

**Results of the Rapid District Assessment of Existing Public-Private
Partnerships for Health Services Delivery**

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District Rapid Assessment: Executive Summary

Purpose and Methodology

To provide baseline information for Strategy Seven - Public/Private Partnerships of the Health Sector Reform, a rapid assessment of existing partnerships on the district level was conducted in February-March 2001. The objectives of the assessment were to document the types of existing partnerships, to identify the factors necessary to successful partnership and to evaluate the level of trust and mistrust between potential partners at this stage of Health Sector Reform (HSR). Four districts were chosen to represent a range of situations in which a variety of partners might be found: Arusha Municipality with a large number of private health facilities in a small area, Iringa Rural with its intensive donor assistance, Kasulu District with its large refugee population and Kilombero District with its District Designated Hospital partner.

Two teams of two researchers visited the districts for one week. Researchers were chosen from retired senior officials of the Ministry of Health who have district and regional experience and are familiar with the HSR and vertical programmes. The teams conducted structured interviews with the District Health Management Teams (DHMT) and other members of the District Councils, and with Voluntary Agency and NGO hospitals, health centres and dispensaries, directors of training institutions, private for-profit health facilities, Ward Executive Officers, local donor representatives and local business leaders.

Comprehensive quantitative and qualitative information were gathered on available health services including HIV/AIDS activities according to 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. Data analysis for each area was based on a model categorisation of possible partnerships according to three dimensions: stages of partnership ranging from Communication, Co-ordination, Co-operation to Collaboration (including pooling of resources); duration of partnership (short-term, recurring, mid-term, ongoing); and mechanisms of partnership ranging from informal to formal (documented, work plans and budgets, MOU's, tenders and contracts, MOH Agreements).

Extent and types of partnerships

Results from the assessment show that the majority of existing partnerships are between the District Council/DHMT and health facilities and training institutions owned by faith institutions and NGO's.

- Partnership for curative services is almost entirely limited to central MOH agreements for financial support and seconded staff of District Designated Hospitals and Medical Grants-in-Aid for Voluntary Agencies.
- Preventive health partnerships and the HMIS system collaboration are very largely determined by centrally organised vertical programmes which were initially designed and implemented as collaborative ventures so as to increase access to services and information.
- Partnerships are weaker and more variable for core functions such as planning, budgeting and supervision. Core function partnerships are controlled principally by the DHMT. The relative advantages of joint planning and budgeting are not yet perceived by all.

- Very few experiments in tendering for goods or services, outside of renovation/construction projects, have been attempted.

Most existing partnerships are formal and take the form of ongoing collaboration for the execution of a common work plan and objectives set by the DHMT or the central MOH. Far fewer informal partnerships were identified. These usually entail pooling a piece of equipment and technical staff between institutions or periodic communication.

Opportunities and modalities of information exchange are limited and some opportunities are neglected. Although joint supervisory partnerships were found in Iringa Rural and Kilombero Districts, systematic written feedback on supervision and on HMIS data is unusual. More seriously, few private sector providers and other partners are involved in planning and budgeting despite the new basket funding process; associations to represent private health facilities on the DHMT have not been formed. Only Kilombero District has created an Extended DHMT to include private sector partners systematically.

Private for-profit providers and the business community are only rarely included as partners. In particular, the very low level of participation by business in the National Immunisation Days, as compared to other countries, is a signal that this part of Civil Society is neglected as a potential partner. The most notable exception is in Arusha Municipality where business leaders have formed an ongoing committee to renovate and extend Mount Meru Hospital.

Sector-wide partnerships were observed for HIV/AIDS activities and to face emergencies and epidemics. These partnerships, as well as some construction projects, include the community and CBO's directly. Ward leaders have a key role to play as liaisons between the DHMT with its district-level private sector partners and the villages. Several examples of successful partnerships involving different levels from village to ward to District Council levels were noted, including INGONET in Iringa Rural District which mobilises a wide variety of Community Based Organisations, clusters, and NGO's for HIV/AIDS interventions.

Factors which favour successful partnerships

Concerning the factors favouring successful partnership, there is almost complete consensus among the public and private sector groups interviewed. Factors cited include:

- ✓ Regular opportunities for communication, frank exchange of information and group problem solving with participation from all sectors;
- ✓ Organisation of the private sector providers into a group to facilitate dialogue and co-ordination with the public sector;
- ✓ Joint planning with common objectives and clear definition of each partner's role and terms of reference;
- ✓ Joint assessment of training needs and joint training sessions;
- ✓ Performing joint public-private supervision using a common check list and providing feedback;
- ✓ Reliability, being able to count on a partner for informal collaboration or assistance, including stable personnel so that long term relationships may develop;
- ✓ Clarity about the interests of each partner and the benefits which the partnership should provide to each of them;
- ✓ Learning from experience. Partnerships should be flexible enough to allow evolution and modification as the situation changes and as the partners learn to communicate, co-operate and collaborate better.

Recommendations and use of the assessment results

The results of this district assessment will be used in several ways in the coming year. Primarily, they will be used to refine the Government's strategy for encouraging and

facilitating public-private partnerships and to set the baseline against which changes will be measured. The case studies and examples found by this assessment will be used to develop advocacy materials for specific reforms and to inform potential partners about modalities and opportunities. Finally, they will be used to identify district level needs for technical support and capacity building for skills related to partnership.

The following recommendations will guide the activities during the next period of work:

1. District planning and budgeting will be more effective if private sector health facilities, training facilities and HIV/AIDS groups are included. District associations of private sector groups involved in health should be formed and representatives elected to participate as standing members of Extended District Health Management Teams.
2. Central government (MOH, PORALG) should provide regular information to the districts and partners on the evolution of the reforms and on basket funding. These information should be discussed openly at the district level.
3. Additional forums to discuss the problems of seconded staff should be organised by the District Councils and, as a first step, problems and questions should be noted and communicated to the regional and central government.
4. Any pilot activity should involve the DHMT from the start so as to increase the probability of a smooth transition from intense support from NGO's, international PVO's and donors to normal functioning. A transition plan should be worked out well in advance of the termination of initial support.
5. Opportunities to leverage business support for district health services, in terms of contributions to NIDs, HIV/AIDS clusters and other community activities, and development of work site/employee health programmes should be sought out and encouraged.
6. District Councils should evaluate potential cost savings and effectiveness of tendering the purchase of goods and services.
7. Opportunities to extend access to preventive services and to offer public health coverage of under-served areas through contracting, MOU's and collaboration with isolated private for-profit providers should be examined closely by DHMTs.
8. Finally, successful partnerships should be identified, preserved and encouraged, according to the maxim "Don't fix what isn't broken".

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Acronyms

AIDS	-	Acquired Immune Deficiency Syndrome
AMREF	-	African Medical Research Foundation
BOG	-	Board of Governors
CBD	-	Community Based Distribution
CBO	-	Community Based Organisation
CEDHA	-	Centre for Education Development in Health- Arusha
CIDA	-	Canadian International Development Agency
CORD	-	Christian Outreach Relief and Development
COTC	-	Clinical Officers Training Centres
DAC	-	District AIDS Co-ordinator
DANIDA	-	Danish International Development Agency
DC	-	District Commissioner
DCCO	-	District Cold Chain Operator
DDH	-	District Designated Hospital
DED	-	District Executive Director
DFID	-	Department for International Development
DHMT	-	District Health Management Team
DHMTE	-	District Health Management Team Extended
DMB	-	Diocese Medical Board
DRCHCO	-	District Reproductive and Child Health Co-ordinator
DMO	-	District Medical Officer
DPO	-	District Planning Officer
ELCT	-	Evangelical Lutheran Church of Tanzania
EPI	-	Expanded Program on Immunisation
FP	-	Family Planning
GIA	-	Grants-in-Aid to Voluntary Agencies
GOT	-	Government of Tanzania
HC	-	Health Center
HIV	-	Human Immuno-deficiency Virus
HMIS	-	Health Management Information System
INGONET	-	Iringa NGO Network
JICA	-	Japanese International Cooperation Agency
KaDP	-	Kasulu Austria Development Programme
MD	-	Medical Doctor
MOH	-	Ministry of Health
MOU	-	Memorandum of Understanding
MTUHA	-	Mfumo wa Taarifa wa Utoaji Huduma za Afya
N/M	-	Nurse/Midwife
NGO	-	Non-Governmental Organisation
NID	-	National Immunisation Day
OPD	-	Out Patient Department
PHC	-	Primary Health Care
PSI	-	Population Services International
PORALG	-	President's Office, Regional Administration and Local Government

PVO	-	Private Voluntary Organisation
RAS	-	Regional Administrative Secretary
RC	-	Roman Catholics
RCH	-	Reproductive and Child Health
RLGO	-	Regional Local Government Officer
RRCHCO	-	Regional Reproductive and Child Health Co-ordinator
RMO	-	Regional Medical Officer
SDP's	-	Service Delivery Points
TAHEA	-	Tanzania Home Economics Association
UMATI	-	Family Planning Association of Tanzania
UNFPA	-	United Nations Population Fund
UNHCR	-	United Nations High Commission for Refugees
UNICEF	-	United Nations Children's Fund
USAID	-	United States Agency for International Development
UWT	-	Women Association of Tanzania
VA	-	Voluntary Agency
WEO	-	Ward Executive Officer
WFP	-	World Food Program
WHO	-	World Health Organisation

Introduction

Purpose

This assessment of public-private partnerships in four districts is designed to provide baseline information for development of the 2001-2003 implementation strategy for Strategy Seven of the Health Sector Reform (HSR) of the Ministry of Health (MOH). The assessment is one of the four key activities for the start-up phase of Strategy Seven, which began in December 1999. The other activities include 1) a series of stakeholders' workshops to define basic terms and identify the level of awareness concerning partnerships¹, 2) a rapid assessment of the legal environment for public-private partnerships², and 3) ongoing strategic planning. These activities are led by the Strategy Seven Co-ordinator, Dr. Peter MMBUJI, Head of Voluntary and Private Services, Directorate of Hospital Services, Ministry of Health.

The mission of Strategy Seven of the Health Sector Reform (HSR) is to develop mechanisms for supporting and facilitating partnerships between the public and private sectors for delivery of high quality health services. This mission requires close collaboration with other facets of the HSR, especially Strategy Three - Policy Streamlining, with the new District (or Municipality) Health Management Teams (DHMTs) and with the President's Office of Regional Administration and Local Government (PORALG) and District Councils. It also requires continuous improvement of the dialogue, co-ordination and consultation with private sector representatives and partners at all levels. This assessment is one example of direct consultation with the public and private sector actors on the local level.

Prior to this study, little information has been available about the nature and range of formal and informal partnerships between health care institutions, decision-makers, donors, the business sector and community groups at the district level. Discussion during the stakeholders meetings (December 1999, September 2000) has suggested that a wide range of situations exist – from frank suspicion and resistance to close collaboration. These discussions also suggested that a large number of partnerships already existed at the district and ward levels, many of which were temporary and informal. Furthermore, it became obvious that public, NGO, faith institutions, private for-profit providers and community groups had concerns about future collaboration. These concerns have been intensified by the decentralisation of health sector control and funding. Trust and mistrust between present and future partners emerged as a key issue.

Thus, in order to document the range of situations present in the districts at this stage of Health Sector Reform (on the brink of the first year of direct basket funding) and

¹ "The Analysis of the Public Private Mix: Strategy Seven of the Health Sector Reform", TPHA and Ministry of Health, Workshop Report, 21-23 December 1999 and "Workshops Report: Public-Private Partnerships Consultative Workshops", TPHA and Ministry of Health, 11, 12, 18, 28 September 2000.

² "Assessment of the Legal Framework for Public-Private Partnerships in the Health Sector", Ngonyani, Kyuki, et al., TPHA and Ministry of Health, November 2000.

in order to provide detailed information about factors influencing success of partnerships at the district level, this rapid assessment of a sample of districts was conducted in February and March 2001.

Partners

Direction for this district assessment was provided by the Strategy Seven Co-ordinator, Dr. Peter Mmbuji. Technical support has been provided by Management Sciences for Health through its ongoing programme of technical assistance to MOH, first under the Family Planning Management Development Project and now under the Management and Leadership Development Project financed by the United States Agency for International Development (USAID).³ - ⁴ Local technical and logistical support for protocol development and field testing were provided by the Tanzanian Public Health Association and the National Institute for Medical Research. Local technical support, logistics, and analysis support for the field study were provided by HealthScope Tanzania Ltd, based in Dar es Salaam. Field researchers include Ms. R. Kapoja, Dr. Tengio Urrio, Dr. H.Y. Simbaulanga, and Dr. K. R. Mchatta. The research co-ordinator for HealthScope was Mr. Peter Riwa.

Organisation of the report

This report is organised into six sections. In the Background section, the history and theory underlying development of the Public-Private Partnerships strategy are described and an overview of partnership options is provided. In the Methodology section, the protocol for the assessment is explained and the four study districts are described briefly. The Results section contains two parts. The first part summarises the findings of the assessment by district. The second part examines the results in detail according to possible areas of partnership including:

- Core functions of planning, budgeting, training, supervision, Health Management Information System (HMIS) and purchasing of goods and services.
- Service delivery functions including curative services, preventive services and HIV/AIDS activities
- Special activities such as National Immunisation Days (NIDs), construction/renovation of health facilities, emergency preparedness, and refugee support.

In the following Discussion and Conclusions sections, these results are examined for their structural characteristics. Factors favouring and limiting partnerships are identified. Conclusions are drawn about the extent of existing partnerships and the promise for future ones. In the final Recommendations section, the uses of the results are indicated and eight major recommendations are made for priority areas of partnership. The Annexes to the report include more detailed information on the fieldwork in each district. Direct quotes from interviews are shown in *italics*.

³ This work is supported by USAID Co-operative Agreement No. HRN-A-00-00-00014-00. USAID is not responsible for the opinions expressed within.

⁴ Technical guidance provided by Mr. Paul Fishstein and Ms. Catherine Severo of Management Sciences for Health.

Background

Tanzania Health System and Health Sector Reform

Public – private partnership in the delivery of health care services is not new in Tanzania. Under both the German and British regimes (1888-1961), a public health care delivery system was developed while at the same time, the establishment of health services by faith organisations was allowed and encouraged. These organisations were also at the forefront in establishing schools and churches.

The dual system of health care provision was inherited at Independence and minimal changes were made until 1967, when the country adopted a central planning approach. This strategy emphasised equity in the access of health services and the dominant role of the Government in ensuring access to basic health services as a fundamental human right. In 1977, the Private Hospitals Act limited private sector health institutions to those owned by voluntary agencies. Until 1991, the private for-profit sector and NGO sector were systematically suppressed and either functioned in quasi-clandestine fashion or registered under the umbrella of voluntary agencies, which enjoyed government tolerance.

Physical deterioration of the health facilities and declining quality of the health services resulting from the decline in the per capita health expenditure undermined the desire of the Government to provide free health care services to all. Recognition of this reality, combined with the increasing openness of the political system in the 1990s are considered as some of the key factors which led to the enacting of the Private Practice Act 1991. Since its enactment, the number and variety of NGO's, private for-profit health facilities and private practitioners and health-related associations have grown rapidly.

The possibility of increasing efficiency in the delivery of health care as demonstrated by the World Development Report 1993 produced by the World Bank was among the driving forces behind the adoption of the on-going Health Sector Reform. Key features of the Health Sector Reform include redefinition of the role of central government and decentralisation of key functions to the district level, and recognition and encouragement of the participation of the private for profit and the community in health care.

Under the Health Sector Reform, public-private partnership is actively promoted under Strategy Seven. The main objective of partnership under the reform is to extend access to quality health services (including HIV/AIDS activities) throughout Tanzania.

Partnerships – Concepts and Operational Mechanisms

A considerable body of documentation exists on developing partnerships in health. This district assessment has relied particularly on the MSH analysis of stages of partnership⁵, which identifies four levels of intensity:

1. **Communication** – when organisations begin to talk to each other about their interest in creating a partnership and continue to talk to each other openly to improve the functioning and effectiveness of an ongoing partnership.
2. **Co-operation** – when two or more communicating organisations reach an understanding to assist each other.
3. **Co-ordination** – when organisations combine their resources and strengthen their individual roles for a common programme of work.
4. **Collaboration** – when two or more groups already communicating work together to develop an activity, programme, or policy that did not exist previously.

Institutions and individuals may have several different kinds of partnerships at any one time. The level of partnership must be adapted to the objectives pursued. Fixing the objectives of a joint effort is crucial for determining which strategy will be applied, which groups or institutions should become partners and what form the partnership should take. For example, if the objective is to increase contraceptive prevalence by enlarging access to family planning services on the village level, the partners will include the community, village and ward leaders, Service Delivery Points (SDP's) offering family planning in the district and the District Reproductive and Child Health (DRCH) Co-ordinator, as well as possibly a non-governmental organisation (NGO), a donor, trainers and the MOH Community Based Distribution (CBD) Co-ordinator. However, if the objective is to increase contraceptive prevalence by enlarging access to family planning services by opening more family planning units, then the partners would include SDP's that do not yet offer this service, their parent institutions, the DMCH Co-ordinator and perhaps the central MOH.

At all times, communication is the basis of partnership. Opening and preserving channels of communication between institutions and groups creates common ground upon which future partnerships can be explored.

Then too, the partnership between parties may evolve over time from simple communication to co-operation through to collaboration. In the case of short term or periodic activities, partners may move rapidly from non-communication to

⁵ "Forming Partnerships to Improve Public Health", *The Manager*: Volume VII, Number 4, Winter 1998-1999; Management Sciences for Health, Boston, Massachusetts, USA.

collaboration and then back to non-communication once the activity is over. Thus, it is also useful to characterise the duration of partnerships as:

- **Short-term** - concerning a specific goal or project for a well-defined time period
- **Recurring** - concerning a specific and recurring activity that occupies a well-defined time period
- **Mid-term** - partnerships which cover a period of years, but which have a defined time period and usually, goals, objectives and terms
- **Ongoing** - partnerships which have no defined end-point but which are assumed to continue under known conditions.

Besides these two dimensions of partnerships, which may be summarised as the Level of Engagement and the Duration, there is a third dimension that can be called the Mechanism of partnership. A variety of mechanisms exist which can be summarised as follows:

- ✓ **Informal** - partnerships for which no formal, written document of engagement, or contract, is prepared. Informal partnerships may range from a "handshake" arrangement to verbal engagement in front of witnesses or the community.
- ✓ **Formal** - those partnerships for which a written engagement is made and signed. There are several types of documents, each suited to different types of partnerships.
 - ✓ **Documented informal partnerships** for which there are minutes of meetings, trip reports, and other indirect notes recording the partners' commitments.
 - ✓ **Work plans and budgets** - These documents record the engagements of partners for co-ordination, co-operation and collaboration. Budgets may show the pooling of resources under co-operative and collaborative partnerships. They are usually accompanied by programme documents of some sort -- project proposals, grant applications, annual strategic plans and such.
 - ✓ **Memorandum of Understanding (MOU)** - This is a document wherein the common work is described and the contribution of each partner is explained. An MOU may be developed for any of the four levels of partnerships, but is most common for Co-operation, Co-ordination and Collaboration. Memorandums of Understanding are often the legal form for donor projects. They may also provide documentation for informal partnerships made by communities to participate in larger activities.
 - ✓ **Tenders and public bidding** - These are the most rigidly structured forms of collaborative partnership because the rules for the selection of the partners are defined by laws and regulations on tendering. In almost all cases, one partner purchases the services or goods of the other partner. However the content and duration of the purchase may vary from a one-time transaction to a recurring purchase arrangement to a mid-term plan of work with complex objectives. Tenders, once granted, are expressed by contracts, standing work orders, co-operative agreements and other legal devices.

- ✓ **Agreements** - The Government of Tanzania has developed special forms of ongoing partnerships with certain types of institutions. These partnerships are defined by Acts of Parliament and are formulated by regulations and legal instruments. They involve an exchange of services against financial support and in-kind assistance. In the health sector, the two most common devices are the District Designated Hospitals Agreement and The Medical (Grants-in-Aid to Voluntary Agencies) regulations.⁶

This assessment has sought to identify the partnerships that exist in each of the study districts and to classify them according to these three dimensions. It has also sought to identify to what extent the Form, Level and Duration of the partnerships was adapted to the activity, and to what extent the partners experience the partnerships as satisfactory. Finally, this assessment has sought to identify those areas in which no partnerships or incomplete partnerships exist and the willingness of potential partners to engage themselves further.

⁶ The District Designated Hospitals (DDH) Agreement and the Medical Grant-in-Aid to Voluntary Agencies Regulations (1980)

Methodology

Selection Criteria

Since the objective of the assessment was to observe the range of possibilities for public-private partnerships, a random sample of districts was not considered the optimal selection technique. Instead, selection criteria for the sample of districts were defined to represent a range of situations that might yield a variety of partnerships. The 37 districts in Phase 1 of Local Government Reform were sorted into categories by situation. The final sample was defined by the Strategy Seven Co-ordinator, taking into account geographic distribution of these districts.

The five categories and the corresponding districts are:

Table 1: CATEGORIES AND SAMPLE DISTRICTS

Category	District
A municipality containing a large number of providers in a small area.	Arusha Municipality
A district with a District Designated Hospital contract.	Kilombero
A district with a large refugee population and assistance programmes for them	Kasulu
A district with an intensive donor programme.	Iringa Rural
A rural district with a public hospital and few donors	Hai

Protocol

This rapid assessment of existing partnerships in health services delivery was designed to provide some basic information about the types of partnerships that already exist at the local level and the basic pre-requisites for partnerships such as communication, information, and trust. Facilitating factors and obstacles to partnership were explored to better understand those conditions necessary for success. The protocol consists of a one week visit to each district during which extensive interviews are conducted with representatives of the District Council, the District Health Management Team (DHMT), voluntary agencies and NGO's operating Service Delivery Points, private for-profit health providers, ward leaders, business leaders and others involved in health. A mixture of quantitative and qualitative information is gathered.

Semi-structured questionnaires were developed by Dr. Aziza Mwisongo of the National Institute for Medical Research (NIMR), Prof. Philip Hiza, former Chief Medical Officer of the Ministry of Health, and Ms. Catherine Severo, technical advisor from Management Sciences for Health. Development and implementation of the assessment was directed by Dr. Peter Mmbuji, Strategy Seven Co-ordinator. Additional technical support was provided by Dr. Adeline Kimambo of the Tanzanian Public Health Association. The tool was field tested in Hai District by Professor Philip Hiza and Mrs. Zena Ubwe, former Chief Nursing Officer of the

Ministry of Health in October 2000. Revisions were made subsequently. The questionnaires are listed and described in Annex 1.

The following table summarises the protocol in each district.

Table 2: FIELD PROTOCOL FOR EACH DISTRICT

Day Zero	Travel to district or municipality
Day One (team members together)	Go to the district or municipal headquarters Meet the DMO Courtesy calls to the District Commissioner and the DED Set up meetings with the DED, DPO, and others Long meeting (up to ½ day) with the DHMT
Day Two (team members together)	Visit the main hospital Visit training facilities (if any) Visit other voluntary agencies or NGO's in the main town Visit individual members of the DHMT if necessary
Day Three (team members can split up)	Visit voluntary and NGO health facilities in the town and very close outlying areas Try to identify and visit one or two large businesses or estates Visit the radio station or a newspaper office Visit other hospitals if possible
Day Four	Visit a Ward Executive Officer Visit other private health facilities and/or a community group on the way to the ward Visit individual members of the DHMT if necessary
Day Five	Follow-up meeting with the DMO and the DHMT (long meeting) Write overview report with major findings
Day Six	Travel back

Two research teams of two persons were formed of retired central MOH officials with district experience. Senior officials were chosen because they have the required knowledge about the functioning of the health system on the district level, but also experience with vertical programmes and health policy on the central MOH level. Furthermore, their standing with their former colleagues allows them to probe sensitive areas of institutional collaboration and conflict.

During a three-day training session, researchers familiarised themselves with the questionnaires and with Strategy Seven. The trainers were Peter Riwa of HealthScope, Paul Fishstein of Management Sciences for Health and Dr. Peter Mmbuji, Strategy Seven Co-ordinator.

Researchers also reviewed two documents containing background information on health status and health services. The first was the set of district or municipal data-gathering catalogue from the District Health Profiles compiled in 1999 by NIMR. The second document was the publication containing the MOH objectives for each of the first 37 districts to develop a district health plan for the year 2000. These objectives were to be discussed with the local government team.

Field Visits

Each team visited two districts for a period of one week each. The first round of data collection was conducted from 26th February to 3rd March 2001 in Arusha

Municipality and in Kasulu District. A debriefing was conducted on the 7th March 2001 in Dar es Salaam to discuss the results from the first district and to write a brief narrative district report and case studies of partnerships. The second round was conducted from 12th March to 17th March 2001 in Iringa Rural and Kilombero Districts. A second debriefing was held on 21st March 2001. The Strategy Seven Co-ordinator attended the two sessions.

Table 3 shows the number and type of interviews conducted during the four visits. (The full lists of persons interviewed in each district are found in the district reports in Annexes 2A-2D.) In all, 104 interviews were conducted, about 25 per district.

Table 3: NUMBER AND TYPE OF INTERVIEWS IN EACH DISTRICT

Interviewee	Arusha	Kilombero	Iringa	Kasulu
Regional level	1	-	1	2
District Council	1	1	1	1
DHMT	2	2	2	2
DCCO	-	-	1	1
DAC	1	1	1	-
HMIS CO	1	1	1	1
Hospitals Public	-	-	-	-
VA/DDH	5	3	2	2
Private	2	-	-	-
Health Centres	3	1	-	-
Public	-	-	-	-
VA	-	-	2	-
Dispensaries	3	4	2	1
Public	1	-	-	-
VA	1	1	1	2
Training Centres	2	1	1	1
Ward/Village Officers	1	2	2	1
Business Leaders	1	-	3	3
NGOs		1	6	5
Others	3	3	3	3
Total	28	23	29	25

Data analysis was conducted in four steps. First, the entire team met to clarify findings and close information gaps. Small case studies were developed to illustrate types of existing partnerships. Second, some quantitative information was tabulated using EpiInfo6 software. Third, qualitative information was summarised by hand. Next, quantitative and qualitative information was compared between districts to identify the range of situations and partnerships in place. Existing partnerships were categorised according to the characteristics described in the Partnerships section above. Information were re-sorted and analysed according to functional areas (core functions, service delivery functions, special activities, trust and mistrust). Finally, overviews of the situation in each district were developed in the form of summary tables by functional area and type of partnership (Tables 8-11) and as descriptive statements.

District Sample - Profiles

The principal demographic and health characteristics of the districts are represented in the following tables. Brief descriptions of the district context have been provided.

Arusha Municipality is situated in the cool areas of northern Tanzania. It used to be the seat of the now defunct East African Community that broke up in the seventies. After the break up of the community the municipality continued to be a seat for many international conferences and now houses the East African Co-operation Secretariat, the Regional Commonwealth Secretariat and the International Court Tribunal for Rwanda. Last year (2000) the US President visited the town to witness the signing of the peace agreements between warring groups in Burundi. Situated near to the Ngorongoro Crater and Serengeti National Park considered as one of the seven wonders of the world, it is an important tourist centre and a crossroads for goods and human transport. Unfortunately, Arusha Municipality also experiences high HIV/AIDS transmission, reporting about 50% of the new cases in the region, (2195 in 1999)⁷.

Table 4: ARUSHA MUNICIPALITY - GENERAL CHARACTERISTICS OF POPULATION AND HEALTH

Characteristic	Information
Population, population density	About 300,000 (<i>population density not available</i>)
Maternal and under-5 mortality rates	155/100,000 and 137/1000
Health care services	
Hospitals (public, faith, private)	4 (2 public, 2 faith)
Health centres (public, faith, private)	9 (3 public, 2 faith, 4 private for profit)
Dispensaries (public, faith, private)	47 (2 public, 16 faith, 29 private for profit)
Training institutions	CEDHA training centre
Community based programmes	HIV/AIDS activities

Iringa Rural District is situated in the cool western highlands of Tanzania and boasts of a place in the annals of the history of Tanganyika as the site of wars of resistance against the Germans. Situated 6-8 hours drive on the Dar es Salaam - Zambia highway, it enjoys good communication with the capital city and the south western parts of Tanzania that have now been opened up thanks to the new about 400 km road that links Iringa and Songea in the south. Its cool climate, easy access and poor health indicators are some of the factors that have attracted many donors to the region. The region has benefited from a long history of intensive support from USAID, UNICEF, other donors and research groups.

⁷ National AIDS Control Programme, Ministry of Health, Government of Tanzania.

Table 5: IRINGA RURAL - GENERAL CHARACTERISTICS OF POPULATION AND HEALTH

Characteristic	Information
Population, population density	500,570 (2001 est.), 18 persons per sq. km.
Maternal mortality rate	946/100,000
Health care services	
Hospitals (public, faith, private)	1 (faith)
Health centres (public, faith, private)	7 (5 public, 2 faith)
Dispensaries (public, faith, private)	75 (45 public, 1 parastatal, 26 faith, 3 private)
Private pharmacies	78
Village health posts	182
Training institutions	VA Nurse/midwives training school
Community based services	CBD programme, HIV/AIDS Clusters
School health programme	189 primary, 12 secondary schools

Kasulu District is situated in the western part of Tanzania and borders with Burundi in the north west, Kibondo District in the north east and Kigoma Rural District in the south west. Situated in what used to be the remotest areas of Tanzania, Kasulu used to be very underdeveloped until the villagelisation programme brought the people to live together in reachable villages where they were provided with the necessary basic social services (health, water and education) and agricultural support.

Recurring ethnic fighting in Burundi brings waves of refugees into the district. The latest influx, that started in 1993, has brought in a large group of refugees resulting in far-reaching effects on the road infrastructure, agriculture, security and social services (water, health and education). In response to this crisis a good number of UN organisations and many international NGO's have come into the district to help with the refugees and initiate programmes that address the effects of the crisis on the local population.

Table 6: KASULU- GENERAL CHARACTERISTICS OF POPULATION AND HEALTH

Characteristic	Information
Population, population density	445,260 (1999 est.) including 152,000 refugees in 2 camps (Sept. 2000) , 47 persons per sq. km.
Maternal and under-5 mortality rates	170/100,000
Health care services	
Hospitals (public, faith, private)	3 (1 public, 2 faith)
Health centres (public, faith, private)	6 (4 public, 2 faith)
Maternity waiting home	1 (public)
Dispensaries (public, faith, private)	54 (36 public, 14 faith, 3 NGO SDP's in refugee camps, 1 private for profit)
Training institutions	2 training centres
Community based services	In refugee camps and HIV/AIDS activities

Kilombero District is one of the districts of Morogoro region, a large region that stretches from the rainy south to central areas of the country and from the coastal climate of the east to the cool climate of the mountains of Iringa region to the north. Despite the proximity of the regional town to the capital city (200 Km), some of the

districts, notably Kilombero, are situated long distances from it and from the regional town. The district enjoys extremely good rainfall and with its fertile valleys it has good agriculture produce, including one of the largest sugar plantations in the country. Despite its strong agriculture economy, it is one of the poorest districts in Tanzania. As the district was hewed out of a larger district in efforts to bring administrative and social services closer to the people, Kilombero did not have a district hospital when it was started. Therefore, the Ministry of Health signed a contract in 1976 with the Roman-Catholic Diocese-owned St. Francis Hospital to act as a District Designated Hospital (DDH).

Table 7: KILOMBERO- GENERAL CHARACTERISTICS OF POPULATION AND HEALTH

Characteristic	Information
Population, population density	255,687 (2001 est.), 17 persons per sq. km.
Maternal and infant mortality rates	404/100,000 and 128/1000
Health care services	
Hospitals (public, faith, private)	2 (1 DDH faith, 1 private for profit)
Health centres (public, faith, private)	4 (public)
Dispensaries (public, faith, private)	42 (27 public, 9 faith, 6 private for profit)
Training institutions	DDH based nurses training school
Community based services	HIV/AIDS activities

Results by District

Presentation

Results for each district are summarised in this chapter. First, an overview of each district is provided. Second, the results are summarised in tabular form to show the level, duration and mechanisms of existing partnerships in these districts. The complete trip reports for each district, including Hai District, are found in Annexes 2A-2E.

Arusha Municipality

Because Arusha is a single large town, there is no geographic barrier to partnership. The concentration of large businesses has made possible a successful ongoing Civil Society partnership to renovate and expand Mount Meru Hospital. Yet in core and service delivery activities, Arusha Municipality appears to contain no other unusual examples of communication and collaboration. The district health planning and budgeting process has included only two representatives of an NGO and of the VA hospital. The municipality organises joint training in the zonal training centre CEDHA and provides supervision of private health facilities in RCH, MTUHA, EPI and FP. The public and private hospitals co-operate informally to pool a technical staff person and ultrasound equipment. The DHMT does not have its own HIV/AIDS co-ordinating group, but the Diocese of Arusha runs an AIDS Task Force. Health partners who co-operated during the recent cholera epidemic have learned from that experience and formed Emergency Preparedness Committees and created emergency drug stocks. Arusha has a large number of private, for-profit SDP's, but little collaboration is conducted with them. Their number may pose problems for individual contact; no association or group has been created to organise them. However, there are informal referral and co-ordination partnerships between private health facilities. Although the business community contributes to construction, they do not appear to be involved in NID's or HIV/AIDS activities. Community members collaborate with CBD programmes for family planning and through CBO's for HIV/AIDS activities.

Iringa Rural District

Iringa has received intensive donor support since the 1980's. The large number of private-sector actors, including NGO's, VA's, CBOs, CBD agents, and the INGONET, create a complex range of potential partners for the public sector. Iringa is the site of a Community Health Fund, in which all public and faith SDP's are expected to participate. (The Roman Catholic Diocese has not yet decided to do so.) Marie Stopes Tanzania, an NGO specialised in high quality RCH services, has received authorisation to provide services in specific under-served villages. Iringa Rural District also has a joint supervisory team of public and faith supervisors who visit 5 public and 5 VA SDP's (so far). The DHMT includes most major partners in planning and budgeting exercises. However the district does not have a private

sector association. The District Council has let a tender for sector-wide office supplies and photocopying, the only example of such tendering found in this study.

Some of these experiences have been quite successful, while others have been less so. Communication between NGO's and the DHMT has not always been maintained, reducing the chances of programme sustainability. Iringa Rural District illustrates the value of good communication and the need for co-ordination to make a successful transition from donor funded pilot projects to ongoing programmes.

Kasulu District

Because of the large number of refugees, partnerships in Kasulu District divide into two groups, those concerning refugees and those concerning other types of health activities. Interviews showed that the district collaborates with 7 external agencies, 8 international PVOs, one local NGO and five faith organisations, besides the community. Many of the same groups are involved in both types of partnerships, but the refugee activities are viewed as temporary. Unlike health and HIV/AIDS activities that are co-ordinated by the DHMT, refugee activities are co-ordinated by the UNHCR. The UNHCR has organised a monthly inter-agency meeting to which all partners, including all division directors of the District Council, are invited. However directors are often called to other duties and are unable to attend.

Many NGO's have come into Kasulu in response to the refugee crisis that started in 1993. Because of the refugee crisis, more resources have come into the district and this makes the development of partnerships even more important in order to make the best use of resources to increase efficiency and avoid duplication. In addition to developing partnerships between NGO's, there is also partnership between the NGO's and the public sector. NGO's working in health and health related interventions for refugees are planning to expand their scope. For example, CORD (Christian Outreach Relief and Development) and World Vision are planning to include HIV/AIDS in their interventions and CORD is considering including CSPD in the villages where they are involved. The question of partnership and collaboration is therefore becoming increasingly important as the NGO's consider extension from the refugee crisis to support health programmes that target the general population. The need for a Health Sectoral Group that brings together the agencies supporting health programmes and the DHMT is becoming increasingly obvious. Such a structure used to exist (supported by KaDP, the Kasulu Austrian Development Project) but it is no longer active. Kasulu, like Iringa, is a district where so much is happening that the capacity of the DHMT to co-ordinate and even to stay informed may be insufficient.

Kilombero District

Kilombero District provides a stark contrast with Iringa and Kasulu. Like Hai, its status as a newly formed district means that few longstanding partnerships exist, nor is there a well developed business community. However, unlike Hai District where there is little communication between the public and private sectors, Kilombero District Council has taken the initiative to establish a formal mechanism for

communication and co-ordination, the Extended District Health Management Team (DHMTE). This body includes the two training institutions, the Medical Officer in-charge of St. Francis Hospital (the DDH facility), and representatives of private for-profit facilities, faith groups and donors. However, private health providers would like to form an association and elect the representatives to the DHMTE, rather than waiting for the District Council to appoint the members. Kilombero, like Iringa, has experimented with joint supervision and, exceptionally, includes for-profit health facilities, in NIDs and other activities. Collaboration with the business community appears to be slight however. Partnerships with the villages are strong; the DHMT develops formal documents with villages for construction of dispensaries and annexes to SDP's and rarely contracts out the work. Collaboration on the ward-village level to solve emergencies and for common projects appears to be strong also. Kilombero appears to be a district that strives to prove the maxim "Less is more".

Summary Tables

On the following pages, one table is provided for each district. The levels of partnership are numbered as 1) Communication, 2) Co-ordination, 3) Co-operation, 4) Collaboration. This numbering is not meant as a measure of value or as a score, but only to indicate the level of interaction and resource sharing of the partners.

Table 8: SUMMARY OF EXISTING PARTNERSHIPS: ARUSHA MUNICIPALITY (*FIRST INSTANCE, POTENTIAL FOR RECURRENCE)

Area	Partners	Content/type of Partnership	Level	Duration	Mechanism
Core Functions					
Planning	DHMT, INGO, 1 VA	Formal - develop district health plan	4	Recurring*	2001 Health Plan process
Budgeting	DHMT, VA Hosp.	Formal - develop basket fund allocation	4	Recurring*	2001 Basket Fund allocation process
HMIS	DHMT, all SDP's both public, private	Formal - integrated system of reporting	3	Ongoing	HMIS work plan, training, supervision, report form logistics
Training	DHMT, VA Hosp	Formal - VA trains eye disease technicians	3	Recurring	Supervision and training plan by VA
	DHMT, CEDHA	Formal - CEDHA in-service training	4	Recurring	Training agreements, contracts
	VA, CBD Agents	Formal - DHMT approves VA training plan and target villages	2	Mid-term	MOU, work plan, training lists
Supervision	DHMT, SDP's	Formal - MTUHA, MCH, DCCO, Dental, laboratory, curative	3	Ongoing	Supervision plan by DHMT
Other purchasing	DHMT, CEDHA	Formal - printing training materials and OPD cards	3	Recurring	<i>Not reported</i>
Service Delivery					
Curative	Public Hosp, VA Hosp Public, VA, SDP's	Informal - staff sharing for radiology, ultrasound technician	3	Recurring	<i>Not reported</i>
	VA-VA	Informal/documentated - referral system	2	Ongoing	National referral policy and severity/needs of patients
	MOH-VA Hosp	Informal/documentated - referral system	2	Ongoing	Bloc grant, Letter of posting
Preventive	DHMT- 80% of SDP's	Formal - 3 seconded staff	4	Ongoing	EPI work plan, logistics, Issue voucher
	DHMT - same ex. RC	Formal - EPI programme, equipment loans	3	Recurring	EPI work plan, logistics, Issue voucher
	DAC, NGO, CBO,	Formal - MCH programme	3	Ongoing	MCH work plan and logistics
HIV/AIDS	Diocese Aids Task Force	Formal - FP programme	3	Ongoing	FP work plan and logistics
		Formal and informal - DAC, NGO, CBO	4	Mid-term	MOU's, funds proposals, Diocese AIDS Task Force plans
Special Activities					
NID	PHC, DHMT, Wards, SDP's, Media, Faith, Politicians, 1 Business	Informal/documentated - planning and contributions of non government partners, Formal - DHMT, MOH, Ward	4	Recurring	Official letter, invitation to planning meeting, Annual work plan
Emergencies	District Council, Wards, SDP's, CBOs	Informal with transition to formal - ongoing Cholera epidemic	3	Short-term*	Newly formed Emergency Preparedness Committee, meetings
Construction Refugees	DHMT, Donor group <i>None</i>	Formal - Business support for Mt Meru Hosp	4	Ongoing	Official committee, local funding, plans

Table 9: SUMMARY OF EXISTING PARTNERSHIPS: IRINGA RURAL

Area	Partners	Content/type of Partnership	Level	Duration	Mechanism
Core Functions					
Planning	DMO, DPLO, RC rep., Ingonet, private SDP's	Formal - 2001 District plan Formal - 2001 Basket funding plan, Community	4 4	Recurring* Recurring*	Planning meetings, plan Planning meetings, plan, CHF contracts
Budgeting	<i>Same group</i>	Health Fund (excluding RC SDP's)			with SDP's, members' enrollment
HMIS	DHMT, all faith SDP's, 3 private SDP's	Formal - Integrated reporting system	3	Ongoing	HMIS plan, 67% reporting, training, supervision, forms logistics
Training	VA N/M Training School, DHMT	Formal - DHMT training plan, basket funding Informal - Practical training in SDP's, community	3 3	Recurring Recurring	<i>Not reported</i>
	Training School, MOH	Formal - MOH training plan, seconded staff	3	Recurring	MOH communicates training plan
Supervision	DHMT/VA's	Formal - Joint supervision team	3	Ongoing	Work plan, checklist, written feedback
Other purchasing	Council, Businesses	Formal - Transport, Stationary & general supplies	3	Short-term	Tenders
Service Delivery					
Curative	MOH, VA SDP's MOH, VA Hospital DC, 1 Health Centre VA-VA	Formal - Seconded staff, Inf. - referral system Formal - seconded staff, funding Formal - seconded staff Informal/documented - diagnostic referrals	3, 2 3, 3 3	Ongoing Ongoing Ongoing	Letters of posting, GIA agreements Letters of posting, GIA agreement Letter of posting
Preventive	DHMT, all VA SDP's, Marie Stopes 79 of 82 SDP's	Formal - MCH, training, supervision Formal - EPI, equipment, vaccine, supplies	4 3	Ongoing Ongoing	Referral network with feedback Common objectives, logistics, supervision, training plan Issue vouchers, EPI plan, logistics
HIV/AIDS	62 of 82 SDP's DAC, SDP's, Ingonet, 6 clusters, CBOs, NGO's, 2 businesses, donors	Formal - FP and CBD hand-over to DHMT Formal and informal/documented - extensive planning and sector-wide activities on district, ward, village levels	3, 3 4	Ongoing Mid-term	Plan, logistics, CBD - End of MOU Work plans, MOU, funding proposals, for community based activities, donated transport on a weekly basis
Special Activities					
NID	District Council, Faith & NGO SDP's, Schools, CBOs, Police, Agr., 1 business, politicians	Formal - planning and execution of campaign	4	Recurring	Letters, visits, special meetings, work plan, written promises of participation from faith, NGO and PHC
Emergencies	District Council, Agric., all SDP's	Informal with transition to formal system - Cholera epidemic of 1998-99	3	Recurring*	Creation of Emergency Medical Stock and plans, extensive collaboration
Construction	District Coun., DHMT, 1 MD., businesses	Formal - Rehab of part of public health centre for specialist care unit	4	Short-term	Tender contract and close technical supervision by specialist doctor
Refugees	<i>None</i>				

Table 10: SUMMARY OF EXISTING PARTNERSHIPS: KASULU

Area	Partners	Content/type of Partnership	Level	Duration	Mechanism
Core Functions					
Planning	DHMT, DPLO, RMO, RAS, RLGO, heads of divisions, Counsellors	No active partnerships outside government - <i>(note, no private sector participation but district health plan includes private sector)</i>	1		
Budgeting	DHMT, 2 VA hosp	<i>Not clear, some private participation occurred</i>			
HMIS	DHMT, all VA's	Formal - integrated HMIS system	3	Ongoing	HMIS plan, logistics, training, superv.
Training	VA Training Inst., MOH, Donors, DHMT	Formal district and vertical programmes for pre-service and in-service training, practicums	4	Recurring	Basket funding for DHMT training Central funding for MOH training
Supervision	DHMT, SDP's	Formal - Curative, HMIS	2	Ongoing	Supervision plan, <i>not a joint activity</i>
Other purchasing	DHMT, VA's	Formal - facilitated purchasing of equipment	4	Short-term	Joint ordering and distribution
	DHMT, World Food Pg	Formal - Food stuffs for hospitalized patients	4	Mid-term	MOU based on # of beds
Service Delivery					
Curative	MOH, VA Hosp DHMT, VA SDP's Public Hosp-VA Hosp	Formal - Grant-in-Aid, seconded staff Formal - 26 Staff "loaned" to VA SDP's Informal - shared radiography staff <i>Not specified</i> - Anesthesiology Machine	3 3 3	Ongoing Ongoing Mid-term	Grant-in-Aid, Letters of Posting <i>Not specified</i> Not specified Not specified
Preventive	VA-VA and public SDP DHMT, 53/63 SDP's DHMT, 60/63 SDP's DHMT, 53/63 SDP's	Informal/documented - referral system Formal - MCH programme Formal - EPI programme, equipment, vaccine Formal - FP except RC SDP's	2 3 3 3	Ongoing Ongoing Ongoing Ongoing	Based on available services, feedback Umbrella grant/ World Vision/Aust. Issue vouchers, logistics, supervision Common training, superv. Logistics
HIV/AIDS	DAAC, 1 NGO, 3 clusters, DHMT, 1 business	Formal - joint planning and activities on district and community level	4	Mid-term	Work planning, project development, funding MOU
Special Activities					
NID	D Council, NGOs, Ward Faith, hotel owner, VA training school, leaders	Formal - planning and execution of campaign w. participation of students	4	Recurring	Special meeting by D Council, letters, meeting minutes, DMO requests
Emergencies	DHMT, public, VA SDP's	Formal committee or plan - some VA's and DHMT but partially non functional	4	Potentially recurring	Emergency Committee - D Council, emergency treatment protocols
Construction	<i>No information</i>				
Refugees	DHMT, UNHCR, WFP, Red Cross, AMREF, Wards, Village leaders, Other donors, NGO's	Informal - with communities, wards, initial intake, first wave of efforts is then transformed by Formal - with official relief agencies, donors, DHMT, monthly inter-agency co-ordination mtg	4	Short-term Mid-term	Organisation by village, ward leaders then scaled up by GOT, international organisations to include MOU's with D Council, region, GOT

Table 11: SUMMARY OF EXISTING PARTNERSHIPS: KILOMBERO

Area	Partners	Content/type of Partnership	Level	Duration	Mechanism
Core Functions					
Planning	DHMT, all SDP's, VA/s, training facilities, donors	Formal - DHMTE (extended) has quarterly meetings and planning	4	Recurring	Special extended DHMT with regular schedule of meetings
Budgeting	DHMT, Training centers	<i>Not among first 37 basket funding districts</i>			
HMIS	DHMT, all private and for profit SDP's	Formal - Integrated HMIS system includes all types of private SDP's	3	Ongoing	Work plan, logistics
Training	DHMT, COTC, St Fr Nursing Training Ctr MOH, St Fr NT Centre	Formal - DHMT Training Management Committee, joint pre-service training, practicums in St Francis and public SDP's, DHMT trainers	3	Ongoing	Joint planning and scheduling, shared teaching responsibilities
Supervision	DHMT, CBD	Formal - DHMT trains CBD workers	3	Mid-term	<i>Not specified</i>
	DNO, RMO, DHMT, all SDP's public/private	Formal - MTUHA, STD, MCH, nursing, joint supervision, written and oral feedback	3	Ongoing	Work plan, checklist, feedback
Other purchasing	DHMT, management training institute	Formal - contract for management training courses for DHMT	3	Short-term	<i>Not specified</i>
Service Delivery					
Curative	MOH - St Francis Hosp DHMT - St Francis H.	Formal - DDH, seconded staff, 100% bed support	3	Ongoing	District Designated Hospitals
	SDP's - St Francis H	Formal - 18 local staff seconded, DMO on BOG	3	Ongoing	Agreement, Letters of Posting
Preventive	39/48 SDP's	Informal/documented - referral system	2	Ongoing	Feedback on tests and cases
	39/48 SDP's	Formal - EPI, equipment, vaccines, supervision	3	Ongoing	Work plan and logistics
	39/48 SDP's excl. RC	Formal - MCH, objectives, training, supervision	3	Ongoing	Work plan and logistics
HIV/AIDS	St. Fr., DAC, 7 clusters, 2 donors, CBD	Formal - FP, logistics, training, supervision	3	Ongoing	Work plan and logistics
		Formal - joint action plan, community, referral, orphan programmes, creation of CBOs	4	Mid-term	Quarterly meetings, joint action plan and funding proposals
Special Activities					
NID	D Council, wards, villages, schools, police, soldiers, devel officers, agric., faith, politicians	Informal/documented - planning and execution of programme (<i>note - no business involvement</i>)	4	Recurring	Planning during regular meeting of D Council, letters by DHMT
Emergencies	Ward, village leaders	Informal/documented - 2001 Cyclone in 1 village	3	Short-term	Ward/village government system and community co-operation
	DMO, WEO, St Francis, Community, SDP's	Formal - Emergency preparedness strategy - 1998 cholera epidemic, set up cholera "camps"	3	Short-term	Moved from individual SDP's to DMO management of strategy
Construction	DHMT, villages	Formal - 100% village labour, project belongs to village where work is done	4	Short-term	DHMT makes contracts with villages
Refugees	<i>None</i>				

Results by Area of Collaboration

Types of partners

Within a district, many types of potential partners are available for supporting and executing health services. Public sector partners include the central, regional, district, ward and village governments and sectors. Private sector partners range from external donors and international PVO's, to training institutions, Service Delivery Points (hospitals, health centres, dispensaries and staff), Community Based Organisations, businesses and the community. The four study districts report the following types of partners who contribute support for health.

Table 12: DONORS AND OTHER SUPPORT GROUPS CITED BY THE DHMTs

Type of Donors	Arusha Munply.	Iringa Rural	Kasulu	Kilombero
External Donors	<i>(not determined)</i>	UNICEF USAID DANIDA IRISH AID JICA CIDA World Bank	UNFPA USAID DANIDA Irish AID JICA DFID World Bank Embassy of Japan UNHCR	UNFPA UNICEF DANIDA
International PVOs and NGO's	Plan International PSI	PSI DATEX RED CROSS Plan Int'l UMATI/AVSC Helen Keller Foundation AMREF	CARE AMREF Red Cross AVSC/UMATI World Vision OXFAM AFRICARE Flying Doctors	PSI AMREF Plan International
Faith Organisations	Roman Catholics Lutherans Muslims Seventh Day Adventist	Anglicans Roman Catholics Lutherans Muslims	Anglicans Roman Catholics Muslims Protestant Seventh Day Adventists	Roman Catholics Lutherans Muslims
Local NGO's	Marie Stopes UMATI	UMATI Marie Stopes TAHEA UWT	UMATI	
Others	TAHEA UZIMA UHAI CHAWA-KUWA Univ. of Dar CEDHA TPRI	Scouts Tosamaganga Women's Group Vijana NIMR		Village Health Committees Ifakara Research Centre

Interestingly, none of the DHMTs in this table, nor the Voluntary Agencies and NGO's in the following table, cite local businesses as supporting partners.

Table 13: PARTNERS CITED BY VOLUNTARY AGENCIES AND NGO'S

(NOTE - SPACES BETWEEN ENTRIES INDICATE DIFFERENT INTERVIEWEES)

Type	Arusha Municipality	Iringa Rural	Kasulu	Kilombero
Health facilities	Mount Meru Hosp St Elizabeth Hosp Lula Dispensary Upone Dispensary Selian Lutheran H. Ithnaasheri Hosp. Arusha H for Women Arusha x-ray centre	Ilula Lutheran Health Center Mezombe Government Dispensary	Heri Hospital Government health dispensaries	St Francis Hospital Dr. Mziray dispensary Village private pharmacy St. Francis Hospital Mangula health center St. Francis Hosp. Dr. M.* (private)
Community groups	Diocese of Arusha AIDS Task Force Church youth group	Sokoni Village Group on AIDS, street children, IGA	TBAs TRHW	None (3 responses)

Note* - Doctor's name disguised

Commenting on why the private sector groups prefer certain partners, the most frequent answers include the following:

- Complementary services or skills
- Excellent quality of service
- Geographic proximity
- Good communication, including feedback on referred cases. *"They respond and listen to us."*
- Willingness to engage in informal exchanges, such as HMIS forms, problem solving, information.
- Habit and reputation, *"We have known Dr. M. [private provider] for a long time."* *"We like working with women's groups because they are the majority and the pillars of the nation."*

One District Medical Officer explained, *"Faith institutions are easy to collaborate with because we share resources, borrow and lend or donate and they are less bureaucratic and unlike international or co-operative agencies, they can make decisions spontaneously without much referral. In addition, the faith organisations recognise us as the representatives of the MOH and as such co-operate with us."*

Although discussion of health activities showed that DHMTs, VA's and NGO's do communicate and collaborate with some private, for-profit SDP's and providers, Dr. M. is the only one cited by name in response to the general question about partners. When questioned specifically on their attitudes regarding partnerships with private,

for-profit groups, the non-profit VA's and NGO's responded as seen in the following table.

Table 14: ATTITUDES OF VA AND NGO'S TOWARDS THE FOR-PROFIT SECTOR

District	<ol style="list-style-type: none"> 1. <i>In your opinion, how do private doctors, pharmacies and hospitals (profit making businesses) fit into the health services scheme in this district?</i> 2. <i>What sort of relations do you have with them?</i>
Arusha Municipal	<ul style="list-style-type: none"> • They are a legitimate part of the health system. Because they have the same goals, similar ethics and system of work (treatment, prevention, education). We have good competitive relationship. When we meet at regular individual or private meetings we share experience and opinions. • Some private dispensaries have good equipment and provide good services which are additional to the public health services. • They compete with us. We have no relations. • They are a legitimate part of the health system. We have cordial relations.
Iringa Rural	<ul style="list-style-type: none"> • They sometimes compete with us and they confuse the public, don't give prescriptions and only interested in profit, but some provide good quality services. There is a need to ensure standards. We have a private dispensary near us who refers patients to our MCH clinic.
Kasulu	<ul style="list-style-type: none"> • They compete for us and confuse the public, being only interested in profit. They sometimes give services without any prescription. When the prescribed treatment to patients is a single dose, they will tell the patient to buy for seven days and then repeat again.
Kilombero	<ul style="list-style-type: none"> • They are a legitimate part of the health care system. We refer our cases to the hospital and use their x-ray and laboratory facilities (<i>two responses</i>). • The pharmacy confuses the patients and is only interested in profit. However they are a legitimate part of the system and provide services that we don't provide. They should sell Part II drugs and the District should control this. We have a good relationship. They sell us syringes when our stock is depleted but they are very expensive.

These comments suggest that, in general, the two types of private providers co-exist with some communication and occasional informal co-operation. Competition and quality of care are concerns, but VA's and NGO's tend to recognise a certain complementarity of capacity.

Ward level partners

Ward leaders are situated between the District Council and the villages. Ward Executive Officers are sometimes included in district planning activities and are usually responsible for organising or mobilising support efforts for district-wide activities such as the National Immunisation Day. Thus, WEOs have primarily vertical partnerships with officials above them in the hierarchy and with village leaders and committees below them. The following mini-profile describes a typical ward.

**Mini-profile - Mnanila Ward, Kasulu District, 5 Villages,
Population 30,000**

Mnanila Ward is the site of five health facilities including Heri Hospital, three MOH dispensaries and one Roman Catholic dispensary. The Ward Executive Officer considers that health is a high priority for local residents. Each village has an Income Generating Activity project. He works with the Primary Health and Social Service Committees in the villages to mobilise the community to participate in health activities.

The WEO says that these efforts, such as building a dispensary at Mnanila Village, have met with a hearty response. In his opinion, the Ward has an active role in project planning and decision making for activities at the local level. The W.E.O. also acts as a liaison between the faith health facilities and local residents. He says, *"Sometimes a patient fails to pay, so we discuss it with the hospital and the relatives and the hospital gives them some labour to raise money. When patients fail to pay, the hospital brings the problem to us and we discuss with the relatives."*

Areas of collaboration in core functions

Certain types of activities are essential to the efficient and effective organisation and use of resources for the provision of health services. These activities, or core functions, include planning, budgeting, HMIS (information gathering), and purchasing. Two other activities -- training and supervision -- have been included here as core functions because through them a common basis of knowledge and skills can be assured and a common objective of quality of care be pursued.

Planning

The extent of joint public-private sector planning varies considerably from one district to the next. Kasulu District does not include any private sector partners in their planning cycle. Arusha Municipality includes the Secretary for Health Services of the Roman Catholic Diocese and 1 NGO. On the other hand, Iringa Rural and Kilombero appear to include most private VA and NGO health providers and in Iringa, the HIV/AIDS network, INGONET. Kilombero is unique in formalising their partnership planning group with a new official title of DHMTE - the Extended District Health Management Team which has a quarterly meeting schedule. This team also includes the training institutions, which are excluded from planning elsewhere. However, no DHMT includes for-profit health facilities or providers in their health planning activities. When asked, the DHMTs said they would do so only "if obligatory".

Similarly, no district includes the performance of all health providers in their estimations of performance and objectives. The following table shows the sources of information used to set the most recent district objectives.

Table 15: PRIVATE SECTOR INFORMATION USED BY DHMT IN SETTING HEALTH SECTOR OBJECTIVES

Type of information	Arusha Municipality	Iringa Rural	Kasulu	Kilombero
Faith, NGO sector performance	For 2 NGO's only	"General percentage" estimate	Faith hospital, health centres and dispensaries	No
Private for-profit performance	No	"Rough percentage" estimate	No	No

Another area of planning in which public-private partnerships might be found is the development or discussion of norms and standards of clinical service. Such collaboration is only reported in Iringa Rural District where the VA private hospital participated both informally and formally as a member of the DHMT representing non-government providers. In other districts, occasional communication about protocols or standards is reported in association with training (leprosy, cholera, etc.) or during supervision. All private sector providers interviewed stated that they would be eager to participate in discussions of norms and standards.

Budgeting

Similar budget information could not be obtained from the four District Councils. Neither sources of funding nor budget categories were grouped in a similar fashion.

District Councils all report that they have great difficulty in obtaining information about sources of funding from private health facilities in the districts. This reticence appears to be one of the major motives, if not the greatest motive, for the accusation made by the public sector to the private sector of a lack of transparency. Thus, it was impossible to compare between the four districts of the relative shares of support from the central government, local government, faith institutions, donors, patient revenues and other sources.

Arusha Municipality, Iringa Rural and Kasulu receive basket funding, while Kilombero does not. Each of the three funded districts plan to allocate 5-10% of basket funds to their major VA-hospital partners⁸. No district reported allocating basket funding to a dispensary or community programme. All three DHMTs included one or more private partners in discussions of basket funding budgets. In general however, private health centres and dispensaries were not aware that some part of basket funding may be allocated to private facilities. Only Kabanga Hospital and Heri Mission Hospital in Kasulu had any definite plans. The Medical Officer in-charge of Kabanga says, *"We are using the 10% of unallocated funds and sharing it with Heri Mission Hospital. We are so thankful for this contribution. The money we get from the unallocated is not only spent on Kabanga Hospital. We share it with our 3 dispensaries. According to the protocol, there is money allocated to dispensaries, so I want to point that out to the DMO and discuss it with him."*

⁸ Arusha Municipality - St. Elisabeth's Hospital - 5%, Iringa Rural - Tosamaganga RC Hospital - 5%, Ilula (ELCT) Urban Health Centre - 5%, Kasulu - Kabanga Hospital - 5%, Heri Hospital - 5%

Similarly, private SDP's say that they have little or no information about Local Government Reform and Health Sector Reform. There has been little or no communication with the DHMT or RMO about these changes. This ignorance and absence of communication is generating concern among private providers and among DHMTs particularly concerning seconded staff (see section on Curative Services).

HMIS

The integrated HMIS system began as a public-private programme. All public and private health facilities and providers of whatever type are supposed to complete and submit reports to the DHMT. The most recent rounds of training by the central MOH were planned to include at least one participant from each health facility. The logistics calculations for HMIS records (forms furnished to districts) assume that all SDP's will participate.

This assessment found consistently that HMIS is practised by public and private health facilities in the districts and that private for-profit SDP's are included. Supervision is made to private SDP's. However stock-outs of necessary HMIS forms are reported widely and reporting rates by private sector providers vary from 94% in Arusha Municipality, to 67% in Iringa Rural, 83% in Kasulu and 57% in Kilombero. The DHMT reports that frequent staff changes in private health facilities lower the reporting rate because it is difficult to ensure that there is always a trained staff member. Most SDP's report using the information to order drugs, to understand disease patterns and to write reports.

Kilombero and Iringa Rural districts provide quarterly and annual district statistic reports to the private sector SDP's using data from the HMIS. Arusha Rural provides an annual report, while Kasulu does not seem to provide any written feedback.

Training

Both public and private training institutions are found in the four study districts.

CEDHA is a zonal public training centre in Arusha. It is funded directly by the MOH and collects training fees from groups sending students, from donors sponsoring training, and from the DHMT's which contract with it. CEDHA provides a wide range of training services including management, MCH-reproductive health, CBHC, drug management, supervision and STD/HIV/AIDS prevention. The Arusha Municipal DHMT contracts for clinical and management in-service training, but also for printing of IEC materials and OPD cards. Municipal health workers use CEDHA Library as a resource centre. CEDHA uses the public health facilities for practical training of its students.

Kilombero is the site of the centrally-funded Clinical Officers Training Centre (COTC). Other funding comes from donors and from student fees. (Most students come from outside the district.) Its director is a member of the DHMT and the

District Medical Officer is a member of the COTC training committee. Members of the DHMT act as part-time trainers, while COTC uses district health facilities for field work. The Centre also provides manpower during epidemics. The COTC would like to conduct integrated supervision and collaborative research with the DHMT. Furthermore, the COTC says that partnership with the district would be strengthened if more trainees came from the district through the DHMT.

The other districts have nurse-midwife training schools operated by the faith hospitals, the Tosamaganga School, Kabanga Nurses Training School and St. Francis (in Iringa, Kasulu, Kilombero respectively). Tosamaganga offers only pre-service training. Graduates are employed by both public and private sector facilities. Like CEDHA, Tosamaganga communicated directly with the MOH, Director of Training. MOH has provided one seconded staff member. On the district level, the School communicates with the DHMT primarily to organise community health field work. Currently, communication goes through the Tosamaganga Hospital management.

Kabanga NTS has a Grant-in-Aid contract with MOH and also requests funds directly from the DMO. The district training plan is an approved part of the basket funding plan; in 2000-2001 the plan included home based care in HIV/AIDS, the syndromic approach for STD's and malaria treatment. Kabanga offers other training sessions including Training of Trainers. Kabanga also provides in-service training to other groups and districts. For Village Health Workers, Kabanga has a public-private training team including the MCH Co-ordinator. Kabanga's pre-service nursing students do volunteer during immunisation campaigns, World AIDS Day, the refugee census by the UNHCR and other activities. Kabanga would like to increase the level of collaboration through practical work for students in the public SDP's and in in-service student practicums in Kabanga Hospital.

St Francis Hospital offers only in-service training for nurses (general nursing upgrading course for Nurses A). As in the COTC, some members of the Kilombero DHMT act as part-time trainers in the programme and students do practical training in the public facilities.

St. Elisabeth's Hospital in Arusha offers in-service training in primary eye care for public and private sector medical assistants and nurses working in the rural areas. Practical training is organised in the municipal health facilities. The training curriculum was developed by MOH. These courses are donor sponsored. The DHMT chooses its participants based on outreach assessment of areas with eye problems. St. Elisabeth's would welcome a greater degree of collaboration for this programme, *"The DMO/DHMT should supervise the trained personnel closely and give feedback on their performance. This will help the school to review the training if the performance of the trained staff is poor."*

All training schools regret the fact that they are not included in planning. CEDHA says, *"We should work as partners, they inviting us to their planning meetings and on our part, we should give them information on new technology."* In Iringa Rural District, Tosamaganga says, *"A training institution should be involved in district*

health planning. This will be done by joint meeting, joint planning, etc. When the principal takes part, he can air views on how to plan and implement the objectives of training. Closer collaboration would give us support on training supervision of students. It would enable the principal to set training school objectives properly to address the training needs."

Supervision

"We are the head and eyes of the District Council in health services", Kasulu DHMT.

In principal, the District Health Management Team has the authority to supervise all health services within the district, whether they be public, VA, NGO or private for-profit. Vertical programmes also receive supervision from regional and central level co-ordinators. In recent years, efforts to improve the quality of health services and to implement a unified HMIS system have encouraged three types of public-private interaction: 1) the supervision of private health facilities as well as public ones, 2) the formation of integrated supervision teams (more than one subject at a time), and 3) joint supervision of facilities by mixed teams of public and private sector supervisors.

In the four study districts visited, hospitals, health centres and dispensaries report receiving supervisory visits. Integrated supervision has been tried in all districts, but single focus visits occur as well. The most common supervision reported in all districts was for MTUHA and MCH. Most supervision visits are seen to have some training orientation. Supervision for HMIS appears to consist mainly of collecting reports and correcting mistakes on forms. One dispensary reports that the curative services supervision was *"very helpful, I was instructed in what I had forgotten."* However, only in Iringa was written feedback consistently provided in the form of results of the supervisory checklist. Nor is it clear to what extent supervisory visits in the other districts were made according to a known programme or how the information about visits was communicated to the health facilities.

Iringa Rural District has initiated a programme of joint supervision by a public and private team. This joint programme is sponsored by CUAMM, an Italian NGO. This successful effort is described in the Mini Case Study below. Kilombero District has also experimented with joint supervision and supervises for-profit facilities as well.

Some private health facilities have had unpleasant supervisory experiences. One Health Centre reports, *"Some of the supervisors when they come to supervise us do not take us as colleagues, they correct us in front of juniors while some of these supervisors were our classmates and colleagues! This approach was not good."* Other private facilities speak of "inspection" rather than supervision. They mention supervisors who come to the site *"with a bad eye"*, looking for problems.

Mini Case Study: Joint Supervision in Iringa Rural District

The Joint Health Project (2000-2002), sponsored by CUAMM, brings together four partners: the DHMT, the Roman Catholic, Lutheran and Anglican health facilities. The specific objectives of the project are to strengthen the managerial capacity of the DHMT and the DMD -- the bodies in charge of the district and diocese peripheral health units respectively -- and to enhance the co-operation between the government and the private non profit health sectors. As part of this project, a joint supervisory team of six members has been set up.

How it works: Before the joint supervision began, the partners were trained on Health Sector Reform. Together, they prepared a list of 10 institutions to be supervised. The first round of visits included 3 Catholic SDP's, 5 public SDP's and 2 Lutheran SDP's. The team goes to the furthest during the dry season and to the nearest during the rain season. CUAMM, the secretariat takes the responsibility of writing to each member to remind them of the day to go on the joint supervision and where they are going, although each member also has the supervision schedule. The supervision team uses the same supervision checklist that is used by the DHMT and the other partners during their "solo" supervision.

After completing the round of 10 health units, the partners hold a joint meeting with a larger group from their institutions. The eight most common problems identified during the visits are discussed and solutions are proposed.

Performance ratings from the first round, using the DHMT supervision checklist, show a wide range in the marks - some were very good and some were very poor. There was wide variation in the levels of commitment and competence of personnel, cleanness, good working organisation.

Benefits:

- **Supervision is more thorough** An experienced team spends 2-4 hours at each health unit
- **Problems and experiences are shared.** The partners have opened up their health institutions for supervision to the other partners thus sharing ideas on solutions. One partner said that the supervision is *"Sometimes a kind of group psychotherapy where I learn about weaknesses in the other partners' institutions and find myself saying "Oh, I did not know that they have the same problems as we have"*.
- **Identification of training needs** when the partners identify needs they discuss about mobilisation of resources for training e.g. from the basket funding.
- **Identification of problems of the Community Health Fund** - During the first round of supervision, some of the CHF health units did not know the procedures for reimbursement under the fund. Rules were clarified.
- **Adoption of the DHMT supervision checklist** - During the first joint supervision, the Lutheran members appreciated the use of the form and adopted it, thus making supervision in the district more standardised.

Mini- Case Study - Iringa Supervision continued....

Resources and Sustainability: The CUAMM Joint Health Project provides a vehicle and fuel and a moderate allowance of Tsh10,000 per member (*Tz. govt rate*). There is an ongoing effort to identify resources to sustain this beneficial initiative before the present funding ends. One of the potential sources would be basket funding. Another would be support from the Community Health Fund as this activity improves the quality of care at the health units and so benefits the CHF members. Alternatively, each partner will have to contribute directly. A contract agreement has been prepared for the partners and will be signed during their next meeting.

Purchased services

District Councils and DHMTs have the authority to purchase goods and services. The local government regulations permit Councils to offer tenders and to enter into contracts. In the health sector, the most common purchased services seem to be training services. However, training is purchased through work planning and budgeting, rather than through tenders. The most commonly tendered service is SDP rehabilitation and construction. Only two of the four districts report having obtained other types of goods through tenders.

Mini-Case Study: Using Tenders to Obtain General Supplies

In Kasulu District, the District Council uses tenders to purchase many general supplies.

The local businessman who won the tender for stationary, firewood, brooms for the district hospital says that the District Council is a regular customer. His contacts are the District Medical Officer and the DED. He is satisfied both with the quality of the information and collaboration he receives and also with the fact that he is paid on time by the District Council. He actively seeks work from health facilities and the District Council and would respond to other tenders in the future.

A general supplier won the tender to supply nails, paint and cement for construction of two dispensary houses. His application to the District Council took two months to process; his contacts were the DED, DMO and Common Works. This businessman has won other tenders in the past and has usually been paid on time. This time however, payment was delayed because the funds did not come to the District Council on schedule. A third businessman who also sells construction supplies to the DHMT has always had satisfactory payment and actively seeks this kind of business.

Mini-Case Study: Using Tenders for Indefinite Quantities Contracting

In Iringa Rural District, an office materials firm has won a general tender to supply photocopying, stationery and identity cards for the Health, Education, Administration/Accounts and District Engineering divisions of the District Council. His primary contact is the DC storekeeper. This tender defines the terms for an ongoing supply relationship. The businessman says

"They come to see what I have and anyway they know from the tender documents. If I do not have a certain item, I just contact Dar and in 3 days it arrives here."
Regarding payment, he says *"Sometimes they take on credit, I trust them. There are some bills from 1999-2000 still not paid but I am satisfied because despite late payment, I get the money."*

Because of this ongoing tender, he does not have to continually seek business with the DHMT and the DHMT is assured of stable prices.

These cases show that a well-run tender system provides satisfactory communication and collaboration with local businessmen. Indefinite quantities contracting for sector-wide Council needs, as tried in Iringa Rural, may be very useful in simplifying Council logistics, especially paperwork associated with small purchases. It would be interesting to determine whether the Council has any cost savings on a yearly basis from such a scheme.

The District Council may also collaborate with an international PVO or NGO to provide equipment. World Vision reports, *"We trust and collaborate with the District Council. We ordered millions of shillings worth of equipment through the Medical Stores Department and collaborated with the DMO in distributing it."*

Supplies may sometime be obtained through MOU's with supporting agencies, rather than purchase. This is rare however since donors do not often provide operating support. One example was found in Kasulu District as part of the efforts to mitigate the effect of the refugees on the district.

Mini Case study - World Food Programme in Kasulu District

As part of the general assistance to refugee-affected populations under the UNHCR umbrella, the World Food Programme has an MOU with the DHMT to provide food stuffs to the district hospital and bedded health centres and dispensaries. The MOU specifies that the quantities are tied to the number of beds rather than the daily number of patients. This system simplifies planning of deliveries of foodstuffs. The WFP representative says, *"We trust them with the food. We trust them to distribute it. The food is for sick people and we trust them."*

Areas of collaboration in service delivery

Public-private partnerships for service delivery are currently structured by the District Designated Hospital and Medical (Grants-in-Aid) regulations and by centrally-organised vertical programmes for preventive services. However, a few examples of informal partnerships and communications can be observed as well.

Curative services

The primary-secondary-tertiary referral system is a prime example of public-private co-operative partnership. As in most countries, Tanzania has begun to develop standards and protocols for referral. Usual practice requires that a referral letter or note is carried by the patient to the referral centre. Results and treatment notes are sent back in the patient's file. These informal, documented partnerships are designed to assure the appropriate level of care and effective use of local health resources. This is especially true for diagnostic radiology and laboratory testing.

In Kasulu, patients requiring blood transfusions are transferred by the public facilities to the VA Hospital. The Director says that while this is not "a problem", she would prefer the public hospital to have its own blood bank.

Respect of the referral hierarchy does not always guarantee good relations between institutions. *The referred cases from here, they are not well received at the public hospital. They will always say, "Why did you go to the private sector first? You see now your child is anaemic." VA Dispensary*

Informal partnerships exist to share equipment and personnel. One hospital or health centre will have a machine, usually radiology equipment, while another will have a technician. Arrangements are made for regular or "as needed" visits by the technician. In Kasulu, the district radiographic assistant goes every Tuesday to Kabanga Hospital because they do not have such staff. The Hospital provides transport and a small allowance in exchange for this help. In Arusha, the VA hospital reports, *"The St. Elisabeth's Hospital has ultrasound and nobody can run it, so we call an expert from Mt. Meru (public) or Ithnaasheri Hospital (faith)."*

The DDH Agreement and Grants-in-Aid to VA agreements are the most formal forms of partnership. Kabanga in Kasulu and Tosamaganga in Iringa have GIA agreements receiving bed grants to support part of their costs and seconded personnel from both the MOH and the DHMT. In Kilombero, which does not have a public hospital, St. Francis acts in this capacity under its DDH agreement. St. Elizabeth's in Arusha only has some seconded staff. The level of support is indicated in the following table.

Table 16: CENTRAL MOH AND DHMT SUPPORT FOR VA HOSPITALS

Support	St. Elizabeth's	Tosamaganga	Kabanga	St. Francis
Total beds	100	164	155	371
Funded beds	0	<i>Not available</i>	130	175
Funded, seconded staff	3 doctors	3 staff	5 staff	18 staff
Date of agreement	<i>No written doc.</i>	<i>Not available</i>	<i>Not provided</i>	1976

Under the terms of these agreements, the DMO is a member of the Board of Governors of the hospitals and, at St. Francis, of the Hospital Management Committee.

In these four districts, VA's are "grateful" for the financing, however, are concerned about the partial funding of their beds and staff under the Grants-in-Aid contract.

Mini-Profile - District Designated Hospital in Kilombero District

St. Francis Hospital signed a DDH agreement with the MOH in 1976. It has 371 beds of which 175 are paid for by the MOH. The MOH covers 100% of recurrent costs. Because St. Francis is a Roman Catholic facility, they do not offer family planning services other than natural family planning. The DHMT and the MCH Co-ordinator tolerate this position. St. Francis also has a nurses' training programme in which some DHMT members act as instructors. Also, St. Francis provides diagnostic testing services (laboratory, x-ray) to other facilities.

The transition from centrally funded DDH agreement to a District Council agreement raises concerns. *"We are not sure that the funds which will be budgeted for DDH will be disbursed as budgeted. This is our fear."*

Under government reform, DDH, GIA and seconded staff contracts will be transferred to the District Council. Staff, DHMT and VA Hospitals wonder how this new arrangement will be run. Staff have already come to the DHMT with questions about their futures. *"When HSR started, the MOH informed them that they will be under the District Council and they came to report to us with the letters. The transfer of salaries has not been implemented, they still receive salary from MOH. They did not show any particular reaction, happy or anxious. People are used to their employer being MOH. Job security is a concern of the District Council which needs to be discussed and assumed."* Apparently, little or no information has been provided to the District Councils allowing them to respond. This atmosphere of uncertainty destabilises all parties.

"What will happen to seconded staff benefits if these VA facilities are put under direct management of the DMO? Will the DMO be able to solve problems of all these health facilities?" VA Hospital. *"What about recruitment of professional staff for replacement of retired, deceased, services terminated and for expansion of services? We need to talk with MOH, RMO, local government and Regional Administrative Secretary about seconded staff."* DHMT

All parties agree that additional forums are needed to discuss and regulate the problems of seconded staff. The Arusha Municipal DHMT proposes, "*the MOH, Civil Service Commission and partner institutions should meet and have frank discussions to regulate the existing personnel problems facing workers in the private sector or partner institutions.*"

Preventive services

This assessment concentrated on three types of preventive services: EPI, MCH and FP. As with HMIS, these three programmes were designed and implemented as public-private partnerships, with joint training, logistics and supervision. In all districts, participation by the private VA and NGO facilities is counted on to meet health objectives.

Discussions with the District Cold Chain Co-ordinators and the MCH Co-ordinators showed that in all districts, equipment has been issued to private faith and NGO hospitals, health centres and dispensaries. The usual set of materials distributed includes a refrigerator, vaccine carriers, scales, sterilisers, vaccines and some supplies. In Kasulu and Kilombero, ice bags and stoves (Kilombero) have also been distributed. In all cases, the DHMT is responsible for repairs and replacement of the equipment, except in Kasulu where the repairs are the responsibility of the faith SDP's with the assistance of the DCCC. Regular supervision is provided to the SDP's as well.

Because documentation on the MCH and FP programmes exists already, these services were not assessed to the same extent. However, in Iringa, the assessment team identified a case of a non-partnership or ruptured family-planning partnership. This is a case where the DHMT was not included as a full partner in the development and execution of a new activity and, at the end of NGO involvement, was reluctant to assume responsibility for it. This is an example of what can happen if partnership is not sought actively with an eye to the future.

Mini Case Study - Partnership in Crisis: The Iringa CBD Programme

In 1994, a Tanzanian NGO launched community based family planning services in Iringa region as complimentary services to the hitherto clinic based services provided by the public and NGO static health facilities. This programme was funded by an international donor. Activities to introduce the program in Iringa were co-ordinated by the NGO's field office in Iringa town. The initiative was not unfamiliar to the region as the regional and district MCH co-ordinators had been trained by the national CBD programme under the auspices of the Ministry of Health as trainers of CBD agents using a national curriculum and training manuals. Thus, an opportunity for partnership existed with the Ministry of Health at the regional and district level to use the RMCHCO and DMCHCO as trainers and use the CBD curriculum and training manuals. Unfortunately, this was not done. The NGO conducted seminars to sensitise Regional and District Health Management Teams about the programme and obtain their permissions before selection and training of

Mini Case Study - Iringa CBD continued....

community based agents. After training, the NGO supplied required family planning commodities and supervised regularly the CBD agents parallel to the supply and supervisory chain of the District Health Management Team.

The first sign of an impending partnership crisis emerged as reports from the CBD programme were not filtering into the district health statistics, but no effort was made by either the DHMT or the NGO to streamline and integrate CBD programme including supervision in the district health plan. The parallel system operated until 1998 when funding for the CBD programme was coming to an end and there was a need to hand over the activities to the District Health Management Team. The NGO wanted to hand over to the district the responsibility of supplying family planning commodities and supervising CBD programme. The DHMT refused on the grounds that they were not sufficiently informed about the needs of the programme and had not made provision for these needs in the DHMT work plan and medical/drug supplies orders.

The problem was referred higher in the Ministry of Health, resulting in an official visit by a representative from the Reproductive and Child Health Unit in the effort to resolve the crisis. As donor funding ended, the NGO exited under the assumption the district would take over. However, now, two years later, it is reported that the CBD programme is not supplied from the district because the DHMT is sceptical of the curriculum used for their training. It is unlikely that the programme is still functional.

In Kasulu, the ending of donor support has weakened a formerly successful collaboration between public and private sectors. Three different groups reported the same thing. *"There is no active forum now for bring the stakeholders in health together. KaDP (Kasulu-Austria Development Programme) used to bring them together for a monthly inter-sectoral PHC meeting. Now they have left and the activity has not been sustained. Basically there is poor co-ordination."* Another says, *"We had arranged to have the meetings, but they are not being held because the government side says they "are too busy". KaDP left and the meetings became absent or irregular. CORD took the initiative to communicate with the DHMT to have the meetings restart and we had one in October 2000. We cannot have the meetings because the DHMT has not time, too many travels, seminars, meetings. I came for the December meeting but they were not there, came for the next meeting and was told that they had met the day before."* Finally, a third says, *"We deal a lot with the Village PHC Committees but we hear now that in the HSR other structures will be formed. Have we wasted our time?"* The picture is not all black however. The same groups also say that in general, collaboration on specific matters is good with the DHMT and they can see the DMO or other district officers even without an appointment.

These two cases show that the transition period at the end of funding or a project is a dangerous period for partnership. Old ones are dissolving and new ones must be formed. More thought and advance preparation seems needed to reinforce the partnerships that must survive the change or create new ones.

Development of HIV/AIDS programmes

All districts have named a District AIDS Co-ordinator and begun HIV/AIDS organising. In Arusha the Diocese has formed an AIDS Task Force as well. All have formed two or more clusters, community groups or CBOs and are receiving some donor support. In all the districts, the work includes HIV/AIDS prevention information and education and condom promotion.

In Kilombero, 7 clusters have been formed, three of which are already functional. The integrated strategy includes St. Francis Hospital, offering blood screening, STD treatment and counselling, the Lutheran and Catholic dioceses which organise peer education for youth, and CBOs offering school clubs, community mobilisation, social support for families and orphans. The group meets quarterly with the DAC.

In Arusha, Iringa and Kasulu, the activities include local businesses. Some hotels and lodgings have condom dispensers and boxes displayed. In Iringa, the Tanzania Water Industry collaborates in condom promotion and IEC.

Mini Case Study: Iringa Rural Network - Ingonet

One of the examples of successful partnership in Iringa Rural District is the INGONET that was started in 1994 in response to the problem of HIV/AIDS. It was realised that the health sector alone could not handle the HIV/AIDS problem and that sector-wide NGO's and CBOs had a contribution to make. Yet many of the NGO's lacked capacity in terms of trained staff, technical knowledge, etc. It was also realised that unless the NGO's collaborate, there was a possibility of duplication of efforts and contradictory or confusing IEC messages. A structure was needed to bring all the NGO's under one umbrella. The purpose was to get the NGO's to know each other's activities, to make the NGO's speak with one strong voice, to share resources, to do resource mobilisation together, to solicit funds together, and to increase coverage.

Since its formation, INGONET has been involved in a large range of HIV/AIDS activities. Through advocacy and social mobilisation, the people are mobilised to own the programme and leaders are mobilised so that they have political will to support it. Traditional groups in the community are involved in providing IEC and BCC, reproductive health, FP, Nutrition and MCH. There is social marketing of condoms. Peer educators have been trained and orphans given support.

Funds and technical support for capacity building have been supplied by USAID, first through FHI and TAP, and later by DATEX.

As a result, INGONET has a structure that goes from regional level to the community. There is a Regional Steering Committee of which Regional AIDS Co-ordinator is a member. There is also a District Steering Committee of which the District AIDS Co-ordinator is a member. At the ward level, INGONET operates through the Ward Executive Committee chaired by the Ward Executive Officer. At the village level,

Mini-Case Study - INGONET continued....

representation is through the village government. The village authorities select people for training and when they come back after training they report back to the village government.

Institutional Successes:

- ✓ Local politicians have been informed of the NGO's' partnership and there is political will to support it and its activities.
- ✓ NGO's pool training resources and conduct joint training sessions.
- ✓ The partnership speaks with one strong voice.
- ✓ While the perception of the government used to be that NGO's compete with them for resources, now it is being slowly realised that NGO's work in partnership with the government. INGONET now collaborates with government in joint planning where they represent NGO's. The network is consulted to advise on which NGO can do which activities in HIV/AIDS.
- ✓ INGONET tries to maintain the standards of the NGO's in order to prevent the tarnishing of the NGO image. INGONET brings together the faith organisations that did not collaborate before.

Community Successes:

- ✓ There is more openness in discussing sexual matters.
- ✓ There are more outlets for condom distribution.
- ✓ More people living with AIDS have come in the open and are willing to speak in places like in churches. For example "*While we used to invite them from DSM to speak to our people, now we use our own members.*"

Problems :

- ✓ INGONET asks, "*will the district allocate basket funds to NGO's for HIV/AIDS, orphans, etc. The HIV/AIDS is increasing and the number of orphans is also increasing, hence they need more funds.*"
- ✓ Some NGO's have not changed their approach and some have not joined the INGONET.
- ✓ Capacity is still limited. However this co-operation is expected to help the small ones develop.

The INGONET network is now internationally recognised and it is ready to go on website to share their experience internationally. It hosts visitors from outside and inside the country who come to learn from this partnership experience.

In the next few years, careful monitoring of the HIV/AIDS epidemic in Iringa should be able to measure the health and social impact of INGONET.

Collaboration for special activities

Certain types of activities tend to create partnerships between sectors because they benefit the entire community. These partnerships are usually temporary and may be

informal. However, they can and are reactivated periodically to repeat the activity or address new problems that have arisen.

National immunisation days

National Immunisation Days are annual events. In all countries, they are classic opportunities for sector-wide formal and informal partnerships, bringing together community, leaders, providers, officials, media and businesses in combinations rarely found during other activities. These four districts were no exception. The following table shows the partners included in the planning meetings for the last NID. The table on the following page shows how different partners contributed to that campaign.

In all districts, at least one special meeting was held by the District Council to organise the NID and the activity was included in the annual work plan. In addition, the Iringa Rural and Kasulu DMOs addressed individual letters to some faith institutions and NGO's soliciting their support for the NID. The Iringa Rural DMO also made personal visits to some potential partners. Only in these last two districts was a special document developed defining the participants and their contribution; elsewhere the requests and commitments were documents in meeting minutes.

The amount of business involvement in the NID was limited compared to the level of involvement seen in some other African countries where major sponsorship by businesses is often obtained. In Kilombero, no businesses seem to have participated, while only one business participated in Iringa Rural and Kasulu. There were at least four in Arusha. In Kasulu District, a local hotel owner provided a refrigerator for storing the ice bags for three days during the last two campaigns. The DMO visited him personally to request his assistance. His contribution was recognised through mentions during radio coverage and by visits of thanks after the campaigns. Another businessman says that he encourages his workers to send their children for vaccination and to get involved in other health activities, but neither he nor the three other businessmen who have tenders with Kasulu District Council have been solicited for contributions to NID.

Table 17: PARTICIPATION IN PLANNING AND TRAINING FOR THE NID

Element	Arusha Munic.	Iringa Rural	Kasulu	Kilombero
Last vaccination campaign	Sept. 2000, measles	1998, polio	Aug-Sept, 2000, polio	Aug-Sept, 2000 measles
Objectives	Attain 100%	Attain 100%	Attain 100%	Attain 100%
Planning meeting participants	PHC, Ward EO's, Ward HO's, SDP Directors, Media, Faith and VA's	All District department heads, NGO's, Faith groups - RC, Bakwata, Angl., Scouts	All District department heads, NGO's, Faith groups	Health workers, community leaders, community members
Training participants	PHC members, public and faith SDP's	Public SDP's, Lutheran, RC SDP's	Public and faith SDP's	SDP's, Community leaders, agricultural extension agents, head teachers

Table 18: CONTRIBUTIONS BY PARTNERS TO THE LAST NATIONAL IMMUNISATION DAY

Contributions from various partners	Arusha Municipality	Iringa Rural	Kasulu	Kilombero
Public sector Central MOH DHMT DED and District Council Ward Village leaders Nurses Training School	IEC materials Petrol, lunch Drivers Mobilisation Cold Chain Drivers, transport Home visiting, transport	Contributions according to schedule	IEC materials, Cold packs, petrol Labour, Transport Transport Information Labour	Kerosine IEC Materials, Mobilisation kerosene, petrol, transport Mobilisation, home visits Mobilisation
Other civil servants Teachers, school officials Police Soldiers Development Officers Agricultural agents	Announcement	Announcement Participation Participation		Announcement Participation in NID Day
Collaborative groups PHC Committee	Mobilisation	Transport		Mobilisation
Faith, NGO SDP's	Labour, IEC	Transport - RC, Lutheran	Transport, Labour	Refrigeration, Transport
Donors (specified)	Petrol			Cold Chain, Petrol,transport
Non health sector groups IEC, messages, materials Announcements to congregation, employees Ice, Dry ice Vaccine delivery, team transport Refrigeration Locations for vaccination day	Radio 5 Arusha Times Merewamibeo Bonite Bottlers All faiths Bonite Bottlers Several private participants	HIMA, CONCERN All faiths, CocaCola 3 parishes, HIMA	National radio and television only Hotel owner	All faiths 3 Local NGO's Churches
Community and CBOs	Home visiting, Locations for vaccinations	NID sector wide mobilisation committees	Mobilisation, Locations for vaccination day	Mobilisation, Locations for vaccination day
Local politicians including ten cell leaders	Mobilisation, information, visits, speeches	Mobilisation, information, speeches, home visits for follow-up	Mobilisation, information, visits, speeches	Mobilisation, information, visits, speeches

In Kasulu, interviewees showed willingness to participate in future partnerships of this type. *“Sure yes, it is an area that we work in, we were encouraged from the beginning that the coverage is high except for TT. We wanted to participate in an activity that shows success.”* -NGO. *“It is an MOH strategy. It makes implementation of immunisation services easier, faster and if it is good for the*

people it is good for us and so we have to collaborate. “ - Faith hospital. “ *We are here to improve the health status of the community*”-Faith Nurse's Training School. “*The children being immunised are our children and I understand that the vaccines must be stored in the cold*” - Businessman who stored the vaccines.

Epidemics or emergencies

Epidemics and emergencies spare no one. Responding to an emergency always requires collaboration, successful management also requires good communication. This assessment looked at the extent of prior planning for emergencies, what partners participated in resolving the emergency and to what extent the experience changed plans for the future.

Mini-case - Learning from Experience - Emergency preparedness for cholera in Iringa Rural District

In 1998 and 1999, cholera broke out in Iringa Rural District. Patients started arriving in the Ilula Health Centre, others soon followed from the villages. Ilula HC had no emergency plan for coping with such an epidemic. The District Council had a general emergency plan allowing it to mobilise resources such as vehicles, fuel and funds to enable it to visit affected areas and manage an emergency. This plan called for collaborating with the VA SDP's, NGO's and donors present in the district. During the cholera epidemic, the DHMT called an on-site meeting to organise local partners and form public-private emergency teams for village outreach and case management. The DHMT provided staff, drugs and allowances for teams to share management of the emergency. Partners believe they were successful in limiting the spread of the problem and saved lives.

The Ilula HC Medical Officer says, "*After this emergency, we learnt that we should have a strategy for emergency preparedness. This consists of having a stock of drips and awareness that an emergency can come at any time. We have informed all clinicians that during the period of February to April, they must be ready for emergencies.... In the medicine store, there are two boxes of drips and ORS marked "for emergency cholera epidemic only".* The Lutheran Diocese had unpaid patient charges of over 3 million shillings during the emergency but the Bishop has said, "*We saved lives so we will look for other resources to replace this missing revenue.*"

Representatives of the Tosamaganga VA Hospital say that the group effort was beyond their expectations. Their partnerships with the DHMT, other health institutions and the villages were strengthened by this collaboration. All partners agree that they are more prepared for the next emergency.

Mini-Case Study - Conflicting lines of authority over managing a possible Ebola emergency

Last year, Ebola Virus had broken out in Uganda. In Kasulu District, the VA hospital admitted a patient with diarrhoea and bleeding gums. The severity of his condition made them suspect Ebola. The patient was placed in isolation. According to the Ebola Virus Protocol provided by WHO, the patient should have been transferred immediately to the District Hospital (which the patient requested). However, the District Hospital refused the transfer saying that the district emergency plan required that the infectious cases be treated at the first admitting site.

The VA hospital kept the patient. Serum samples were sent to Dar es Salaam for testing for Ebola but the patient died in hospital before the results were received. Hospital staff were able to respect the protective gear recommendations included in the WHO protocol up to the burial of the patient and no other cases were found. This is an example where protocols from different partners of one institution conflict; it is not surprising that the local authority was able to impose its regulations over those of the distant WHO.

Mini-case - Successful Ward-Level Partnership after a Cyclone in Ifakara Ward

On the 21st of February 2001, a violent windstorm or cyclone hit the village of Kimbunga, destroying a school and three houses. The village chairman and community were the first on the scene; the Ward Development Committee and Executive Officer sent people to Ifakara immediately to report on the damage. The village leaders who had completed the evaluation decided to use the school fund to repair the school building. Involvement in resolution of the problem were Ten-Cell Leaders and the schoolteachers. The community was able to rehabilitate the school building in two weeks. Owners of the destroyed village houses were accommodated in the houses meant for teachers. This incident brought together new informal partnerships within the village population, ones the village could use again.

These cases show that, no matter what the level of prior planning, partners must adapt to a rapidly changing situation. Planning and preparedness (like cholera kits) shorten the initial period of confusion, but communication between partners and activation of the partnership must be done each time. The Ifakara experience is an example of community solidarity and community decision making at their best, local problem solving with no need for referral to higher levels or long delays.

Construction/renovation of health facilities

Every variety of partnership can be observed during construction projects, from 100% contractual construction through tendering, to 100% participatory construction by local artisans and community members. The type of partnership formed will influence the level of ownership felt by the community and may affect its level of engagement in management and upkeep. In some cases, technical

requirements, budgetary conditions or time constraints may dictate the type of partnership to be engaged for a project. The following table indicates what happened in each district during a recent project.

Table 19: RECENT CONSTRUCTION PROJECT PARTNERSHIPS

District	Question	Information
Arusha Municipal	Centre Where Owner Dates Extent of work Partners Planning permission Direction Professional help Status	Ngarenaro Health Centre (public) Ngarenaro Ward Municipal Council – Arusha 8-11, 2000 Partial renovation and internal reconfiguration DHMT – developed plan Pathfinder Intern'l – Labour, material, financial, project included in larger assistance program Yes Municipal Council No Completed within norms of MOH
Iringa Rural	Centre Where Owner Extent of work Partners Planning permission Direction Professional help Status	Isimani Health Centre Isimani Ward Iringa Rural District Council Partial renovation of two rooms District Council and DHMT - planning Local businesses Ophthalmologist in charge – technical supervision Clinical officer of Isimani HC - general supervision Yes DHMT Yes Still underway. Successful because payment is made as agreed. The close supervision made everything go well or if went wrong was immediately corrected.
Kasulu	Centre Partners Status	Hospital DHMT Bagenzi Contractors, Dar es Salaam Still underway <i>Details not made available</i>
Kilombero	Centre Where Owner Dates Extent of work Partners Planning permission Direction Professional help Status	Mbingu Dispensary, Msolwa Ujamaa Dispen. Souji and Mbingu wards Kilombero District Council July 2000 (start) Construction of 2 new staff quarters Kilombero Health Support (DHMT) – financial, material and technical aid Community and village masons – labour, self-help, materials, security SDC –financial support, transport Yes DHMT No (except village masons) Still underway. This is a successful partnership because it is proceeding as planned. Community participation is made without being forced, they accept that this is their project and property.

The ongoing project of Mount Meru Hospital by the local business community is a sterling example of what Civil Society partners can do to support a local health service.

Mini Case Study: Successful Business Support for Mount Meru Hospital

Since the mid-1980's, Arusha's business community has been actively involved in ongoing renovation and expansion of Mount Meru Hospital. Needs and technical criteria are identified by the hospital administration and the business community.

A committee was formed of businessmen and local politicians to leverage support and to plan interventions. Most of the funding for their projects is collected among themselves. The Chairperson of the committee is a leading local businessman in the steel and timber industry. The tendering process is used to engage builders.

Examples of construction projects organised and financed by this group include the operating theatre, the maternity wing, and the patient transfer bridge linking the wards to the operating theatre. Several projects are currently underway, one of which is construction of a new MCH block.

Over the years, membership in this committee has become popular and seats are vied for by local politicians eager to be associated with this successful group.

The Mount Meru businessmen's committee will be the focus of a detailed case study.

Refugees

The population of Kasulu District has risen by almost a third since the influx of refugees from Burundi and Rwanda began. Experienced as a large-scale ongoing emergency by the local population, the crisis has also brought new donors, new NGO's and CBOs into the district, some to help the refugees directly and some to help the Kasulu residents cope with the refugees. In this District, we see the transition from unorganised actions to informal partnership through to highly organised official partnerships involving international agreements with the United Nations.

The Manyovu Ward Executive Officer describes the beginning of the crisis in 1994. *"Police at the border first discovered the problem. We were informed by the people, some of them came to stay with relatives here. We informed the District Council immediately by police radio call. With community leaders and health workers, we worked shoulder-to-shoulder (bega kwa bega) until the Government came to assist us. Mkatanga camp was set up as a temporary camp but when it filled up there was scarcity of food and the refugees became sick. We had to ask for help from the District where we were told that they would report to UNHCR. We requested if we could shift the refugees, as they were too many and increasing. We requested people to help. The community assisted in food, water, firewood, burial sites, to carry refugees to the hospital. We worked in the camps and the wards alternating.*

In the camps, we worked with them to establish leadership. They passed some rules for hygiene and clinic attendance. At the hospitals we set days for the treatment of refugees (Wednesday and Friday) except for emergencies."

The pressure from the refugee population on the Ward is intense, both in terms of population density and needs and in terms of heightened insecurity. The WEO summarises the problems as follows:

- *They come with chronic illnesses that can affect our people*
- *There is environmental degradation. They go into the forests, defecate, cut trees for firewood and building,*
- *The medicines we get in the standard dispensary/health centre drug kit are not enough for ourselves, the refugees come in sick and the medicines finish.*
- *They frighten people and go into their fields to harvest crops by force. They steal crops and go to sell. Some come in with guns and turn to gangsterism.*

An official said, *"They killed one of the Ward Education Co-ordinators. They tied him up, took his bicycle and left his body by the river bank."*

As is their responsibility, the UNHCR has co-ordinated assistance to the refugees and refugee-affected populations. In Kasulu, the UNHCR has established a monthly Inter-Agency Co-ordination Meeting to which all involved NGO's, VA's, the DHMT, donors, CA's and others are invited. Members say that this partnership is good thanks to their common goal of helping the refugees. However, public sector participation could be more regular:

"The district sectors that are invited to the interagency meeting should attend. UNHCR is the convenor of this monthly meeting and some very necessary government sectors do not attend", says one. Another member says, "Relations would improve if meetings were held as scheduled. You cannot collaborate without meetings, communication. Meetings help you to know what the other is doing, after knowing that then you can identify the areas of collaboration."

Trust and mistrust between potential partners

The comments presented in the report so far have shown that both trust and mistrust exists between public and private partners. During the assessment interviews, this topic was discussed with each interviewee. The table on the following page summarises interviewees' attitudes and experiences.

Experiences and attitudes that tend to stimulate mistrust include:

- Supervision which is perceived as inspection or harsh and punitive.
- Family experiences of being overcharged or paying high prices in health facilities.
- Unequal treatment by authorities in resolving conflicts between two disagreeing persons or groups.
- Recruitment of staff by one sector from the other without prior discussion.

- Fear that one cannot count on a partner or fear that a partner may not be able to honour a commitment.
- Lack of transparency over budgets and resources.
- Differences of skills and knowledge.
- Differences in drug prescribing patterns that are interpreted as bad practice. For example, some private health facilities adapt the prescription to the patients' budget, rather than writing a full prescription even if the patient cannot afford it. This is often criticised as bad medicine by supervisors, and upheld as pragmatism by private providers.
- Poor late communications, resulting in missed meetings, late starts for training, exclusion from common activities.
- Fear of change and lack of control over change.

Table 20: TRUST AND MISTRUST BETWEEN PARTNERS

(NUMBERS INDICATE THE NUMBER OF INTERVIEWEES PER CATEGORY)

Public sector opinions	Private sector opinions
1) No mistrust	1) No reasons to mistrust them
2) There is trust	2) Yes, trust exists. We refer patients to the GOT hospital and they provide MCH and TB drugs.
3) Mistrust. Faith organisations overcharge as they are profit making sometimes and not non profit.	3) Yes, because the local government approved creation of the school.
4) I mistrust certain diagnoses in the private hospitals, dispensaries.	4) We trust them but they are not as efficient as we would hope.
5) There is no mistrust.	5) No trust, when they do supervision they come with a bad eye (<i>private, for-profit provider</i>)
	6) No direct involvement with the local government so we cannot say much. Our mistrust comes from our realisation that the local government does not have enough absorptive capacity, especially in emergencies, need to speed implementation and manage resources.
	7) We trust and collaborate with them. They trust us and I can see them without an appointment
	8) No mistrust. We talk freely.
	9) We trust them with the food. They trust us to provide the food.
	10) Mistrust on the future local government capacity to handle all other health service delivery

In general, both public and private sector partners are willing to engage in further partnerships.

Table 21: WILLINGNESS TO ENGAGE IN ADDITIONAL PARTNERSHIPS

Public Sector	Private Sector
<ol style="list-style-type: none"> 1) It is easy to work with faith groups because they are well organised, although they are not transparent about income resources. 2) Yes, needs are many so we should distribute, share the workload. Bring in more resources. 3) We will think about it. 4) Yes we are willing, to achieve increased coverage, reduction of work load and increased efficiency 	<ol style="list-style-type: none"> 1) If this partnership succeeded, the district will deal with preventive services and the private will deal with curative. 2) Yes, beneficial to help patients, improve coverage, problem solving. 3) Yes, in the area of treatments/curative side and prevention because of good collaboration 4) Additional partnerships will increase efficiency of health delivery by private providers and leave the public to do more pressing activities.

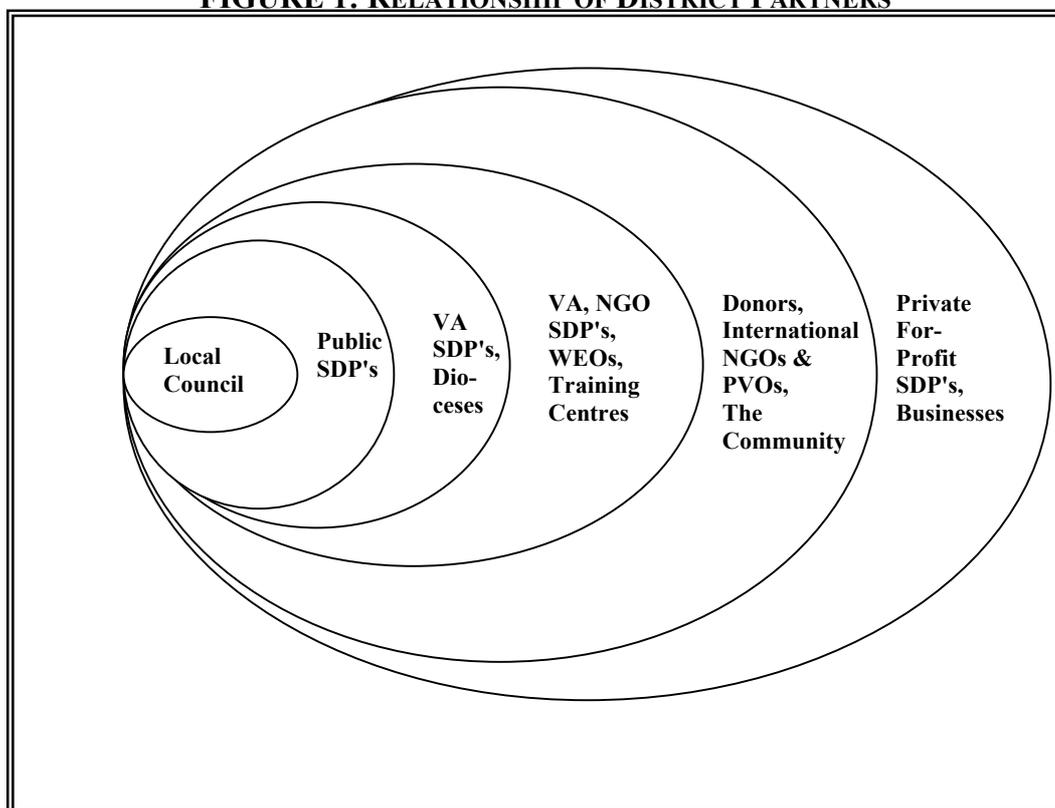
Discussion

Extent and type of existing partnerships in four districts

The results presented in the preceding chapter show that partnerships between the public and private sector do already exist on the district and ward levels. In fact, far more partnerships exist than were expected. However, although the four study districts were chosen because of explicit differences between them in the number and type of potential partners, what is most striking are the similarities in preferences for partners and types of partnerships observed.

If the district were to be represented as a solar system, with the local council at the centre, the "institutional distance" between potential groups of partners might be represented as in the following drawing:

FIGURE 1: RELATIONSHIP OF DISTRICT PARTNERS



The study shows that most partnerships are formal ones. This is not surprising. Most interactions between groups are structured either by official regulations, such as the DDH Agreement and GIA regulations or by the work plans for vertical programmes and special activities. Supporting relationships are almost always defined by MOU's. Contacts between groups are almost always documented, either by letters, meeting minutes or an exchange of documents such as HMIS reports.

Existing formal partnerships are very often vertical partnerships. That is, one partner has more authority than another or is at a higher rung of the hierarchy than another. For example, the decision to engage in joint planning and co-ordination meetings is in the hands of the DHMT. The experience in Kasulu shows that the DHMT may avoid or dissolve communication/co-ordination partnerships even when its private sector partners show continued willingness, and even insistence, on remaining actively engaged. Only in Kilombero District, with the Extended DHMT, has an effort been made to create a official channel for ongoing communication with private sector groups and for participative decision making.

Reciprocity, a characteristic of horizontal partnerships, is seldom observed. Thus, although the DMO sits on the Board of Directors of the VA and DDH Hospitals, the Medical Directors of those hospitals, and even the Bishops or Health Secretaries of the Dioceses, are not automatically members of the DHMT except in Kilombero.

In the area of supervision, some movement from vertical to horizontal partnerships is observed. Supervision is a form of co-operation to improve the quality of service. Each district is implementing some form of supervision of both public and private SDP's. In general, the private SDP's find the supervision useful and wish for it to continue. Yet it is usually the DHMT which sets the supervision schedule and controls the content of the supervisory visit and the type of feedback which is provided. A move towards more collaborative supervision is seen in Iringa and Kilombero. Their joint public-private supervision teams are still in the experimental phase since they do not yet cover all SDP's, but the initial results appear to be attracting other potential participants.

Some horizontal partnerships do exist, and these are often informal. Informal pooling of a capable technician from one institution and the equipment from another institutions occurs in several districts. Informal communication links have been mentioned between faith institutions, between VA's and certain for-profit SDP's, and even, in some cases, between the DMO and some faith institution directors.

It is tempting to characterise the collaboration between the DHMT and the community to construct or renovate a health facility as a horizontal, formal collaboration in which the DHMT brings expertise and oversight and the community brings material and labour. However, it is not clear if communities have a choice in the form of their contribution or whether it is always the DHMT or a donor who decides what the community will provide. A clear case of a horizontal, formal partnership is the renovation of Mount Meru Hospital by the business community, which organises itself as an interest group and defines the form of its support.

What emerges clearly from this assessment is that a very limited definition of the word "Community" is the prevailing operative definition. "Community" appears to be defined as "the individual residents of a geographic area". This definition excludes businesses and businessmen as "corporate residents" which can be called upon to participate in activities. The Mount Meru Hospital experience shows that businesses have resources that can be mobilised for both short-term and long-term partnerships to support health services and that business leaders are willing to invest

in their communities. In other countries, businesses and business philanthropists provide extensive support for NIDs, HIV/AIDS, FP and work site health programmes, emergency interventions, orphan support and IEC campaigns. In Kenya, for example, some tea estates actually contract to manage the public health dispensaries in villages where their workers reside and even construct health centres and provide health equipment to improve the quality of care. In Iringa, Kasulu and Kilombero districts, the business community appears to be a largely untapped resource for health.

Even the most straightforward tendering and contractual relationships with businesses have not been tried in all four of these districts (except for construction). The Iringa District Council sector-wide tendering of secretarial and office supplies support is a very promising example of such collaboration, and one that should be studied more closely.

Few partnerships of any kind exist with the private for-profit health sector (although some supervision is provided). Particular suspicion, on the part of the public and non-profit sectors, is directed towards private pharmacies who are suspected of unscrupulous distribution and price gouging. The general attitude toward the motives of private for-profit health care providers has not evolved greatly since the reform of the Private Practice Act in 1991, re-authorising private care. Although the public sector and non-profit sectors are willing to acknowledge that some private for-profit providers offer services of adequate or high quality, they are critical of the prices charged and of the prescribing practices. Yet, because many public sector practitioners have their own private dispensary or group of private patients in the same district, it is possible that this attitude contains some part of competitive jealousy in disguise. Such jealousies seem un-merited, as the Tanzanian health sector is far from saturated and health needs are great. In wards in which a private practitioner is the only health provider present, opportunities might exist for extending public health access through contracting or a collaborative MOU with that provider.

Factors hindering partnerships

The following factors were cited by the interviewees as hindering the development or maintenance of partnerships:

- Lack of a forum for communication where all providers can discuss their problems and solutions.
- Lack of regular meetings, and the supply of poor, tardy, incomplete information about meetings and other group activities -- all of which prevent participation.
- The large number of private sector providers, and the lack of mechanisms for regrouping and representing them, makes it difficult for DHMTs to invite them all to planning sessions and to work with them individually.
- Infrequent discussions about norms and standards for quality of care.
- Frequent changes of staff that require retraining and constructing new relationships, instead on building on continuity

- Lack of transparency, and unwillingness to share information about capacity, including sensitive information about budgets and revenues
- Decision making processes that are out of the hands of the actual partners. (An example of this is the engagement-disengagement-re-engagement discussion of the Roman Catholic SDP's in Iringa over participation in the Community Health Fund. The actual decision will be made by the Diocese at an unknown date.)
- Mode of supervision; authoritarian supervision puts off providers and blocks two-way communication. It can even discourage some from

Analysis of the interviews as a group also revealed other factors hindering partnerships:

- Lack of information about potential partnership modalities, their advantages and mechanisms.
- Lack of information about the Local Government Reform, the Health Sector Reform, basket funding and other essential changes.
- Inaction and lack of discussion among actual partners faced with common problems of reform such as the future of seconded personnel.
- Inadequate forward thinking about sustainability and project hand-over from NGO's running pilot programmes to the DHMT or another partner after the initial phase ends. (The two examples of this are the Iringa CBD programme and the Kasulu inter-sector health planning meetings.)
- Prejudices and misconceptions about potential partners or the simple exclusion of some groups (such as businesses) from partnership. An example is the complete exclusion of the business community from the Kilombero NID.

Factors favouring partnership

There is almost complete consensus among the districts and the sectors on what constitutes good partnership and the factors favouring partnerships. Factors cited by the interviewees include:

- Regular meetings with frank discussion and group problem solving
- Structures that bring together partners enhance communication
- Joint planning and transparent exchange of information
- Joint assessment of training needs, joint training sessions
- Common objectives developed together through a consensual process
- The possibility for informal communication with authorities through unplanned visits and formative supervision
- Uniformity in the HMIS system and logistics systems
- Performing joint public-private supervision of SDP's
- Being able to count on a partner for informal collaboration or assistance
- Stable personnel so that long term relationships may be developed
- Geographical proximity and/or field visiting for face-to-face contact
- Friendly, formative supervision favours dialogue and partnership.

Analysis of the interviews also shows some additional factors that make partnerships succeed:

- Partnerships between sectors appear to succeed when there is clear definition of each group's role and terms of reference.
- Short-term partnerships for single precise tasks with the community appear to be more common and successful. The mid-term partnerships for ongoing activities, such as CBD and HIV/AIDS activities are either just beginning or have not yet proved to be viable without intensive support of an NGO or other form of proximity technical assistance.
- Partners learn from experience. There are several cases where partners learned from an initial poor or chaotic experience and created a more effective plan or process to face the next incidence of a problem.
- The interests of each partner and the benefits from the partnership for each partner must be clear. Once these are clear, minor problems can be dealt with. (An example is the purchasing tenders for supplies, where payment delays are tolerated by merchants because there is a clear process for payment.)
- For tenders, honouring financial commitments and 100% payment favour trust and increase willingness to pursue further partnerships.

Conclusions

This rapid assessment identified public-private partnerships for health services delivery in four districts, Arusha Municipality, Iringa Rural, Kasulu and Kilombero. In each district existing partnerships, as well as a variety of additional potential partner organisations, were found. The majority of existing partnerships are between the District Council and District Health Management Team and health facilities and training institutions owned by faith institutions and NGO's.

Partnerships for curative service delivery are almost entirely regulated by the central MOH agreements for financial support and seconded staff of District Designated Hospitals and Medical (Grants-in-Aid) for Voluntary Agencies. No experiments in contracting of health services delivery (other than the central MOH agreements) were found. However, in each district, some multi-sectoral HIV/AIDS activities are taking place with partners from the village, ward and district levels, the most exceptional being the INGONET.

Preventive health partnerships and the HMIS system partnership are very largely determined by centrally organised vertical programmes which were initially designed and implemented as collaborative ventures so as to increase access to services and information.

Partnerships are weaker and more variable for core functions such as planning, budgeting and supervision. Core function partnerships are controlled principally by the DHMT who appears able to expand or limit the range of partners it works with and even to refuse certain types of co-operation. Very few experiments in tendering for goods or services, outside of SDP renovation and construction, have been attempted.

Partnerships for training are constrained by the presence of a single or at most two training schools in a district -- however these partnerships are usually characterised as successful. Training schools have varied sources of funding and participants; their relative independence and their status may make them seem particularly valuable partners.

Most formal partnerships take the form of ongoing collaboration for the execution of a common work plan and objectives set by the DHMT or the central MOH. Two examples of failed transitions from pilot programmes to ongoing activities overseen by the DHMT were noted; planning for the end of formal partnerships is insufficient and development organisations may not recognise that the DHMT must participate throughout a pilot in order to increase the likelihood of programme continuity.

Far fewer informal partnerships were identified than were expected. This may partly be due to research bias, in that periodic informal co-operation and communication may not have been recognised as partnerships by interviewees and field researchers. (Similarly, the very limited number of business partnerships identified in Iringa and Kilombero Districts may be due to insufficient probing.) Nevertheless, the fact that groups almost always deal with each other in their formal capacities mean that most interactions leave a formal record, whether it be minutes of a meeting, letters, issue vouchers or more formal MOU's, work plans and contracts.

Despite these formal relations, open, regular communication is limited. Some opportunities modalities of information exchange are under-utilised. For example, written feedback on supervision is rarely provided. HMIS information are under-exploited. Feedback on HMIS is usually limited to reporting rates and corrections, rather than substantive discussion and interpretation. More serious, few private sector providers and other partners are involved in planning and budgeting; associations or coalitions to represent them on the DHMT have not been formed. Only in Kilombero, with its Extended DHMT, has a process been found to include such partners systematically. The presence of the DMO on the Board of Governors of VA Hospitals and DDH's is considered useful and positive by the faith institutions.

Private for-profit providers and the business community are almost entirely excluded from partnerships. It is possible, even probable, that opportunities are being missed for improving access to key preventive services and for leveraging support for local activities. In particular, the very low level of participation by business in the National Immunisation Days, as compared that observed in other countries, is a signal that this part of Civil Society is being ignored as a potential partner.

Most encouraging for the future of public-private partnerships on the district level are the successful partnerships in vaccination, NIDs, SDP construction and renovation (particularly the Mount Meru Hospital experience) and in facing emergencies. Equally encouraging are the joint training activities, the Extended District Health Management Team in Kilombero and use of public and private SDP's

as practical training sites. These partnerships should be maintained and used as examples to others.

The public-private partnerships observed in these districts mirror the situation found on the national level. Relations between the MOH and private sector providers are constrained by lack of established mechanisms for regular dialogue so necessary for creating trust and grounds for collaboration. Formal mechanisms exist for collaboration with the faith institutions and the recent formation of the Christian Social Services Commission to regroup and represent them is a significant step forward. Similarly, the recent formation of the Association of Private Hospitals of Tanzania creates a much-needed channel for communication to the private for-profit sector. As in the districts, leverage of business support for health and HIV/AIDS activities has been quite minimal, yet evidence from recent discussions with the private sector Technical AIDS Committee and other representatives suggest great potential and interest. While the Sector-Wide Approach is gradually being used for national donor funding and organisation, sector-wide thinking and collaboration is only in its infancy.

Therefore, the results of this assessment should neither disappoint nor surprise. They simply show that the need for public-private partnership and the willingness of private sector potential partners to collaborate more fully is only now being recognised. They also show that more conscientious efforts and explicit actions from both the central and district levels to nurture partnerships are needed to realise this potentiality for an expanded sector-wide approach to a quality health care system.

Recommendations

The results of this district assessment will be combined with those of the legal assessment conducted in September-November 2000 and those of the four stakeholders' workshops conducted in August and September. These results will be used in several ways in the coming year. Primarily, they will be used to refine the Government's strategy for encouraging and facilitating public-private partnerships and to set the baseline against which changes will be measures.

Secondly, the case studies and examples found by this assessment will be used to develop advocacy materials for specific reforms and to inform potential partners about modalities and opportunities.

Additionally, results from this assessment can be used to identify areas in which capacity building and technical support are needed to enable the public and private sectors to engage in effective partnerships. The results show several areas in which technical support for institutional strengthening would be useful.

Copies of this assessment report will be distributed to the DHMTs and principal private sector partners. DHMTs which find this assessment interesting are encouraged to consider conducting their own assessment. The entire protocol may be used or questionnaires covering specific areas of interest can be selected. The protocol and questionnaires for the assessment will be provided to interested

districts and other groups by Dr. Peter Mmbuji, Strategy Seven Co-ordinator, Directorate of Hospital Services, Ministry of Health.

The assessment results point clearly to a number of obvious yet important recommendations. The following will guide the activities during the next period of work:

1. District planning and budgeting will be more effective if private sector health facilities, training facilities and HIV/AIDS groups are included. To facilitate this, district associations should be formed of private sector providers, NGOs and CBOs involved in health (and HIV/AIDS) and representatives should be elected to participate as standing members of Extended District Health Management Teams.
2. Central Government (MOH, PORALG) should provide regular information to the districts and partners on the evolution of the reforms and on basket funding. This information should be discussed openly at the district level.
3. Additional forums to discuss the problems of seconded staff should be organised by the District Councils and, as a first step, problems and questions should be noted and communicated to the regional and central government.
4. Any pilot activity should involve the DHMT from the start so as to increase the probability of a smooth transition from intense NGO/CA/donor support to normal functioning. A transition plan should be worked out well in advance of the termination of initial support.
5. Opportunities to leverage business support for district health services, in terms of contributions to NIDs, HIV/AIDS clusters and other community activities, and development of work site/employee health programmes should be sought out and encouraged.
6. District Councils should evaluate potential cost savings and effectiveness of tendering the purchase of goods and services.
7. Opportunities to extend access to preventive services and offer public health coverage of under-served areas through contracting, MOU's and collaboration with isolated private for-profit providers should be examined closely by DHMTs.
8. Finally, successful partnerships should be identified, preserved and encouraged, according to the maxim "Don't fix what isn't broken".

Annex 1: List of Questionnaires

The protocol includes the following questionnaires:

1. **District/municipality cover sheet.** This page summarises the work completed during the field visit and provides an inventory of completed questionnaires. This should be filled in at the end of the visit by the team.
2. **Health Services Inventory.** A series of tables inventorying the health services offered in the district or municipality. This should be filled in on Day One during the long meeting with the DHMT. If necessary, work on this table could continue with one or more members of the DHMT later on during the week. The HMIS person may have information for this table. If the DHMT has ready made lists with the same information, photocopies may be attached to the questionnaire.
3. **Services and Personnel.** Provides an overview of services and relationships within the district and gathers information about public sector personnel. This should be filled in on Day One during the long meeting with the DHMT.
4. **Budget and Planning.** Summarises public health financing and provides an overview of planning in the district. Explores the level of collaboration for planning and provides a first look at communication between the public and private sectors. The District Financial Officer and the District Planning Officer might have some information, but it is most likely that the DMO is the main resource. If possible, discuss planning with the DPO to get a second opinion on the level of interaction. This should be filled in on Day One during the long meeting with the DHMT. If necessary, leave the budgeting questionnaire for completion during the week.
5. **HMIS.** This questionnaire has two parts, one for the DHMT or the person responsible for the HMIS in local government. The other part should be completed with each private health facility that is visited. This questionnaire explores the level of integration and participation of the private sector into the public HMIS system. This may be a delicate or touchy subject with private sector institutions.
6. **Equipment.** This questionnaire notes the equipment loaned by the public sector to private facilities and the type of collaboration surrounding these loans. It should be completed by the District Cold Chain Supervisor or the MCH Co-ordinator or both. This questionnaire could be left with them for completion during the week.
7. **Public Sector Training.** Gather information about pre-service and in-service training in the district. Probably more collaboration arises from in-service training, so probe this area thoroughly. Propose this subject during the long meeting with the DHMT, but also try to visit the public training sites, if any, and interview the principal.
8. **Vaccination campaigns.** These campaigns are almost always the focus of recurring informal partnerships. Get as much detail as possible about WHO DOES WHAT. Explore this subject thoroughly with the District Cold Chain Supervisor or the MCH Co-ordinator or both, during a separate discussion. Separate questionnaires on the same subject are provided for private sector health facilities. Interview the director or medical officer or the person responsible for EPI.
9. **Emergency Preparedness.** Every district or municipality probably has a plan, but only a few will have actually had an emergency. If you find an emergency, get as much detail as possible about who did what and how the different institutions did or didn't work together. Explore whether this was a successful or damaging experience for relations between the public and private sectors. There are separate questionnaires for the DHMT and the DED or DC, for the private health facilities and for the Ward Leader.

10. **Construction/renovation of a health facility.** These projects always involve multiple partners and usually informal groups. This questionnaire should focus either on a project currently underway or on the LAST project completed in the district. Identify the project with the DMO. Then, meet with the person who was responsible for general management of the project, whether someone from local government or someone from a voluntary organisation, an NGO, a donor, or someone else. This questionnaire is in two parts. Probe thoroughly to identify any informal partners, like the community, and any business partners, like plumbers or electricians who may have been engaged for part of the work.
 11. **HIV/AIDS Interventions.** Discuss this subject first with the District HIV/AIDS Co-ordinator, if there is one, or with the DMO. Then, try to visit at least one health facility or community group which is working in this area. Try to get information both on health activities, including condom distribution, and on social support activities, like feeding programmes for patients or orphan programmes, or agricultural assistance to families with AIDS patients. If there is a group of People Living With AIDS, try to visit it. Copies of the same questionnaire can be used for all groups.
 12. **DDH Hospitals, Voluntary Agency Collaborating Hospitals.** This questionnaire is only for non-profit hospitals with contracts with the MOH. Try to meet the Medical Officer in charge or the Director or other top level person. It is important to define the type of contract and who are the signatories (diocese? NGO?). The questionnaire covers contractual relations and explores the extent to which the institution collaborates actively with the local government health officials. Relations may be cold, ambiguous or even hostile, so be prepared to explore this area carefully to understand WHY and HOW this negative situation works. On the other hand, if relations are good, explore thoroughly the FACTORS FOR SUCCESS.
 13. **Voluntary and NGO outpatient health facilities.** This questionnaire is only for health centres and dispensaries. It could eventually be completed at the local headquarters of an NGO or voluntary agency which runs health facilities in the district. It explores relations and collaboration with the private sector and with other private health facilities and community groups within the district. Relations may be different than those you find in hospitals, so be prepared to explore this area carefully. If you find a good example of a partnership, take notes on details and explore thoroughly the FACTORS FOR SUCCESS.
 14. **Private Sector Personnel.** This questionnaire, although shorter than the one for the public sector, explores similar areas of training and personnel, including seconded personnel. Interview the Medical Officer or person in charge of the health facility or NGO of hospitals, health centres and dispensaries.
 15. **Trust and Mistrust Among Partners.** At the end of each interview with a private health facility and on Day Five with the DHMT, use this questionnaire to discuss obstacles to partnership and the level of trust and mistrust between the public and private sectors. You may find that this subject has arisen spontaneously during the interview, in which case use the questionnaire to regroup the comments you heard.
 16. **Partnerships-Successes/Failures.** Use this questionnaire at the very end of interviews with groups that have actually had partnerships already and with the DHMT. Ask them to reflect on those partnerships and try to define the conditions for success and those insurmountable obstacles that made others fail. Often, interviewees will have thought about this subject already and have clear ideas to share.
 17. **Ward Executive Officer Questionnaire** Only for use if you visit a ward. If you find a construction project or an emergency, complete those questionnaires.
- Business leaders.** Only for use if you visit a business which has participated in a vaccination campaign or which offers health care to its personnel or which is a contractual partner of the DHMT for a good or service. Try to visit at least two businesses or estates.

Annex 2: Case Studies

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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

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

committee accepted the challenge and asked the 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 29th 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 8th 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 12th 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 Solomon 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/Optomestrist
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.⁹ 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.

⁹ 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).

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.

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 zinashohuhulika 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.

<u>Iringa Urban Cluster NGOs</u>
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

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

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

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.

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.
- 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

Cutting on the wall in the
INGONET office

*Get drunk, get stupid,
get AIDS*

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 2nd 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:

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

The District Tender Board

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

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

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

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

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.

LPO vote book adjustments

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

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.

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.