project Manager visited the project area. Together they agreed that the following activities be done before handing over:

- A sensitisation seminar for the DHMT
- A refresher course for the CBDAs to orient them on DHMT supply logistics and reporting procedures
- Training of dispensaries and HC staff in CBDA supervision.

On her return to the MOH, the National CBD Co-ordinator consulted the NGO's headquarters. Together, they agreed to execute the three activities before handing over the project to the DHMT.

The DHMT was involved in the transition activities and relations appeared to be good during the transition. Project staff and the DHMT visited the project area and were introduced to the communities and explained that the communities were now to deal with the DHMT as they were now being handed over the project.

The District Council was also involved during the transition. The District Executive Director was invited to officiate at the closure of the training of the facility staff to prepare them to supervise the CBDAs. He promised to support them and promised that bicycles if available would be provided to them.

In fact, only two of the three activities were completed. The sensitisation seminar for the DHMT and the training of dispensaries and HC staff on supervision were done using funds provided by the NGO. In addition, the NGO provided funds for orientation of the communities and informing them that the DHMT was going to assume responsibility for the project. During these meetings, the two DMCH Co-ordinators were introduced to the communities.

Funds for the refresher course for CBDAs were to have been provided by the MOH and the NGO but were not forthcoming, as they had not been budgeted for. Refresher training was never conducted.

The NGO ceased activities with the CBD project in March 1999. The transition activities that should have carried out before handing over actually started in June 1999, three months after the NGO had ceased activities. No official hand over was done. In June 2001, the CBDAs are no longer being provided with supplies and they are not being supervised.

The Clinical Officer i/c of one of the dispensaries explained that the dispensary staff had been involved in the project from the beginning. They were trained on FP clinical skills and counselling, including insertion of IUD's, so that they could handle referrals from the CBDAs. After training, they improved the Quality of Care at the health units and earned more respect from the community. Later during the period of transition they were trained as supervisors. *"We were shocked when we heard that the project*

*was being handed over to us and that the dispensary would support the CBDAs without the assistance of the NGO. We at the dispensary had not developed a system to supply them with contraceptives. The FP supplies we receive from the district are not enough to share with them. They come to the dispensary for supplies but we cannot give them enough regularly and so they cannot offer the services as they used to do before. Even the community respect for them has diminished"- CO i/c of dispensary.*

### ***Superficial partnership, an NGO-driven project isolated from its environment***

#### **Involvement of the DHMT**

The DHMT was involved in the selection of the project area. Training might have provided opportunity for collaborating with the DHMT members acting as trainers. Training would have provided an opportunity to make contacts with the CBDAs. However, the DHMT did not have a District Trainer in FP. The Regional Trainer in FP participated in all the training that was done by the project. The DHMT was informed about the training sessions and the DMO would be invited to officiate at the closing ceremonies.

Neither was the DHMT nor dispensary and health centre staff involved in the supervision of the CBDAs nor in CBD logistics. Occasionally, when the project ran short of supplies before delivery from the NGO, the project would request supplies from the District MCH Co-ordinator.

When the project was coming to an end and the NGO was going to hand over the project, the DHMT raised concerns that it was not adequately involved in the project. However, the DHMT had not expressed any concerns about non-involvement till the period of handing over arrived. For example, the DHMT had never been involved in supervision. When it came time to assume responsibility for the project, the DHMT regretted the benefits that "might have" accrued from joint supervision, citing such elements as shared transport, assistance by the DHMT in collecting reports (instead of the NGO following them up with the CBDAs), and assistance by the DHMT in delivering supplies to the CBDAs during DHMT supervision or deliveries to the HC/dispensaries.

This type of relationship can be characterised as "passive co-existence" rather than partnership.

#### **Logistics/supplies and reporting**

The NGO established an independent logistics, supplies and reporting system for the project. The Project Manager sent project reports to the NGO zonal office and to the NGO headquarters. There was no system of reporting to the DHMT, except when supplies were borrowed from the DHMT. In 1997, when another district (Mufindi) started a CBDA project, the Regional MCH Co-ordinator began to compile regional monthly statistics for CBDA activities. The project started sending reports to the District MCH Co-ordinator with a copy to the Regional MCH Co-ordinator.

## **Training**

The protocols used to train the first group of CBDAs were designed by the NGO. At that time, the MOH had not yet developed training protocols for CBDAs. By the training of the 2<sup>nd</sup> group of CBDAs, the MOH had already developed a CBDA training protocol and it was used.

The CBDAs were trained on early diagnosis and referral of STD's and prevention of HIV infection. They were involved in HIV/AIDS activities such as distribution of condoms, advocacy and counselling. They did early diagnosis of STD's and referral. They had choir and drama groups involved in composing and reading poems and drama on HIV/AIDS and FP.

The training of CBDA supervisors, however, used a protocol different from that used by MOH, as the project supervisors were selected from the existing CBDAs while the MOH protocol trained health facility staff as CBDA supervisors.

## **The Project Advisory Team**

The Project Advisory Team (PAT) met twice a year. The PAT consisted of a Member of Parliament, District Councillors, the District Community Development Officer, representatives from ward level, the District Nursing Officer, the District MCH Co-ordinator, a clinical officer from a referral HC, the Regional MCH Co-ordinator, the Medical officer i/c of Ilula Lutheran HC and a representative from POP FLEP. The District MCH Co-ordinator was a member of PAT for the first project area. The District Nursing Officer was a member of PAT for the second project area.

The terms of reference for the PAT included monitoring of project activities, motivation of community members to support the project, and assisting CBDAs in their work especially in counteracting rumours.

The Ward Steering Committees also met twice a year and consisted of representatives from the villages in the ward, influential people who supported Family Planning, and MOH personnel in charge of dispensaries.

Participants' opinion of the PAT is that although it was a very interesting group, it did not serve adequately as a forum for discussing technical CBD issues. It did not function as a forum where the NGO and the DHMT could resolve the technical problems of the project or conduct joint planning. On the DHMT side, there was no other appropriate forum where project progress could be discussed.

## ***The CBD network since 1999***

During the NGO project management phase, CBD clients obtained services at their doorsteps or at the CBDAs home. Since June 1999, some of the clients visit MOH health facilities for supplies of contraceptives. No records of client transfer have been kept. Many CBD clients have dropped out because of distance to the health care facilities and the unfamiliar environment of health care facilities.

The CBDAs are not receiving any supplies or supervision. Those that were not trained in Growth Monitoring have completely stopped offering services. Some have even left their villages, as there was nothing for them to do.

The few CBDAs that continue to offer services are those that live close to town. Some of them come irregularly to the NGO's office for supplies. Some of the CBDAs that were trained in GM still offer this service at the nearest dispensary or HC.

Integration of Family Planning and Growth Monitoring has been an advantage. The CBDA we visited works at the dispensary during GM days and says, *"I am very happy with the new UNICEF weighing scale that was brought to replace the former Salter scale. Mothers did not like the Salter scale as all the babies in the clinic used it. With the new scale, I stand on the scale or the mother stands on the scale and I or she holds the baby in my/her arms and we read the weight of the baby easily"*.

A former CBD leader (supervisor) says *"People in the village still come to us and today I referred a patient with suspected STD to the NGO's clinic. She came to me complaining of pain on micturation and ulcers in her private parts. About 5-6 people a week come to consult me but I have no contraceptives so I advise them to go to the dispensary and when I have time I escort them."*

### ***The Transition Plan - too late and not enough***

Clearly neither the NGO nor the DHMT understood that partnership is not built in a day by simple participation in ceremonies or discussions. Programme sustainability must be built in from the start.

The NGO management of the project devoted time and attention to make sure that the project succeeded and it did succeed as long as the NGO was there. However, management did not spend enough time developing a management partnership with the DHMT.

In hindsight, none of the possible explanations are satisfactory as to why the NGO failed to make sufficient efforts to involve the DHMT. Some say that this was a pilot project that was introducing and testing innovations in the field of Family Planning. The CBDA approach was being tested and its integration with GM was a bold innovation that has perhaps not been tested anywhere else in the Tanzania. When trying out an innovation in a pilot project, one may not be sure about its success and there may be a hesitation to open up the project to other organisations. The NGO perhaps felt that there was no need to involve the DHMT till sufficient lessons were learnt. Perhaps the NGO intended to involve the DHMT during the period of extension. However the extension was not forthcoming and the opportunity came to naught.

### **Family Planning Supply Logistics**

Probably the central reason for the failed transition was inadequate organisation of FP commodities logistics. Creation of an independent NGO management system for logistics, supplies and reporting is a classic error for CBD projects. Failure to link with the standard MOH management system has caused CBD programmes and other

health services to fail in many countries. Although NGO's sometimes protest that linking to government logistics systems slows programme start-up, it tests long term programme sustainability.

The transition plan relies heavily on IEC and training activities. It does not appear to address the logistical problems in detail. To fully prepare for logistical support to the CBDAs, family planning commodity orders would have to be adjusted for the appropriate quarter and HC/dispensary stocks increased accordingly. Such adjustments might take six months or more to calculate and complete.

It was envisaged that the community would sustain the project. The assumption was that as the community was sensitised and was involved in the implementation of the project and the use of the services they would sustain the project. The villages have active PHC committee and the CBDAs are members of the committees. The villages would give incentives to the CBDAs e.g. provide tax exemptions, monthly allowances (some villages had already started providing allowances before the end of the project). The village sources of funds are from the development levy (a % of the development levy remains with the village) and from licenses collected from villagers with small businesses. However, in the absence of supervision and logistics, community support is not enough.

### **Transition to new supervisors**

Transition from one supervisor to another is always a difficult process. In this case, an entire set of supervisors were being replaced. No joint supervision sessions were held with the old and new supervisors and their agents to re-organise the supervision schedules or programmes, to identify strengths and weaknesses or to review essential issues. Undoubtedly, the retraining session of the CBDAs would have accomplished some of these objectives, but individual hand over from one supervisor to another would have been appropriate also.

### **Family Planning - what level of priority for the DHMT?**

On the other side, the DHMT did not make enough efforts to develop partnership with the NGO. Perhaps as this approach was being introduced to the district for the first time and the DHMT was used to delivering services through conventional fixed health facilities, the DHMT was not inquisitive enough about this innovative approach. Curiosity by the DHMT about what the NGO was doing in "its" district would have established a dialogue.

Furthermore, the DHMT did not apparently see the CBD activity as a significant contribution to contraceptive coverage in the district, a contribution that would reflect well on the district's performance as a whole. Family planning may not have been seen as a high priority in the district, so that good performance did not necessarily attract prestige to the DHMT.

Most unfortunately, neither the PAT nor the DHMT seem to have been sufficiently committed to serving the family planning needs of the district. A successful transition from the NGO to the DHMT would have maintained the strong contraceptive prevalence results found in the intervention villages. Instead, FP clients have been

lost, discouraged or may have switched to less effective methods available through commercial outlets.

### **Partnership at the top, but not in the district**

The NGO's national policy is to work in partnership with the public sector and later hand over successful programmes to the public sector. Although the national level organisations (NGO and MOH) are accustomed to working in partnership, it is possible that the local partners (NGO-Iringa and DHMT) did not have pre-established relationships allowing them to work together. Unfortunately, the Project Advisory Committee failed to become a district level forum where crucial technical issues and project plans could be addressed.

### ***Hope for the future***

Although this is a very discouraging picture, there is some hope that the network will be revived. The DHMT recently received registers from the MOH and are planning to train the CBDAs on how to use them before starting supplying the CBDAs with contraceptives.

## Case Study 6:

### **Iringa Rural District Council: Multi-sectoral tendering for purchase of goods and services**

Health providers often forget that for-profit businesses in other sectors can be their partners. Such partnerships are usually defined by contracts for goods and services that are bought by the health facility or institution. Under Local Government Reform, local councils may engage in contracts and let tenders for competitive bidding of work. In Iringa Rural District, the District Council has rationalised purchases of goods and services used by all sectors through a tendering process.

Iringa Rural District purchases the following goods and services by tender:

- Stationery supplies
- Maintenance of office equipment
- Maintenance of motorcycles
- Maintenance of vehicles
- Supply of fuel
- Supply of hardware
- Supply of timber
- Making of furniture
- Provision of food to health centers
- Buildings and renovation

#### *The tendering process*

##### **Determining requirements**

Each District department makes estimates of requirements such as stationery supplies for its work, based on the needs of individual units. The quantities are calculated on the past year's experience and requirements needed to implement the plan of action for the new year. The list of requirements also depends on the expected budget allocation. The list is sent to the Stores Officer in the District Council who compiles a list of requirements for the whole district.

##### **Call for tender applications**

The District Council Management Officer advertises the tender locally. A notice is placed on notice boards throughout the Region. The notice specifies the type of tender (the services or goods to be purchased), deadline for applications and the pre-qualification and accreditation requirements, which are:

- Applicant must be a local person (lives in Iringa Region)
- With known business premises
- Has valid trading licensee
- Has known capability to deliver the services
- The application has to be accompanied by an application fee of Tsh. 20,000.

### **The Tender Sorting Out Committee**

A day is appointed for opening the applications. The Chairman of the District Council opens the applications which are then sorted out by the Tender Sorting Out Committee. This committee is composed of the following members:

The committee goes through each application to see if the application meets the requirements as stated in the notice calling for applicants.

Tender Sorting Out Committee
The District Council Management Officer (Chairman)
The District Medical Officer
The District Engineer
The District Accountant
The District Planning Officer
The District Trading Officer

### **The District Tender Board**

The District Tender Board then reviews the applications that meet the requirements and selects the winner.

The winning applications are now presented to the District Council Finance Committee. The Committee consists of :

- The Chairman of the District Council
- Members of Parliament
- Three Councilors
- 3 members from the Council Permanent Committees (Health/Education/Water and (Public works/economic production/environment)

District Tender Board
The District Council Chairman-Chairman
The District Executive Director -Secretary
The District Council Treasurer,
The District Trading Officer
The District Engineer
The District Council Clerk
The District Council Management Officer
Heads of Department

Finally the winners are presented to the Councilors Committee. This Committee consists of the 48 Councilors in the District. The Committee goes through the list of winners and losers. If it is convinced that proper procedures have been followed and the selection has been done fairly, then it confirms the winners.

The process of selecting and confirming the winners seems like a long one. However, this is necessary in order to reduce the chance of conflicts of interests where applicants may be favored by people who know them or by interested parties that are “inside” the system and at the same time are members of the business community.

### **The tender is awarded - the winners and losers are informed**

After the names have been confirmed, the District Council Management Officer writes to the winners and losers. The letter invites the winners to come to the district office to sign the contract. The letter mentions the type of tender and the period.

The letter to the losers mentions why they have been refused. Last year, one of the people refused was a businessman who was the current holder of a tender for repair of vehicles. There was a theft at the medical stores and when the thieves were caught it was discovered that the vehicle they used belonged to the person with the tender for

repair of motor vehicles. For this reason the tender committee refused to renew his tender and wrote to him and informed him of their decision. Another unsuccessful candidate had not signed the application letter himself. He had another person sign for him. A third losing candidate had been awarded a tender the previous year. The Council discovered that at times the vendor did not follow the procedures limiting issue of stationery supplies to only one pre-identified officer. He had issued the supplies to department staff who had not been appointed to collect supplies.

### **Signing the tender contract**

The tender contract is signed by the Chairman of the District Council and the District Executive Director, and by the person awarded the tender (hereby called the supplier) and a witness.

### **Duration of current agreements**

Tenders are offered for a period of one year. Till 2000 tenders used to be offered for 6 months (January- June/July-Dec) but starting 2001 tenders are offered for the period of one year January to December.

### ***Multi-sectoral tendering for office supplies and photocopying***

Iringa Rural District decided to let a tender for office supplies and photocopying. Supply needs for all departments were calculated according to the process described above.

Five bidders responded to the tender. One of the bidders did not sign the application letter himself, so he was eliminated during the sorting out process. Thus there were 4 of the 5 valid applications.

The District Tender Committee eliminated three applications on the following basis:

- Did not have a business premises (*a briefcase businessman*)
- Had doubtful capacity to implement the tender
- Was awarded the tender during the current year but did not follow the laid down issuing procedures

The contract was awarded to the remaining supplier.

### **One supplier - several users: how does it work?**

The amount of goods a department buys depends on the availability of funds in its line item in the vote book. The vote book shows the amount of money allocated in each budget line. Expenditures are recorded in the vote book and deducted accordingly, so that the amount spent and the amount remaining is recorded after each expenditure. Before ordering for any item, the storekeeper first refers to the vote book to make sure that there is money available.

The actual supply procedure has several steps:

1. The head of department requests the Storekeeper by word of mouth or by a written note to order for the supplies. The Storekeeper fills a form for ordering of supplies.
2. The Stores Officer sends the form to the supplier to fill in the prices.
3. The supplier issues a pro forma invoice that is attached to the order form.
4. The form and pro forma are sent for signatures to:
  - The head of department
  - The District Planning Officer or District Accountant or District Manpower Officer
  - District Executive Director or Acting District Development Director.
5. The form and signed proforma are returned to the Stores Officer who now writes an Local Purchase Order (LPO), signs it, sends it to the head of department (the DMO) for a second signature and then to the District Accountant or District Planning Officer or District Executive Director for a third signature.
6. The LPO is now detached from the LPO book and sent to the vote book controller who checks the relevant section where the expenditure is to be entered, in this case budget line item - stationery supplies. If money is available in the budget line he passes the expenditure and stamps the LPO, providing the information found in the box.
7. The LPO is now sent to the accountant to check to make sure that all the procedures have been followed and it has all the necessary signatures and documents attached.. He ticks the particulars with red ink and if all is well he stamps it "*Checked and passed for payment*".
8. The LPO now goes to the person who writes cheques. Each dept has a separate cheque book. The cheque is sent to three signatories: Head of department, District Council Treasurer, District Executive Director or District Planning Officer. The General Fund used for development activities requires 4 signatures, the 4th one being that of the District Accountant.
9. The supplies officer is issued the cheque by dispatch and signs in the dispatch book. The supplies officer takes the cheque to the supplier and receives delivery of the goods. The supplier issues a receipt for the cheque, a delivery note for the goods and an invoice. These are attached to a copy of the LPO on which is also attached the receipt voucher for the goods that is signed by both the storekeeper and the head of department. These records are archived in a box file ready for checking by the auditors when they come once a month. Before they come in the internal auditors would have checked the documents to make sure that all was in order.

**LPO vote book adjustments**

*Page of vote book  
 Funds allocated  
 Funds spent  
 Funds remaining  
 Funds requested on this LPO-  
 Funds remaining after this  
 expenditure*

### **When goods are not available**

It rarely occurs that the current holder of the tender does not have a certain item in stock. If a shortage occurs, the supplier orders from Dar es Salaam. Delivery is rapid as the bus services Dar-Iringa are very efficient.

Drugs and medicines are bought from Medical Stores Department and occasionally a certain item is not available. The MSD therefore indicates on the requisition that the item is out of stock. For example this occurred when the district wanted to buy safari beds and they were not available at the MSD. The MSD marked the requisition O/S. The district requested for quotations from persons who had tender to supply general equipment, chose the lowest quotation and bought the safari beds by a Local Purchase Order (LPO)

### ***Advantages of tendering***

Iringa Rural District Council has identified several advantages from tendering:

- The tendering process is a competitive one and so reduces cost as it allows selection of the lowest bidder after considering other factors like the quality of the product and the efficiency of the supplier. It eliminates price hiking especially when there is shortage of a certain item in town. Without the tendering system, businessmen would take an opportunity to hike prices whenever there are shortages
- Standardization of prices is necessary to reduce incidences of forgery where a buyer colludes with the seller to sell items at prices higher than normal.
- Quality assurance is important when purchasing. The tendering system makes sure that one buys from identified sellers and not from any businessman.
- The tendering system reduces the number of audit queries. The system introduces a procedure for selection of a service provider and procedures for making payment. A lot of time can be spent in researching into audit queries and replying to them. In addition, audit queries give a bad image to a department and to the whole District Council. They sometimes leads to punishing the person who caused the misallocation or mis-expenditure.

### ***More tendering in the future***

(The Iringa Rural DMO thinks that in order to increase the efficiency of the storekeeper he would like to appoint a person to assist him. One candidate would be the District Pharmacist as he has experience in stores and could assist the storekeeper in ordering and management of supplies.

## Case Study 7

### Joint supervision teams: Examples from Kilombero and Iringa Rural Districts

Management of district health services requires careful planning, implementation, monitoring and evaluation supported by supervision. In supervision, problems are identified. Supervision at district level has been improved by training on supervision and the development of supervision instruments like supervisory checklist. Other strategies for improving efficiency of supervision have been developed. Thus districts have moved from single supervision (where a member of staff went to the health care facilities to supervise one health service to team supervision where a team from the DHMT supervises several of the activities of the health services together. In the last few years, DHMTs have moved towards joint supervision where a partnership for supervision is formed between the public and private sector.

This case study looks at group supervision in Kilombero. Read with the Iringa supervision case study on joint supervision, the case will show that there are benefits to joint supervision over DHMT group supervision.

#### *Group supervision in Kilombero*

##### **Members of the supervisory team**

In Kilombero district, the mode of supervision is the DHMT group supervision. The team consists of members of the DHMT. They usually go in a team of four people that can be accommodated in one car. This is different from the joint supervisory team of Iringa that is real joint that it consists of the public sector (DHMT) and the private sector (the private for non-profit).

At the site the team splits up according to their subject area (such as MCH or EPI). Subjects that are not represented in the team are covered as the team members have now acquired experience in supervising sections other than their own by seeing how their colleagues supervise these areas. Later they all come together to compile their findings and discuss them with the staff.

The diocese and other partners in the district do their own supervision. They do not to use the same checklist as the DHMT uses.

##### **Supervisory routes**

There are 6 supervision routes set up depending on the geography, terrain and state of the roads, depending on the availability of public and private health units and the type of services offered e.g. MCH services. The facilities offering MCH services are visited once a month, the private facilities every three months and all others every 2 months.

### **Support for group supervision**

The activity is supported by funds for supervision provided by the Ministry of Health. The SDC, the main donor for Kilombero health services, provides support for supervision. When the DHMT goes out to supervise specific projects, they also supervise the health units along the route.

### **Reporting and feedback**

The DHMT is conversant with 4 supervisory checklists: the Kilombero DHMT supervisory checklist for health facilities, the MOH checklist for supervision, the HMIS (MTUHA) supervisory format and the EPI supervision form. For each health unit visited, the team fills in the supervisory checklist for health facilities in Kilombero district. A copy of the report is left at the health unit. At the end of the visit, the supervisory team sits with the staff to provide feedback and on the job training.

On return, the supervisory team presents a report to the management meeting that is held every Monday. On discussion of the report, the participants may decide that an official revisit some centers that have seen to have problems and offer technical support in solving them.

### ***Supervision in Iringa Rural compared to Kilombero***

In Kilombero district, joint supervision of health services as was seen in Iringa (bringing in the private sector to supervise with the public sector) is non-existent. For example, the Diocese of Mahenge does its own supervision. The last visit was done in August 2000, before the present rains. During this supervision, 19 health units, six of which are in Ifakara, were visited. The team of diocese staff inspected physical buildings, medicines and looked at the staff situation. A supervisory checklist was not used but the team wrote a very detailed report.

The advantages of a joint supervision as done in Iringa over the singly supervision of Ifakara are very evident here.

In Iringa, every 6 months the DHMT supervisory team uses criteria to select best performing health unit and offers a reward in the form a letter and money. The criteria include cleanness, increased vaccination coverage, and increased number of deliveries. Some of the money is shared among the staff and some is used to buy something that can be displayed in the health unit, such as a wall clock. The letter of congratulations for winning the award of the best health unit is shown to the ward and village leaders so that they are aware that their health facility is among the best in the district. This motivates the village and ward leadership to give their support to the health unit and also increases the confidence of the community in their health unit and its staff. Chitta and Mbingu dispensaries are the recent health units that have won the award.